Health and Welfare

Benefits Handbook

For coverage effective January 1, 2012

Benefits Handbook for health and welfare plans

Your benefits are a valuable part of the rewards of working at Citi. To make the most of your benefits, you need to understand how they work.

This Benefits Handbook will help you do just that. It provides general information that will help you understand how the plans work so you can make the most of your benefits.

Additional tools

This site features several tools to help you find information about Citi benefits.

- Citi for You eGuide – Check out this video guide for news about your Citi benefits.
- Explore the Employee Roadmap, which list all the benefits Citi provides in one place. You can find contact information about a program quickly, in just a few clicks.
- Visit **Steps to enrollment** to access all the resources you need to enroll in your 2012 benefits coverage.

The Handbook describes the health and welfare benefits available effective January 1, 2012. It contains the official documents for your Citi health care and insurance benefits plans.

In the Benefits Handbook

The information in this Benefits Handbook is broken up into sections, including:

- About this Benefits Handbook
- Eligibility and participation
- Health care
- Spending accounts
- Disability coverage
- Insurance benefits
- Administrative information
- Glossary
- For more information

Your Spending Account™ website

The Your Spending Account™ (YSA™) website makes it easy for you to manage your spending accounts. You can file claims, confirm which expenses are eligible, check your account balance, and more! See the YSA™ Guide for more information.

No Internet access?

If you do not have access to the Citi intranet or the Internet, you can request a copy of the Benefits Handbook at no cost to you by speaking with a Citi Benefits Center representative.

- Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.
- From outside the United States: Call the Citi Employee Services (CES) North America Service Center at **1-469-220-9600**. Press 1 when prompted. From the ConnectOne main menu, choose the "health and welfare benefits" option.
- If you use a TDD (telecommunications device for the deaf): Call the Telecommunications Relay Service at 711 and then call ConnectOne as instructed above.

Puerto Rico

See the English and Spanish version of the 2012 annual enrollment guide for information about changes to the plans for 2012 as well as the 2008 Summary Plan Description listed below:

- 2008 Health and Welfare Benefit Plans (English)
- 2008 Health and Welfare Benefit Plans (Spanish)

You can view earlier versions of the Benefits Handbook in the Archives.

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About this Benefits Handbook

This Benefits Handbook, available at www.benefitsbookonline.com, serves as the plan document *and* Summary Plan Description (SPD) for health and welfare benefits for specified U.S. employees of Citigroup Inc. ("Citigroup" or "Citi") and its participating companies (collectively the "Company") as in effect January 1, 2012. Citi reserves the right to change or discontinue, at any time, any or all of the benefits coverage or programs described here. The benefits described in this Benefits Handbook are:

- Citigroup Health Benefit Plan
  - Aetna ChoicePlan 500;
  - Aetna High Deductible Health Plan-Basic and Premier;
  - Empire BlueCross BlueShield High Deductible Health Plan - Basic and Premier;
  - Empire BlueCross BlueShield ChoicePlan 500;
  - Oxford Health Plans PPO (a United HealthCare company);
  - United HealthCare Hawaii Health Plan;
  - Fully insured health maintenance organizations (HMOs);
  - Citigroup Prescription Drug Program administered by Express Scripts;
  - Medco Prescription Drug Program (for Oxford Plans in NY, NJ, CT); and
  - On-site medical clinics.
- Citigroup Dental Benefit Plan
  - Cigna Dental HMO; and
  - MetLife Preferred Dentist Program (PDP).
- Citigroup Vision Benefit Plan
- Citigroup Wellness Benefits
- Citigroup Employee Assistance Program
- Citigroup Work/Life Program
- Citigroup Disability Plan
- Spending Accounts
  - Health Care Spending Account (HCSA);
  - Limited Purpose Health Care Spending Account (LPSA)
  - Dependent Day Care Spending Account (DCSA); and
  - Transportation Reimbursement Incentive Program (TRIP).
- Life Insurance
  - Citigroup Basic Life and Accidental Death and Dismemberment (AD&D) Insurance;
  - Group Universal Life (GUL) and Supplemental AD&D Insurance; and
  - Citigroup Business Travel Accident/Medical Insurance.
- Citigroup Long-Term Care Insurance Plan.

This Benefits Handbook is intended to comply with the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and other applicable laws and regulations. In addition, this Benefits Handbook is designed to comply with the requirements of a cafeteria plan under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code").

This Benefits Handbook has been written, to the extent possible, in non-technical language to help you understand the basic terms and conditions of the health and welfare benefit plans described (the "Citigroup Health and Welfare Plans" or collectively the "Plans" and individually a "Plan").

The Plans are subject to the provisions of ERISA, with the exception of DCSA and TRIP. This Benefits Handbook serves as the plan document and summary plan description (SPD) for the Plans subject to ERISA and the Code, as applicable. To the extent applicable, the Plans will be interpreted and administered in accordance with ERISA, the Code, and applicable law.

The terms and conditions of these Plans may be further prescribed in insurance policies, the provisions of which, as may be amended from time to time, are hereby incorporated by reference.

If you do not have access to the Citi intranet or the Internet, you can request a copy of the Benefits Handbook at no cost to you by speaking with a Citi Benefits Center representative. Call ConnectOne at **1-800-881-3038**. From the ConnectOne main menu, choose the "health and welfare benefits" option. Representatives are available from 8 a.m. to 8 p.m. Eastern time on weekdays, excluding holidays.

About this Benefits Handbook

This Benefits Handbook provides no guarantee that you are eligible to participate in every benefit or program described. Each Plan may have its own eligibility requirements, so be sure to review individual eligibility requirements carefully. In addition, Citi in no way guarantees the payment of any benefit that may be or becomes due to any person under the Plans.

Benefits provided under the Plans described in this Benefits Handbook are not in any way subject to you or your dependent's debts or other obligations and may not be voluntarily or involuntarily sold, transferred, alienated, or encumbered.

Your right to receive any reimbursement under the Plan shall not be alienable by assignment or any other method and shall not be subject to being taken by your creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

Medicare eligible?

If you and/or your dependents are enrolled in Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices for your prescription drug coverage. See the Health Care Benefits section for details.

Tax information

This Benefits Handbook includes summary information about the federal tax treatment of employee benefits. It does not address state or local tax consequences. The information provided here is general guidance only and may not be relied on as tax advice for any purpose. Citigroup Inc. and its affiliates are not in the business of providing personal tax or legal advice to its employees. The information in this document is not intended or written to be used — and cannot be used or relied on — by any taxpayer to avoid tax penalties.

For information on how applicable tax law may apply to your personal situation, consult your tax adviser.

No right to employment

Nothing in this document represents or is considered an employment contract, and neither the existence of the Plans nor any statements made by or on behalf of Citi shall be construed to create any promise or contractual right to employment or to the benefits of employment between Citi and any individual. Your employment is always on an at-will basis. Citi or you may terminate the employment relationship without notice at any time and for any reason.

Eligibility and participation

Your Citi health and welfare benefits are a valuable part of the rewards of working at Citi. To make the most of your benefits, you need to understand how they work. This section describes the eligibility and participation rules for the following Citi benefit plans and programs:

- Health care benefits (medical, prescription drug, dental, vision, and wellness benefits);
- Spending accounts;
- Employee Assistance Program;
- Disability coverage; and
- Insurance benefits (including Basic Life and Accidental Death and Dismemberment [AD&D], Business Travel Accident/Medical, and Long-Term Care).

Section contents

Benefits overview

Citi provides a basic level of benefits coverage, called core benefits, as well as the opportunity to enroll in additional coverage for yourself and your family. Coverage is effective on your date of hire or the date you become eligible for benefits. Other than for the core benefits, you must enroll to have coverage.

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

- **Basic Life and Accidental Death and Dismemberment (AD&D) insurance**, each equal to your total compensation, if less than $200,000, on your date of eligibility. Basic Life insurance is administered by MetLife, while AD&D is administered by Cigna; if your total compensation is equal to or exceeds $200,000, you are not eligible for Basic Life/AD&D insurance;
- **Business Travel Accident/Medical insurance**, administered by ACE American Insurance Company, of up to five times your total compensation to a maximum benefit of $2 million; and medical coverage related to covered accidents and/or sickness while traveling on behalf of Citi;
- **Employee Assistance Program (EAP)**, administered by Harris Rothenberg International LLC; a confidential, professional counseling service designed to help you and your family resolve issues that affect your personal lives or interfere with job performance;
- **Citi Live Well Program**, administered by Health Advocate and ActiveHealth; Citi's comprehensive health and wellness program provides you and your family with the tools and resources to manage your health care and help you achieve your health goals;
- **Work/Life Program**, administered by Health Advocate; provides assistance and helps employees save time as they face common everyday challenges, such as finding child care, free legal assistance, help with identity theft, and more;
- **Short-Term Disability (STD) coverage**, administered by MetLife; coverage to replace generally up to 100% of your annual base salary for an approved disability leave of up to 13 weeks; the number of weeks at 100% pay will depend on your length of service with Citi; see "Short-Term Disability (STD)" in the Disability section for the STD schedule of benefits that applies to you; and
- **Long-Term Disability (LTD) coverage**, administered by MetLife, equal to 60% of your total compensation, provided your total compensation is less than or equal to $50,000.99.

Additional benefits to consider that require active enrollment:

- Benefits paid with before-tax dollars (as long as you are receiving a paycheck):
  - Medical (including the Health Savings Account (HSA) if you are enrolled a High Deductible Health Plan);
  - Dental;
  - Vision;
  - Health Care Spending Account (HCSA);
  - Limited Purpose Health Care Spending Account (LPSA);
  - Dependent Day Care Spending Account (DCSA); and
  - Transportation Reimbursement Incentive Program (TRIP).
- Benefits paid with after-tax dollars:
  - LTD, if your total compensation is $50,001 and above; if your total compensation is below this amount, LTD is a core benefit provided at no cost to you;
  - Group Universal Life (GUL) and Supplemental AD&D insurance; and
  - Long-Term Care insurance.

Eligibility

Citi provides benefits coverage for you, your spouse (same or opposite sex), civil union partner or qualified domestic partner, and/or eligible dependents.

For employees

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

- You work in the United States for Consumer Banking, North America Cards, Institutional Clients Group, or Corporate Center or one of their participating businesses; and
- You are an active:
  - Full-time employee (regularly scheduled to work 40 or more hours a week); **or**
  - Part-time employee (regularly scheduled to work at least 20 or more hours a week); **and**
- You receive regular biweekly or monthly pay; and
- You are employed by a participating employer.

A "participating employer" is Citigroup Inc. and any subsidiary in which Citi owns at least an 80% interest. Consumer Banking, North America Cards, Wealth Management, Institutional Client Group, and the Corporate Center are the Citigroup businesses that participate in the Plans.

For purposes of determining whether you are an eligible employee under the Plans, you are an "active" employee if you are working for your employer doing all the material and substantial duties of your occupation at your usual place of business or some other location that your employer's business requires you to be or absent from work solely due to vacation days, holiday, or scheduled days off.

Note: If you are on an approved leave of absence your eligibility for certain benefits may change. Refer to the "Continuing coverage" section within this document for additional details.

If both you and your spouse (same or opposite sex)/civil union partner/domestic partner are Citi employees

If both you and your spouse (same or opposite sex)/civil union partner/domestic partner are employed by Citi and are benefits-eligible, each of you can enroll individually or one of you can enroll and claim the other as a dependent. You cannot enroll as an individual *and* be claimed as your spouse's/civil union partner's/domestic partner's dependent.

Plan	Applicable rules
Medical, dental, and vision	Each of you may be covered under the medical and dental plans as either an employee or a dependent but not as both. Either of you may cover your children, but they cannot be covered by both of you.
Health Care Spending Account ("HCSA")	Either of you may contribute to a Health Care Spending Account but you may not file more than once for reimbursement of the same eligible expense. However, your civil union partner, or your qualified domestic partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of Section 152 of the Code as determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.
Limited Purpose Health Care Spending Account ("LPSA")	If either of you enrolls in the Citi Basic or Premier High Deductible Health Plan, either of you may contribute to a LPSA but you may not file more than once for reimbursement of the same eligible expense. Neither of you can enroll in the HCSA, and you may be reimbursed only for dental, vision, or preventive care expenses under this account. Your civil union partner or your qualified domestic partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.
Health Savings Account ("HSA")	The maximum amount that can be contributed to an HSA for the 2012 calendar year is $6,250 for family coverage. This does not mean that both family members can contribute $6,250 each, it is a combined contribution amount. Citi makes up to a $1,000 annual contribution for employees with family coverage and up to $500 for individual coverage.
Dependent Day Care Spending Account ("DCSA")	Either of you may contribute to a Dependent Day Care Spending Account but you may not file more than once for reimbursement of the same eligible expense. Your civil union partner, or your qualified domestic partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of Section 152 of the Code as determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.

Eligibility and participation

Plan	Applicable rules
Transportation Reimbursement Incentive Program ("TRIP")	Spouses (same or opposite sex)/civil union partner/domestic partner are not eligible to enroll in TRIP.
Group Universal Life ("GUL") / Supplemental AD&D	Each of you may be covered under the GUL plan as either an employee or a dependent, but not as both. Either of you may cover your children, but they cannot be covered by both of you.
Live Well Credits	**Health Assessment:** Rewards for you and your spouse (same or opposite sex)/domestic partner/civil union partner will be applied to the employee that has medical coverage for the company couple. If neither of the couple has medical coverage, then dental or vision will be used to determine appropriate assignment of this reward. **Tobacco Free:** You and your spouse (same or opposite sex)/domestic partner/civil union partner should coordinate your elections so the "Spouse Tobacco Free Reward Attestation" is elected on the account of whoever has elected medical, dental or vision coverage. **Note:** If Tobacco Free Reward Attestation is elected both as a "Spouse Tobacco Free Reward Attestation" and "Employee Tobacco Free Reward Attestation", then the "Spouse Tobacco Free Reward Attestation" Reward will be removed from your account.
Employee Assistance Program ("EAP")	Both you and your eligible dependents are covered under this program.

When you are not eligible to enroll

You are not eligible to enroll in the Plans if:

- Your compensation is not reported on a Form W-2 Wage and Tax Statement issued by a participating business;
- You are employed by a Citi subsidiary or affiliate that is not a participating business;
- You are engaged under an agreement that states you are not eligible to participate in the applicable Plan or program;
- You are a non-resident alien performing services outside the United States; or
- You are classified by Citi as an independent contractor or consultant, or you are employed on a temporary basis, hired with the intent to work fewer than six months, or you are not classified as an active full-time or part-time employee, as described above.

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

If you are a U.S. citizen or legal resident employed outside the United States or if you are otherwise unsure whether you are eligible to participate in the Plans, call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. You can also contact Human Resources for more information.

No pre-existing condition limitations

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

For dependents

When you add a new dependent to your coverage, you will be required to submit proof of the dependent's eligibility for coverage (for example, a marriage license or birth certificate). If proof is not received by the deadline stated in the dependent verification package, the dependent(s) will be dropped from coverage.

Your eligible dependents must be U.S. citizens or legal residents and generally are:

- Irrespective of sex, your lawfully married spouse, or your common-law spouse if you live in a state that recognizes common-law marriages, same or opposite sex, or your civil union partner, if you live in a state that recognizes such partnerships; if you are legally separated or divorced, your spouse is *not* an eligible dependent unless mandated by state law; at any time, you cannot cover more than one person as your spouse/civil union partner or domestic partner.
  - **Note:** Because civil union partnerships are recognized by certain states and generally provide the same protection as marriage, civil union partnerships are not subject to the domestic partnership certification process. However, under federal law, civil union partnerships are subject to the same tax treatment as domestic partnerships. Alternatively, if your domestic partnership is registered in any state or under any local government authority authorized to provide such registration, documentation of such registration will be accepted as proof of your domestic partnership, without satisfying the listed requirements for nonregistered domestic partners.
- Your domestic partner;
- Your domestic partner's eligible dependents;
- Your children up to age 26 who are:
  - Your biological children;
  - Your legally adopted children;
    - For purposes of coverage under the Plans, adopted children will be considered eligible dependents when they are lawfully placed in your home for adoption or when the adoption becomes final, whichever occurs first.
  - Your stepchildren; and
  - Any other child for whom you are the legal guardian in accordance with the laws of the state in which you reside.

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

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

Please note that not all HMOs cover civil union partner's/domestic partner's and/or their children. For more specific information, contact your HMO directly.

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

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

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

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

For domestic partners

You are eligible to enroll your domestic partner who is a U.S. citizen or legal resident in Citi coverage if you are a U.S. employee who is active or on an approved leave of absence. For GUL or Long-Term Care insurance to be effective for your domestic partner, you must be actively at work.

To be eligible for coverage, you and your partner may be of the same or opposite sex and if your domestic partnership is registered in any state or under any local government authorized to provide such registration, your registration will be accepted as proof of your domestic partnership, or both of you must meet the following criteria:

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

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

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

To cover a domestic partner, you and your domestic partner must first complete forms attesting to your domestic partnership. Alternatively, if your domestic partnership is registered in any state or under any local government authority authorized to provide such registration, documentation of such registration will be accepted as proof of your domestic partnership, without satisfying the previously listed requirements. If your domestic partnership ends, you and your domestic partner must attest to the termination of your domestic partnership. Alternatively, if your registration (as noted above) is terminated or no longer effective pursuant to state law or local government authority, documentation to that effect will be accepted as proof of the termination of your domestic partnership. You can obtain the required documents 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 must wait six months from the time your termination attestation form is received before you can add a new domestic partner.**

The children of your domestic partner are eligible for coverage if they are U.S. citizens or legal residents, are under age 26 as of December 31 of the plan year that precedes the year for which coverage applies, and they are your domestic partner's:

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

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

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

For Long-Term Care insurance, dependents must be age 10 or older. See the 'Insurance' section for more information

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

HMO eligibility

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

1. Coventry Health Care of Iowa;
2. Geisinger Health Plan (Pennsylvania);
3. Health Plan Hawaii Plus (HMSA);
4. SelectHealth (Utah and part of Idaho);
5. Independent Health (upstate New York);
6. Kaiser FHP of California - Northern;
7. Kaiser FHP of California - Southern;
8. Kaiser FHP of Colorado;
9. Kaiser FHP of Georgia;
10. Kaiser FHP of Hawaii;
11. Kaiser FHP of the Mid-Atlantic States;
12. Presbyterian Health Plan (New Mexico); and
13. Sanford Health Plan (South Dakota).

For more information, use the information on "Health care plan offered by Citi" to contact the insured HMO provider in your state. Coverage may be available only on an after-tax basis if your covered children are not your tax dependents, and other costs may apply.

Other coverage

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

However, if you are enrolling in coverage from two sources, be sure you understand how benefits are paid when you are covered by two group medical plans or group dental plans. In many instances, you may pay for coverage from two group plans but you will not receive double benefits or even be reimbursed for 100% of your costs as a result of what is called "coordination of benefits." See "Coordination of benefits" on page 40 for the guidelines on whose plan pays first.

Health Advocate

Health Advocate can help you understand your benefits and compare the costs and benefits of different plans. Call **1-866-449-9933** and select option #2 to speak with your Personal Health Advocate.

Enrollment

You can enroll in Citi coverage within 31 days of the time you first become eligible or during the annual enrollment period. Your enrollment materials will contain the coverage available to you, the enrollment deadline, and how to enroll. You can enroll in any or all of the plans offered to you.

Coverage categories

Citi offers four coverage categories for medical and dental coverage:

- Employee Only: Coverage for you only;
- Employee Plus Spouse/Partner: Coverage for you and your spouse (same or opposite sex)/civil union partner/domestic partner only;
- Employee Plus Children: Coverage for you and your eligible children including the eligible children of your civil union partner/domestic partner; and
- Employee Plus Family: Coverage for you, your spouse (same or opposite sex)/civil union partner/domestic partner, your eligible children, and your civil union partner's/domestic partner's eligible children.

You can choose a different coverage category for medical and dental. For example, you might enroll in "Employee only" coverage for medical, since your spouse has medical coverage from his or her employer and "Employee + spouse" for dental coverage if your spouse's employer does not offer dental coverage.

Each category has a different cost. In addition, your cost for medical coverage will depend on your total compensation band as defined in "Your contributions" on page 21. You will find your costs in your enrollment materials.

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

Changing your coverage category

You can change your coverage category during the annual enrollment period and within 31 days of a qualified change in status. See "Changing your coverage" beginning on page 25 for more information.

As a new hire or newly eligible for benefits

As a newly-hired benefits-eligible employee, or if you are newly eligible for benefits, you will have 31 days from your date of eligibility to enroll in Citi benefits. *Enrolling in Citi health and welfare benefits is not mandatory.* You must enroll during your initial enrollment period to have voluntary benefits, including medical, dental and vision coverage. You must also enroll to participate in a Health Care Spending Account, Limited Purpose Health Care Spending Account, Health Savings Account, Dependent Day Care Spending Account or the Transportation Reimbursement Incentive Program. If you do not enroll, you will have the core coverage, described in "Benefits overview" on page 12.

Dependent notification

The first time you enroll new dependents in Citi benefits, you will be asked to report information about each of your eligible dependents such as name, date of birth, Social Security number and, if over age 26, whether the child has a mental or physical disability. You will also be required to submit proof of the dependent's eligibility for coverage. For more information on the dependent verification process, see "For dependents" on page 14, under "Eligibility" on page 13.

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

You must also keep your dependent information current:

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

If you do not enroll

If you do not enroll in coverage within your initial 31-day enrollment period, you can enroll during a subsequent annual enrollment period or as the result of a qualified change in status.

During annual enrollment

If you want to enroll in Citi coverage, drop Citi coverage, change to a different medical, dental, or vision option, or change your coverage category — for example from single to family or viceversa — you must do so during your enrollment period. Outside of annual enrollment, you can only make changes to your coverage if you have a qualified change in status.

Medical, dental, and/or vision coverage

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

Health Care Spending Account/Limited Purpose Health Care Spending Account, and/or Dependent Day Care Spending Account

You must enroll each year to have coverage.

Health Savings Account

You are eligible to participate in a Health Savings Account if you are enrolled in a High Deductible Health Plan. Initially, you must accept the Terms and Conditions of the program to complete your enrollment. Once the Terms and Conditions have been accepted you only need to enroll each year to have coverage.

Basic Life/AD&D Coverage

If your total compensation, for benefits purposes, increases to $200,000 or above effective January 1, 2012, you'll be ineligible for company-paid Basic Life/AD&D coverage. However, if you have not previously elected the maximum coverage under Group Universal Live (GUL) insurance, during annual enrollment you'll have the opportunity to enroll in GUL insurance equal to one times your total compensation, not to exceed $500,000, without providing proof of good health.

Long-Term Disability coverage

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

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

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

After you enroll or default

Confirmation of enrollment

- **If you enroll by telephone by speaking with a representative:** A confirmation statement will be mailed to your permanent address on file after your enrollment period ends. It will list your benefits elections and their costs. Review this confirmation statement carefully for accuracy, and retain it as proof of your enrollment. If you find an error, immediately call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.
- **If you enroll online:** A confirmation statement will appear after you enroll and before you log out. Print and retain a copy as proof of your enrollment. A confirmation statement will be mailed to your permanent address on file after your enrollment period ends. If you find an error, immediately call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Confirmation of default

If you do not enroll, you will have the "default" coverage shown on the Your Benefits Resources™ website, available through Total Comp @ Citi at **www.totalcomponline.com** or by going directly to **http://resources.hewitt.com/citigroup**. If you are a new hire, default coverage will also be shown on your Personal Enrollment Worksheet.

A confirmation statement will be mailed to your home after your enrollment period ends. The confirmation statement will list your default coverage.

Naming a beneficiary

Your beneficiary information should be on file with Citi. If you have never designated a beneficiary, visit the Your Benefits Resources™ website through Total Comp @ Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet and click on "Beneficiary designation." You can also go directly to Your Benefits Resources™ at **http://resources.hewitt.com/citigroup.** (Note that you need a user ID and password to access this site. If you do not have a user name and password, visit Your Benefits Resources™ at **http://resources.hewitt.com/citigroup.** See the Log On Help in the upper right.)

If you do not have intranet or Internet access, call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "pension and retiree health and welfare" option. Speak with a Citi Benefits Center representative to name a beneficiary for Basic Life (including AD&D) insurance, Business Travel Accident/Medical insurance, Citigroup 401(k) Plan, and/or Citigroup Pension Plan.

If you enroll in Group Universal Life (GUL) insurance, you must complete a MetLife Beneficiary Designation (Form 201) available on **Citi For You** (intranet only) and return it to MetLife at the address on the form. You can also enroll or change your beneficiary by visiting Total Comp @ Citi at **www.totalcomponline.com** and clicking on "Dental/Disability/Group Universal Life (GUL)." Your beneficiary for GUL insurance is also your beneficiary for Supplemental AD&D coverage.

If you change your beneficiary designation for either Basic Life or GUL, it will *not* automatically apply to the other Plan. You must change the beneficiary for each Plan separately.

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

Your contributions

Your contributions for medical, dental, and vision coverage are based on the plan and the coverage category you elect. Your medical contribution also depends on the total compensation band that applies to you. The employee contributions for the medical plan increase as total compensation increases. The compensation bands for 2012 are shown below.

Total compensation bands on which employee contributions for medical coverage are based:

- $30,000 or less
- $30,001 – $50,000
- $50,001 – $100,000
- $100,001 – $200,000
- $200,001 +

For purposes of calculating your medical contributions and coverage amounts, total compensation is determined each year and will apply for the entire calendar year.

Before tax contributions

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

Social Security taxes

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

Total compensation and your benefits

Total compensation is used to determine:

- Medical contributions;
- Long-Term Disability (LTD) benefits and, where applicable, LTD contributions;
- Basic Life/Accidental Death and Dismemberment (AD&D) insurance benefits;
- Optional Group Universal Life (GUL)/Supplemental AD&D insurance and costs;
- Eligibility for the Dependent Day Care Spending Account subsidy;
- Short-Term Disability benefits for Account Executives in the Institutional Clients Group; and
- Business Travel Accident/Medical insurance benefits.

Definition of total compensation

If you are enrolling as a new hire or newly eligible employee

Your total compensation at the time you are hired is equal to your annual base salary. If you are to be paid commissions only, your total compensation is calculated differently and is based either on a default amount or an amount established as appropriate for your position. Ask your HR representative for details.

For future years, your total compensation will be based on a formula that includes your actual base pay plus commissions, performance-based bonuses, and annual incentive bonus. **Note:** Your total compensation does not necessarily equal the amount reported as salaries and wages on your Form W-2 Wage and Tax Statement.

With respect to the current plan year, total compensation consists of:

For the current plan year, total compensation consists of:

- Annual base pay as of June 30, 2011;
- Commissions paid from January 1-December 31 in the year prior to enrollment to capture an entire year of commissions paid; commissions paid from January 1, 2010 -December 31, 2010, will be used for the 2012 annual enrollment calculations;

- Cash bonuses (other than the cash portion of any annual discretionary incentive/retention award package) paid in the period January 1-December 31 in the year prior to enrollment; cash bonuses paid in the period January 1, 2010-December 31, 2010, excluding the cash portion of the annual discretionary incentive/retention award package dated January 2010, will be used for the 2012 annual enrollment calculations;
- Annual discretionary incentive/retention award package dated in the year of enrollment; includes the following, if applicable: (Cash Bonus, Incentive Stock Payment Program (ISPP) Award, CAP Award); annual discretionary incentive//retention award packages dated January 2011 will be used for the 2012 annual enrollment calculations;
- Guaranteed Bonus effective in the current year (2011);
- Short-Term Disability benefits paid from January 1-December 31, 2010, for employees paid on commissions only.
- Salary Stock paid on any of the following four dates: September 30, 2010, October 29, 2010, November 30, 2010, or December 30, 2010; and
- Long-Term Restricted Stock (LTRS) awarded on January 18, 2011.

For Wealth Management Financial Advisors

In your first year of employment, your compensation is considered to be $60,000. If you earned more than $60,000 at a previous employer in the prior year and want your insurance coverage to represent your prior earnings, you must provide a copy of your previous year's Form W-2 Wage and Tax Statement to your HR representative within 30 days of your hire date.

If you decide to provide a copy of the form, your Basic Life insurance amount, if applicable, will be set at the higher amount shown on the form. (Basic Life is available only to those employees whose total compensation is less than $200,000.) Your contributions for medical coverage, Optional GUL amount, and LTD benefits and contributions will also be based on the higher amount.

Your decision to have your total compensation set at $60,000 or based on your Form W-2 amount is irrevocable.

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

If you are enrolling during the annual enrollment period

If you are enrolling during the annual enrollment period for coverage effective January 1, 2012, your total compensation for purposes of benefits enrollment is made up of the following:

1. Annual base pay as of June 30, 2011;
2. Commissions paid from January 1-December 31 in the year prior to enrollment to capture an entire year of commissions paid; commissions paid from January 1-December 31, 2010, will be used for the 2012 annual enrollment calculation;
3. Cash bonuses (other than the cash portion of any annual discretionary incentive award package) paid in the period January 1-December 31 in the year prior to enrollment; cash bonuses paid in the period January 1-December 31, 2010, excluding the cash portion of the annual discretionary incentive award package dated January 2010, will be used for the 2012 annual enrollment calculations;
4. Annual discretionary incentive/retention award package dated in the year of enrollment includes, as applicable, cash bonus, Incentive Stock Payment Program (ISPP) Award, Capital Accumulation Program (CAP) Award. Annual discretionary incentive/retention award packages dated January 2011 will be used for the 2012 annual enrollment calculation;
5. Guaranteed bonus effective in 2011;
6. Short-Term Disability benefits paid from January 1, 2010-December 31, 2010, for employees paid on commissions only;
7. Salary stock paid on any of the following four days: September 30, 2010, October 29, 2010, November 30, 2010, or December 30, 2010; and
8. Long-Term Restricted Stock (LTRS) awarded January 18, 2011.

For new hires in the Institutional Clients Group:

Any guaranteed bonus will be considered in the calculation of your total compensation for benefits purposes.

Domestic partner/civil union partner/same sex spouse benefits

Citi offers benefits coverage to your certified unmarried domestic partner of the same or opposite sex. (You must submit a domestic partner coverage application or your registration, as applicable, before you can enroll a domestic partner or a domestic partner's child[ren] under your Citi coverage.) Citi also offers benefits coverage to your civil union partner/same sex spouse.

You may cover your domestic partner/civil union partner/same sex spouse and his or her eligible children under the following Plans:

- Medical;
- Dental;
- Vision;
- Health Care Spending Account, provided your domestic partner/civil union partner/same sex spouse and his or her eligible children are considered tax dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; (**Note:** Civil union partners/domestic partners/same sex spouses who are not considered tax dependents under Section 152 cannot have their claims reimbursed under the Health Care Spending Account);
- Limited Purpose Health Care Spending Account, provided your domestic partner/civil union partner/same sex spouse and his or her eligible children are considered tax dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof;
- Dependent Day Care Spending Account, provided your domestic partner/civil union partner/same sex spouse and his or her eligible children are considered tax dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof;
- GUL/Supplemental AD&D insurance for domestic partners/civil union partners/same sex spouses and life insurance for children;
- Long-Term Care insurance.

You may enroll your domestic partner/civil union partner/same sex spouse and his or her eligible children in the medical and/or dental Plan in which you enroll. You may enroll your domestic partner/civil union partner/same in spouse GUL/AD&D insurance, Long-Term Care insurance, and/or the vision plan even if you do not enroll in those Plans.

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

When you can enroll your domestic partner

You can enroll your domestic partner and his or her eligible children in Citi benefits during annual enrollment (for coverage effective January 1 of the following year) or within 31 days of a qualified change in status. Examples of qualifying events that will allow you to enroll your domestic partner and his or her eligible children during the plan year are:

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

You must speak with a Citi Benefits Center representative to request the Domestic Partner Coverage Forms. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" options.

For information on domestic partner eligibility, see "For Domestic Partners" under "Eligibility."

Cost of civil union partner/domestic partner/same sex spouse benefits

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

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

Tax implications

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

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

If your civil union partner/domestic partner/same sex spouse qualifies as a tax dependent

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

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

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

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

If your civil union partner/domestic partner/same sex spouse does not qualify as a dependent for tax purposes

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

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

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

The $450 cost for partner coverage (known as imputed income) will be treated as taxable income to you.

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

If you terminate domestic partner coverage

To terminate domestic partner coverage, you must complete a form attesting that your domestic partnership has ended, or submit a document showing the termination of your domestic partner registration, as applicable. To request the form, call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. Taxes paid on the imputed income are not refundable.

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

This coverage will be similar to Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) coverage offered to spouses, civil union partners, and other covered dependents, excluding domestic partners and their children. See "COBRA" beginning on page 36 for more information.

If you and your domestic partner marry

Report your qualified change in status to the Citi Benefits Center as soon as possible after your marriage and request that the imputed income be stopped. You will be required to provide proof of the marriage in order to stop the assessment of imputed income permanently. Otherwise, imputed income will continue to be calculated. Call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

If your partner is of the same sex, imputed income will continue to be calculated unless your partner meets the definition of a dependent under Section 152 of the Code. Consult your tax adviser.

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

Changing your coverage

Qualified changes in status

The rules regarding qualified changes in status apply to coverage elections you make for medical, dental, vision, Health Care Spending Account, Limited Purpose Health Care Spending Account coverage, Dependent Day Care Spending Account, Long-Term Disability, Supplemental AD&D, and Group Universal Life insurance. In general, the benefit plans and coverage levels you choose during annual enrollment remain in effect for the following calendar year. However, you may be able to change your elections between annual enrollment periods if you have a qualified status change or other applicable event, as explained below.

You must report to the Citi Benefits Center any change of status that affects your benefits within 31 days of the qualified event by following the process described under "How to report a qualified change in status event" on page 28.

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

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

Depending on the event, you may be permitted to:

- Enroll in or drop your medical, dental, vision, HCSA, LPSA, or DCSA coverage;
- Increase or decrease the amount of your HCSA, LPSA, or DCSA coverage;
- Enroll in LTD without having to provide evidence of good health;

- Enroll in or increase GUL/Supplemental AD&D insurance without having to provide evidence of good health. (For GUL, you may increase your coverage if the first, second, third, or sixth events below apply. Initial election of spouse/civil union partner/domestic partner or child coverage under this program is available if you marry, establish an eligible domestic partnership, or in the event of the birth or adoption of a child.)

Examples of qualified changes in status are:

1. Your marriage, legal separation, or divorce;
2. Meeting the eligibility to qualify as a domestic partner;
3. The birth or adoption of a child;
4. The loss of coverage eligibility for a dependent child who, for example, becomes ineligible due to age or recovery from a disability;
5. The loss of coverage under your spouse's (same or opposite sex)/civil union partner's/domestic partner's or other employer's plan;
6. The death of a spouse (same or opposite sex)/civil union partner/domestic partner or dependent child;
7. The issuance of a Qualified Medical Child Support Order (QMCSO);
8. Relocation outside your medical and/or Cigna Dental HMO's network area;
9. The start of a military leave of absence;
10. The loss of group Basic Life insurance;
    - If your total compensation for benefits purposes increases such that you become ineligible for Basic Life/AD&D, this loss of coverage constitutes a qualified change in status for enrollment in GUL/Supplemental AD&D insurance. If you have not previously elected the maximum coverage under GUL, during annual enrollment you can elect GUL equal to one times your total compensation, not to exceed $500,000, without providing evidence of good health.
11. The loss of Medicaid or Children's Health Insurance Program (CHIP) coverage; and
12. The start of eligibility for state premium assistance.

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

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

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

The following is a list of qualified changes in status that will allow you to change your elections (as long as you meet the consistency requirements, as described below):

- **Legal marital status**: Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, or annulment;
- **Domestic partnership status**: You enter into or terminate a domestic partnership;
- **Number of dependents**: Any event that changes your number of tax dependents, including birth, death, adoption, and placement for adoption;
- **Employment status**: Any event that changes your, your spouse's, or another dependent's employment status that results in gaining or losing eligibility for coverage. Examples include:
    - Beginning or terminating employment;
    - A strike or lockout;
    - Starting or returning from an unpaid leave of absence;
    - Changing from part-time to full-time employment or vice versa; and
    - A change in work location.

- **Dependent status**: Any event that causes your tax dependents to become eligible or ineligible for coverage because of age or recovery from disability;
- **Residence**: A change in the place of residence for you, your spouse, or another dependent if outside your medical or Cigna Dental HMO's network area.

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

Consistency requirements

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

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

Coverage and cost events

In some instances, you can make changes to your benefits coverage for other reasons, such as midyear events affecting your cost or coverage, as described below. However, in no event will any cost or coverage event allow you to make a change to your Health Care Spending Account or your Limited Purpose Health Care Spending Account election.

Coverage events

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

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

Also, if an election change is permitted during a different annual enrollment period applicable to a plan of another employer (or, if applicable, to another plan sponsored by Citi), you may make a corresponding midyear election change.

If another employer's plan allows your spouse (same or opposite sex)/civil union partner/domestic partner or other dependent to make a mid-year change to his or her elections in accordance with IRS regulations, you may make a corresponding midyear election change to your coverage.

Cost events

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

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

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

Other rules

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

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

Special note regarding civil union partner/domestic partner coverage/same sex spouse: The events qualifying you to make a midyear election change described in this section also apply to events related to a civil union partner/domestic partner/same sex spouse. However, IRS rules generally do not permit you to make a midyear change "on a before-tax basis" for such events unless they involve a tax dependent. Thus, if you make a midyear change due to an event involving your civil union partner/domestic partner/same sex spouse, generally that change must be made on an after-tax basis, unless your civil union partner/domestic partner/same sex spouse can be claimed as your dependent for federal income tax purposes. (Exceptions may be made if your civil union partner/domestic partner/same sex spouse makes an election change under his or her employer's plan in accordance with IRS regulations.) See *IRS Publication 17, Your Federal Income Tax,* for a discussion of the definition of a tax dependent. The publication is available at **www.irs.gov/formspubs/index.html.**

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

Medicaid and the Children's Health Insurance Program (CHIP) offer free or low-cost health coverage to children and families

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

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

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

How to report a qualified change in status event

You have 31 days from the date of the event (60 days in the event of the loss of Medicaid and CHIP coverage, and the start of eligibility for state premium assistance) to report a qualified change in status event and, if applicable, to change your and/or your dependent's coverage. To add a newborn child to your coverage, you must do so within 31 days of the child's birth.

To add a dependent, report the name, date of birth, and, if available, Social Security number for each dependent you want to add or remove from your coverage. If a newborn does not yet have a Social Security number, you must report all other information within 31 days and add the Social Security number once you obtain it. When you add a new dependent to your coverage, you will be required to submit proof of the dependent's eligibility for

coverage (for example, a marriage license or birth certificate). If proof is not received by the deadline stated in the dependent verification package, the dependent(s) will be dropped from coverage.

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

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

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

- Call the Citi Benefits Center via ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.
- Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Health and welfare benefits."
- To enroll in Group Universal Life (GUL) insurance, call MetLife at **1-800-523-2894**.

Deadline to report qualified changes in status

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

Newborns/newly adopted children

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

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

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

- Extension of benefits; and
- Continuation of coverage.

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

Plan changes you can make at any time

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

Long-Term Disability (LTD)

You can enroll at any time. However, you must provide evidence of good health except when enrolling as a new hire, when your total compensation increases to $50,001 or above (you will be enrolled automatically and the applicable contributions will be deducted from your pay unless you decline coverage), or as a result of certain qualified changes in status.

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

Group Universal Life (GUL)/Accidental Death and Dismemberment (AD&D) insurance

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

- When first eligible (as a new hire or newly eligible for Citi benefits) if enrolling for up to three times the amount of your total compensation and the total is less than $1.5 million;
- For one times your total compensation as a result of losing Basic Life coverage because your total compensation was increased to $200,000 or above.

However, MetLife will require evidence of good health if you want:

- To enroll at any other time;
- To enroll for an amount three times greater than your total compensation or $1.5 million; or
- To increase the amount of your current coverage.

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

Once enrolled in GUL, you will automatically receive Supplemental AD&D coverage in the same amount as your GUL coverage. Cigna administers the Supplemental AD&D coverage of the benefit and does not require evidence of good health.

Long-Term Care insurance (LTC)

You can apply for coverage at any time for yourself; your eligible dependents may apply for themselves. Coverage will begin on the first day of the month after you or your dependent's application is approved. You must be actively at work for coverage to be effective. Your eligible dependents must not be disabled on the date their coverage is to become effective. The John Hancock Life Insurance Company (U.S.A.,) which insures the benefit, will require evidence of good health before coverage is approved.

After your initial eligibility period you must provide evidence of good health and be actively at work before coverage will be effective. See the 'Long-Term Care insurance' subsection of the 'Insurance' section for more information.

Transportation Reimbursement Incentive Program

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

Health Savings Account

You can enroll or change your contribution at any time as long as you are enrolled in the High Deductible Health Plan – Basic or Premier.

When coverage begins

If:	Then:
You become eligible for Citi benefits coverage.	You have 31 days to enroll yourself and your eligible dependents. Coverage and contributions will be retroactive to your date of hire or date of eligibility.
You enroll for yourself and your eligible dependents during the annual enrollment period.	Coverage will begin on January 1 of the following year.
You enroll in medical, dental, vision, and/or spending account coverage for yourself or a new dependent within 31 days of a qualified status change.	Coverage for yourself or your dependent(s) will begin on the date of the qualified status change, such as the date of your marriage or divorce, your biological child's birth date, or the date your adopted child was placed for adoption.

When coverage ends

Your coverage under the Citigroup Health Benefit Plan, Dental Benefit Plan, and Vision Benefit Plan will terminate automatically on the earliest of the following dates:

- The date the Plan is terminated;
- The last day for which the necessary contributions are made;
- Midnight of the last day of the month in which your employment is terminated, you retire, or you otherwise cease to be eligible for coverage;
- The day you die;
- To the extent applicable, the date benefits paid on your behalf equal the lifetime maximum benefit under the Plan for such category of benefits;
- Midnight of the last day of employment if your termination is due to gross misconduct; or
- Upon a finding of fraud or intentional misrepresentation related to a claim for eligibility or benefits under the Citigroup Health Benefit Plan; in such an event, coverage may be terminated retroactively.

Basic Life insurance coverage, Short-Term Disability, Long-Term Disability, and coverage under the Dependent Day Care Spending Account, Health Care Spending Account, and Limited Purpose Health Care Spending Account end on the date your employment is terminated. GUL and Supplemental AD&D insurance coverage end on the last day of the month in which your employment is terminated. See the 'Long-Term Care insurance' subsection of the 'Insurance' section for more information.

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

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

You and your eligible covered dependents may be able to continue coverage under COBRA. See "COBRA" beginning on page 36.

Coverage when you retire

You could be eligible for retiree health care coverage if:

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

For more information about eligibility for retiree medical coverage and the cost of coverage, call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

A note for employees who were involuntarily terminated

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

1. The date you would have met the age and service requirements for retiree health program eligibility had you remained employed;
2. If you elected COBRA, at any time during your COBRA continuation period after you have met such age and service requirements; or
3. If you elected COBRA, at the end of such COBRA period. *If you don't enroll in retiree health coverage at or before the end of your COBRA period, you'll waive all rights to future enrollment in the Citi retiree health program coverage.*

Alternatively, if (a) you are eligible for coverage under the U.S. Separation Pay Plan and (b) you are projected to meet the age and service requirements for retiree health coverage eligibility within 12 months after your termination date, but choose not to enroll in Citi COBRA coverage upon your termination, you will later have a one-time opportunity to enroll in Citi's retiree health programs at the time you meet the age and service requirements for Citi's retiree health programs, determined as if you had remained employed with Citi through such date.

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

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

Coverage if you become disabled

You and your eligible dependents may continue medical, dental, and vision coverage for up to 13 weeks as long as you make the active employee contributions. You may also continue to participate in the Health Care Spending Account or Limited Purpose Health Care Spending Account for 13 weeks or if a COBRA election is made, until the end of the calendar year, if the calendar year extends beyond the initial 13 weeks of coverage.

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

Medical: Coverage will continue for 52 weeks, including the 13-week period of Short-Term Disability (STD), as long as you pay the active employee contributions. After the 13-week paid STD period, the Citi Benefits Center will bill you for your benefits. (The cost is not deducted from your Long-Term Disability [LTD] benefit.)

If your disability extends beyond 52 weeks, you may continue medical coverage for the lesser of a length of your disability or the medical continuation period, based on your years of service (as shown below). For the purposes of the Plan, a year of service is any twelve (12) consecutive months in which you have provided 1,000 hours of service.

Note: After 52 weeks of disability, your employment will be terminated.

Citi years of service as of the LTD effective date	Medical continuation period after week 52 (the termination of your employment)
Less than 2 years	6 months
2 years to less than 5 years	Equal to your length of service
5 years or more	As long as you are disabled and have not received the maximum LTD benefit available under the Plan

At the end of the medical continuation period, shown above, you may continue coverage through COBRA, if applicable. The above continuation period is considered part of the COBRA period.

The disability administrator will medically manage your disability to determine your eligibility to continue in applicable health and welfare benefits at the active rate. If you are a totally disabled employee who has been denied LTD due to a pre-existing condition, did not enroll

in LTD coverage, or who has reached the maximum benefit under the two-year limitation rule, the disability administrator will medically manage your claim.

If you are enrolled in a non-HMO medical Plan, once you become disabled for more than 29 months and are approved for Social Security disability or if earlier, you become eligible for Medicare because you attained age 65, Medicare will become your primary medical coverage while benefits under the Citi plan become secondary.

Dental: Coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. Then you may continue coverage under COBRA.

Vision: Coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. Then you may continue coverage under COBRA.

Basic Life/Accidental Death and Dismemberment (AD&D): Coverage stops after 52 weeks, but you can convert your Basic Life/AD&D coverage to an individual policy 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.

Group Universal Life (GUL) insurance: Coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. After that, you may continue GUL insurance. MetLife will bill you at the active employee rate for a length of time based on your years of service as shown in the table above. Your Supplemental AD&D coverage will continue until the last day of the month in which you have received your 52nd week of disability benefits. You can convert your Supplemental AD&D coverage to an individual policy 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.

Health Savings Account (HSA): Participation will continue for the 13-week period of STD as long as you pay the active employee contributions. Then you may choose to make additional contributions, on an after-tax basis, directly to your HSA by contacting ConnectYourCare. Any remaining balance is yours to take with you when you leave Citi.

Health Care Spending Account (HCSA): Participation will continue for the 13-week period of STD as long as you pay the active employee contributions. Then you may continue coverage on an after-tax basis under COBRA for the remainder of the calendar year in which your employment was terminated. You will have until June 30 of the following calendar year to submit claims.

Limited Purpose Health Care Spending Account (LPSA): Participation will continue for the 13-week period of STD as long as you pay the active employee contributions. Then you may continue coverage on an after-tax basis under COBRA for the remainder of the calendar year in which your employment was terminated. You will have until June 30 of the following calendar year to submit claims.

Dependent Day Care Spending Account (DCSA): Participation ends on your first day of STD. When you return to work from your approved disability, if you want coverage through the end of the year, you must re-enroll within 31 days of your return. Once re-enrolled, you can incur expenses through the end of the calendar year and will have until June 30 of the following calendar year to submit claims. You cannot be reimbursed for claims incurred while you were on a leave. With the exception of a military leave of absence, you cannot continue DCSA during a leave of absence.

Transportation Reimbursement Incentive Program (TRIP): Coverage ends on your first day of STD. When you return to work from your approved disability, you can re-enroll. If your employment is terminated, your payroll deductions will stop and your account will be closed as of your termination or transfer date. You will forfeit any balance in your account.

Coverage for surviving spouse (same or opposite sex)/civil union partner/domestic partner and/or dependents

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

If the employee was not eligible for retiree health care coverage at the time of death

The Citi Benefits Center will send your surviving spouse (same or opposite sex)/civil union partner/domestic partner and/or dependent children a COBRA notification package. For your surviving spouse (same or opposite sex)/civil union partner/domestic partner and/or dependent children to have six months of free medical and/or dental coverage, they must elect COBRA continuation coverage by signing and returning the election form to the Citi Benefits Center within the election period. See "COBRA" beginning on page 36.

If the employee was eligible for retiree health care coverage at the time of death

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

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

Continuing coverage

During an FMLA leave

The Family and Medical Leave Act (FMLA) entitles eligible employees to take a job-protected leave for their own serious illness; the birth or adoption of a child; or to care for a spouse (same or opposite sex)/civil union partner/domestic partner, child, or parent who has a serious health condition.

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

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

If you lose any coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your coverage will start again on the first day after you return to work and pay the required contributions.

If you do not return to work at the end of your FMLA leave, you will be entitled to enroll in COBRA to continue your medical, dental, vision, and HCSA or LPSA coverage.

If your employment is terminated while you are on an FMLA leave, you may also be eligible to continue your coverage under COBRA.

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

If your HCSA or LPSA participation is terminated during your leave and you return to work during the same year in which your leave began, your contributions will resume. You can choose to resume contributions at the same level in effect before your FMLA leave or elect to increase your contribution level to make up for the contributions you did not make during your leave.

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

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

Coverage if you take an unpaid leave of absence

If you go on an approved leave of absence, you may continue coverage under the medical, dental, vision, and Health Care Spending Account/Limited Purpose Health Care Spending Account. Your reduction in hours (less than 20 hours per week) constitutes a COBRA-qualifying event under the plans. See "COBRA" on page 36 regarding continuation of coverage.

Call the Citi Benefits Center through ConnectOne about your rights to continue medical, dental, vision, and HCSA or LPSA coverage. You will be billed directly for them and failure to pay the billed amount will result in a loss of coverage. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Continuing coverage during a military leave of absence - Citi policy

The Citigroup Paid Military Leave of Absence Policy is updated from time to time. For the latest copy of the policy, visit **www.citigroup.net** (intranet only). From the home page, use the search function and enter "military leave." Then click on the most current policy.

If you take a military leave of absence — whether for active duty or for training — you are entitled to continue your medical, dental, vision, DCSA, and HCSA or LPSA coverage at active employee rates for the length of your leave. Employee contributions will be deducted automatically from your pay.

The start of a military leave is considered a qualified change in status. As a result, you may stop coverage under any of the health and welfare benefit plans in which you are enrolled or, if you have not previously done so, you may enroll in certain coverage.

You must contact the Citi Benefits Center to enroll in or stop coverage. If you do not contact the Citi Benefits Center, your benefit elections will continue in effect for the remainder of the year in which you are on a military leave with the exception of:

- TRIP participation, which stops automatically when your leave begins and
- STD, LTD, and Business Travel Accident/Medical insurance, which are suspended automatically when your leave begins.

You can participate in any annual enrollment periods that occur while you are on a military leave. If you are unable to make elections during annual enrollment, your elections will continue in effect until you return from your leave when you can make new elections for all health and welfare benefit Plans. If you elect to discontinue coverage while on a leave, you will have the right to re-enroll when you return to work.

Under the Heroes Earnings Assistance Relief Tax Act of 2008, if you are a reservist called to active military duty for more than 179 days, you are entitled to receive a taxable distribution of your HCSA or LPSA balance (contributions less the amount reimbursed) if you request a distribution by the last day of the calendar year in which you made such contributions.

Call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. You can also contact your HR representative for more information about a military leave of absence.

Continuing coverage during military leave — no Citi policy

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

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

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

If you are on a military leave for fewer than 24 months and you do not return to work at the end of your leave, you may be entitled to purchase COBRA continuation coverage. Your eligibility for COBRA will begin on the date your leave ends. Call the Citi Benefits Center or contact your HR representative for more information about a military leave. For the Citi Benefits Center, call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires that most employers sponsoring group health plans offer to employees, their spouses (same or opposite sex)/civil union partners/domestic partners and eligible dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances (called "qualifying events") where coverage under the Plan would otherwise end.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of the law.

You do not have to show that you are insurable to elect continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage.

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

You must pay the entire contribution (employee plus employer cost) plus a 2% administration fee for your continuation coverage. A grace period of at least 30 days applies to the payment of the regularly scheduled contribution. A 45-day grace period applies to your first payment.

Who is covered under COBRA

You have a right to choose this continuation coverage if:

- You are enrolled in Citi medical, dental, vision, or HCSA or LPSA coverage; and
- You lose your group health coverage because of a reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct on your part.

If you terminate employment following a leave of absence qualifying under the Family and Medical Leave Act (FMLA) the qualifying event that will trigger continuation coverage will be deemed to occur on the earlier of (a) the date that you indicate you will not be returning to work following the leave; (b) the date that you do not return to work after the leave; or (c) the last day of the FMLA leave period.

If you are the spouse (same or opposite sex)/civil union partner/domestic partner of an employee and are covered by a Citi-sponsored medical, dental, or vision plan (or your claims can be reimbursed through your spouse's (same or opposite sex)/civil union partner's/domestic partner's HCSA or LPSA) and you lose coverage under a Citi-sponsored group health plan for any of the following four reasons on the day before the qualifying event, you are a qualified beneficiary and have the right to elect continuation coverage for yourself:

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

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

1. The death of the employee;
2. The termination of the employee's employment (for reasons other than the employee's gross misconduct) or a reduction in the employee's hours of employment;
3. The employee's divorce or legal separation;
4. The employee's entitlement to Medicare; or
5. You cease to be a "dependent child" under the Citi-sponsored medical, dental, or vision plan or HCSA or LPSA.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption, or placement for adoption) during that period of continuation coverage the new child is also eligible to become a qualified beneficiary.

According to the terms of the employer-sponsored group health plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Citi of the birth or adoption.

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

Separate elections

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

Electing COBRA

To inquire about COBRA coverage, speak to a Citi Benefits Center representative. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

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

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

Duration of COBRA

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

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

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

If you lose coverage because of a termination of employment or a reduction in hours, these events can, but do not always, result in an extension of an 18-month continuation period to 36 months for your spouse (same or opposite sex)/civil union partner/domestic partner and dependent children. However, in no event will COBRA coverage last beyond 36 months from the date of the event that originally allowed a qualified beneficiary to elect such coverage. You must notify the Citi Benefits Center if a second qualifying event occurs during your continuation coverage period. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

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

Special rule for HCSA and LPSA

Unless required by law, continuation coverage for HCSA and LPSA will not be available beyond the end of the year in which the qualifying event occurs.

Special rules for disability

The 18 months may be extended to 29 months if the employee or covered family member is determined by the Social Security Administration (SSA) to be disabled (for Social Security disability purposes) at any time during the first 60 days of continuation coverage.

This 11-month extension is available to all family members who are qualified beneficiaries due to termination of employment or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified beneficiary must inform Citi within 60 days of the SSA determination of disability and before the end of the original 18-month continuation coverage period. If, during continued coverage, the SSA determines that the qualified beneficiary is no longer disabled, the individual must inform Citi of this redetermination within 30 days of the date it is made at which time the 11-month extension will end.

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

Medicare

If, within 18 months after becoming entitled to Medicare, you subsequently lose coverage (medical, dental, vision, or HCSA or LPSA) due to your termination of employment or reduction in hours, your eligible dependents' COBRA coverage will not end before 36 months from the date you became entitled to Medicare. However, your eligible dependents' early termination of COBRA coverage will not extend beyond 36 months.

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

1. Citi no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time (within the applicable grace period);
3. The person who elected COBRA becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation for any pre-existing condition of the covered individual;
4. The person who elected COBRA becomes entitled to Medicare after the date COBRA is elected; or
5. Coverage has been extended for up to 29 months due to disability, and the disability carrier makes a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated.

However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses (or otherwise under applicable law), the Plan may terminate your COBRA coverage.

COBRA and FMLA

A leave that qualifies under the FMLA does not make you eligible for COBRA coverage. However, regardless of whether you lose coverage because of non-payment of premiums during an FMLA leave or you decide not to return to active employment you are still eligible for COBRA on the last day of the FMLA leave. Your continuation coverage will begin on the earliest of the following:

- When you definitively inform Citi that you are not returning to work at the end of the leave; or
- The end of the leave, and you do not return to work.

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

- You or your spouse (same or opposite sex)/civil union partner/domestic partner and/or dependent child is covered by the Plan on the day before the leave begins (or you or your spouse (same or opposite sex)/civil union partner/domestic partner and/or dependent child) becomes covered during the FMLA leave) and
- You do not return to work at the end of the FMLA leave.

Your duties

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

- A divorce or legal separation;
- The loss of a child's dependent status under the medical, dental, or vision plan or HCSA or LPSA;
- An additional qualifying event (such as a death, divorce, or legal separation) that occurs during the employee's or family member's initial continuation coverage period of 18 (or 29) months;
- A determination by the SSA that the employee or family member was disabled at some time during the first 60 days of an initial continuation coverage period of 18 months; or
- A subsequent determination by the SSA that the employee or family member is no longer disabled.

This notice *must* be provided within 60 days from the date of the divorce, legal separation, a child's loss of dependent status, or an additional qualifying event. In the case of a disability determination, the notice *must* be provided within 60 days after the SSA's disability determination and before the end of the initial 18-month continuation coverage.

If the employee or a family member fails to provide this notice to Citi during this notice period, any individual(s) who loses coverage will not be offered the option to elect continuation coverage.

The notice must be in writing and must include the following information:

- The applicable Plan name;
- The identity of the covered employee and any qualified beneficiaries;
- A description of the qualifying event or disability determination;
- The date on which it occurred; and
- Any related information customarily and consistently requested by the Plan's COBRA administrator.

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

Citi Benefits Center
2300 Discovery Drive
P.O. Box 785004
Orlando, FL 32878-5004

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

Citi's duties

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

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

Cost of coverage

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

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

The initial payment for continuation coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis for which you have a grace period of at least 30 days.

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

All notices and other communications regarding COBRA and Citi-sponsored group health Plan should be directed to:

Citi Benefits Center
2300 Discovery Drive
P.O. Box 785004
Orlando, FL 32878-5004

You may also call the COBRA administrator through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Coordination of benefits

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

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

The following definitions apply to terms used in this section:

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

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

How coordination of benefits works

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

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

The Citi Plan will be the primary plan for claims:

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

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

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

In case of divorce or legal separation

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

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

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

Coordination with Medicare

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

- Eligible active employees age 65 and over who are entitled to Medicare benefits;

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

If you or a covered family member becomes covered by Medicare after a COBRA election is made, your COBRA coverage will end.

If you or your dependent are eligible for Medicare, and you are no longer an active employee, enrollment in Medicare cannot be deferred based on enrollment in COBRA.

No-fault automobile insurance

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

Facility of payment

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

Right of recovery

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

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

Release of information

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

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

How to file a claim

Claims must be submitted in order to receive reimbursement for charges incurred under the Plans. Many times, the claim is submitted electronically to the claims administrator without your intervention needed. However, you may be required to manually submit a claim for expenses to be paid or approved for reimbursement. Listed below are the forms needed to claim benefits that may not be reimbursed automatically or paid directly. Claims should be sent to the Claims Administrators as detailed under "Claims Administrators" in the Administrative Information section. If you do not receive benefits to which you believe you are entitled, see the applicable "Claims and appeals" subsection in the section that describes each plan at **www.benefitsbookonline.com**, available from the Citi intranet and the Internet. No password is required.

Name of Plan	Name/form number and when to use the form	How to obtain a form
Aetna ChoicePlan 500 High Deductible Health Plan – Basic and Premier	Aetna Medical Benefits Request (Form 301) Use the form to file a claim for covered out-of-network expenses.	Visit **Citi For You** (intranet only) Or Visit Your Benefits Resources™ through Total Comp @ Citi at **www.totalcomponline.com** and click on "Health and welfare benefits." You can also go directly to **http://resources.hewitt.com/citigroup**.
Empire BlueCross BlueShield ChoicePlan 500 High Deductible Health Plan – Basic and Premier	Health Insurance Claim Form for the plans administrated by Empire BlueCross BlueShield (Form 322) Use the form to file a claim for covered out-of-network expenses.	
UnitedHealthcare (Hawaii Health Plan)	Citigroup Health Claim Transmittal (Form 303) Use the form to file a claim for covered out-of-network expenses.	
Oxford Health Plans PPO	Oxford Health Insurance Claim Form (Form 309) Use the form to file a claim for covered out-of-network expenses.	
HMOs	Call your HMO for any claim-filing information.	
Express Scripts (Prescription drug coverage for ChoicePlan 500, High Deductible Health Plan-Basic and Premier, and Hawaii Health Plan)	Express Scripts Prescription Drug Claim (Form 310) Use the form to file a claim for covered out-of-network expenses.	In addition to the instructions at the top of this column, call Express Scripts at **1-800-227-8338** or visit **www.express-scripts.com**.
Medco (Prescription drug coverage for Oxford PPO)	Form 320 — Medco by Mail Order Form (Form 320).	Call Medco at **1-800-905-0201** or visit **http://www.medcohealth.com**
MetLife Dental	MetLife Dental Claim Form (Form 304) Use the form to file a claim for covered dental expenses.	
Cigna DHMO	There are no claim forms required with the Cigna Dental HMO plan. When your Patient Charge Schedule lists a copay, pay that amount to the dentist directly after you receive care.	
Vision Plan	Vision Claim Submission Form to be reimbursed for covered out-of-network expenses.	Visit **www.aetnavision.com**.
Health Care Spending Account (HCSA)	If you do not use the Your Spending Accounts™ Card, you can file a claim using the HCSA/LPSA Reimbursement Request Form (Form 316). Use the form to submit eligible health care claims for reimbursement.	Visit **Citi For You** (intranet only) Or Visit Your Benefits Resources™ through Total Comp @ Citi at **www.totalcomponline.com** and click on "Spending accounts." You can also go directly to **http://resources.hewitt.com/citigroup.**
Limited Purpose Health Care Spending Account (LPSA)	HCSA/LPSA Reimbursement Request Form (Form 316) Use the form to submit eligible vision, dental, and/or preventive care health care claims for reimbursement.	
Dependent Day Care Spending Account (DCSA)	DCSA Reimbursement Request Form (Form 317) Use the form to submit eligible dependent care claims for reimbursement.	
Transportation Reimbursement Incentive Program (TRIP)	Not applicable **Note:** With the exception of the Parking Cash Reimbursement Option (CRO). CRO claims must be filed within 12 months from the date of service.	

Eligibility and participation

All claims for benefits must be filed by these deadlines:

- Medical, dental, and vision claims must be filed within two years of the date of service. If you participate in an HMO, call your HMO for its claim-filing deadlines.
- Prescription drug claims must be filed within one year of the date of service.
- HCSA claims must be filed by June 30 following the year in which the expense was incurred.
- LPSA claims must be filed by June 30 following the year in which the expense was incurred.
- DCSA claims must be filed by June 30 following the year in which the expense was incurred.
- TRIP claims must be filed within 12 months from the date of service.

Health care benefits

Your Citi health care benefits are composed of:

- Medical coverage (including the Citigroup Prescription Drug Program);
- Dental coverage;
- Vision coverage;
- Wellness benefits.
- Employee Assistance Program (EAP); and

Other valuable benefits include the Work/Life Program.

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Medical

The Medical Plan offers several medical options to protect you and your eligible dependents against the high cost of treating major illness and injury.

The following information applies to all Citi medical options except HMOs. Your Benefits Resources™ lists the medical options available to you based on your home zip code. For information about a specific HMO, see the HMO fact sheets on Your Benefits Resources™. If you are a new employee, you will receive these fact sheets in your enrollment kit.

Depending on your location, you may choose from one of the following medical options or an HMO:

- ChoicePlan 500 administrated by Aetna (Choice POS II Open Access) and Empire BlueCross BlueShield (PPO Preferred Provider Organization plan);
- High Deductible Health Plan – Basic administrated by Aetna (Choice POS II Open Access) and Empire BlueCross BlueShield (PPO Preferred Provider Organization plan);
- High Deductible Health Plan – Premier administrated by Aetna (Choice POS II Open Access) and Empire BlueCross BlueShield (PPO Preferred Provider Organization plan);
- Oxford Health Plans PPO (available in the Connecticut, New Jersey, and New York tri-state area only); or
- Hawaii Health Plan (United HealthCare, available in Hawaii only).

HMOs:

1. Coventry Health Care of Iowa;
2. Geisinger Health Plan (Pennsylvania);
3. Health Plan Hawaii Plus (HMSA);
4. SelectHealth (Utah and part of Idaho);
5. Independent Health (upstate New York);
6. Kaiser FHP of California - Northern;
7. Kaiser FHP of California - Southern;
8. Kaiser FHP of Colorado;
9. Kaiser FHP of Georgia;
10. Kaiser FHP of Hawaii;
11. Kaiser FHP of the Mid-Atlantic States;
12. Presbyterian Health Plan (New Mexico); and
13. Sanford Health Plan (South Dakota).

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Medical

Administrator of the ChoicePlan and Preferred Provider Organization (PPO)

ChoicePlan 500 is administered by Aetna and Empire BlueCross BlueShield throughout the United States. The ChoicePlan 500 design is essentially the same no matter which vendor administers the Plan. The PPO is administered by Oxford Health Plans (a United HealthCare company).

Medical options at a glance

For HMO information, see the Health Plan Comparison Charts on Your Benefits Resources™ (YBR™). To access YBR™, visit Total Comp @ Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet, and click "Health & welfare benefits." **Note:** In ChoicePlan 500 and the High Deductible Health Plan – Basic and Premier, precertification is required for certain procedures and services both in and out-of-network. Penalties may apply. Call your Plan for details.

	ChoicePlan 500 Administered by Aetna and Empire BlueCross BlueShield		Oxford Health Plans PPO (Available in CT, NJ, and NY only)	
	Network	*Out-of-network*	*Network*	*Out-of-network*
Annual deductible (network and out-of-network combined)				
Individual	$500	$1,500	$500	$1,500
Maximum per family	$1,000	$3,000	$1,000	$3,000
Annual out-of-pocket maximum (includes deductible; network and out-of-network combined)				
Individual	$3,000	$6,000	$3,000	$6,000
Maximum per family	$6,000	$12,000	$6,000	$12,000
Lifetime maximum	None	None	None	None
Professional care (in office)				
Doctor/primary care physician (PCP) visits	90% after deductible	70% of MAA* after deductible	90% after deductible	70% of MAA after deductible
Specialist visits	90% after deductible; 95% after deductible for Aetna Aexcel specialists	70% of MAA after deductible	90% after deductible	70% of MAA after deductible
Preventive care, subject to frequency limits				
Well-adult visits and immunizations	100%, not subject to deductible	100%, not subject to deductible up to $250 maximum, then covered at 70% of MAA; immunizations covered at 70% of MAA not subject to deductible	100%, not subject to deductible	100%, not subject to deductible up to $250 maximum, then covered at 70% of MAA; immunizations covered at 70% of MAA not subject to deductible
Well-child visits and immunizations	100%, not subject to deductible	100%, not subject to deductible up to $250 maximum, then covered at 70% of MAA; immunizations covered at 70% of MAA, not subject to deductible	100%, not subject to deductible	100%, not subject to deductible up to $250 maximum, then covered at 70% of MAA; immunizations covered at 70% of MAA, not subject to deductible
Routine cancer screenings (PAP test, mammogram, sigmoidoscopy, colonoscopy, PSA screening)	100%, not subject to deductible	100%, not subject to deductible up to $250 maximum, then covered at 70% of MAA	100%, not subject to deductible	100%, not subject to deductible up to $250 maximum, then covered at 70% of MAA
Hospital emergency room				
No coverage in any medical option if not a true emergency	$100 copayment (waived if admitted within 24 hours of emergency room use; precertification required for hospitalization)		$100 copayment (waived if admitted within 24 hours of emergency room use; precertification required for hospitalization)	

Medical

	ChoicePlan 500 Administered by Aetna and Empire BlueCross BlueShield		Oxford Health Plans PPO (Available in CT, NJ, and NY only)	
	Network	*Out-of-network*	*Network*	*Out-of-network*
Urgent care center				
	90% after deductible	90% after deductible	90% after deductible	90% after deductible
Hospital inpatient and outpatient				
Semiprivate room and board, doctor's charges, lab, radiology, and X-ray	90% after deductible; precertification required for hospitalization and certain outpatient procedures	70% of MAA after deductible; precertification required for certain outpatient procedures	90% after deductible; precertification required for hospitalization and certain outpatient procedures	70% of MAA after deductible; precertification required for hospitalization and certain outpatient procedures
Non-hospital outpatient				
Lab, radiology, and X-ray	90% after deductible; precertification required for certain outpatient procedures	70% of MAA after deductible; precertification required for certain outpatient procedures	100%, not subject to deductible; precertification required for certain outpatient procedures	70% of MAA after deductible; precertification required for certain outpatient procedures
Mental health and substance abuse				
Inpatient	90% after deductible; precertification required	70% of MAA after deductible; precertification required	90% after deductible; precertification required	70% of MAA after deductible; precertification required
Outpatient	90% after deductible; precertification recommended	70% of MAA after deductible, precertification recommended	90% after deductible; precertification recommended	70% of MAA after deductible precertification recommended
Therapies				
Physical/speech/occupational therapy (all therapies combined): Limited to 60 visits a year for network and out-of-network combined; you may be eligible for additional visits with Plan approval after a medical necessity review	90% after deductible; 70% after deductible for approved visits over Plan limits	70% of MAA after deductible; 50% of MAA after deductible for approved visits over Plan limits	90% after deductible; 70% after deductible for approved visits over Plan limits	70% of MAA after deductible; 50% of MAA after deductible for approved visits over Plan limits
Chiropractic therapy: Limited to 20 visits per calendar year for network and out-of-network combined	90% after deductible;	70% of MAA after deductible	90% after deductible; precertification required	70% of MAA after deductible; precertification required

*Maximum allowed amount

	High Deductible Health Plan Administered by Aetna and Empire BlueCross BlueShield				Hawaii Health Plan administered by United HealthCare
	BASIC		PREMIER		
	Network	*Out-of-network*	*Network*	*Out-of-network*	
Annual deductible (network and out-of-network combined)					
Individual *Maximum per family (no benefits will be paid to an individual until the family deductible has been met)*	$2,100 $4,200 Includes prescription drug expenses	$3,100 $6,200 Includes prescription drug expenses	$1,200 $2,400 Includes prescription drug expenses	$2,400 $4,800 Includes prescription drug expenses	$200 $600
Annual out-of-pocket maximum (includes deductible; network and out-of-network combined)					
Individual	$5,000	$7,500	$2,500	$5,000	$1,000
Maximum per family	$10,000 Includes prescription drug expenses	$15,000 Includes prescription drug expenses	$5,000 Includes prescription drug expenses	$10,000 Includes prescription drug expenses	$2,000
Lifetime maximum	None	None	None	None	None
Professional care (in office)					
Doctor/primary care physician (PCP) visits	80% after deductible	70% of MAA* after deductible	90% after deductible	70% of MAA after deductible	90% after deductible when using network providers; 80% of MAA after deductible when using out-of-network providers
Specialist visits	80% after deductible	70% of MAA after deductible	90% after deductible	70% of MAA after deductible	
Preventive care, subject to frequency limits					
Well-adult visits and immunizations	100%, not subject to deductible	100% of MAA, not subject to deductible	100%, not subject to deductible	100% of MAA, not subject to deductible	100%, not subject to deductible when using network providers; 80% of MAA after deductible when using out-of-network providers
Well-child visits and immunizations	100%, not subject to deductible	100% of MAA, not subject to deductible	100%, not subject to deductible	100% of MAA, not subject to deductible	100%, not subject to deductible when using network providers; 80% of MAA after deductible when using out-of-network providers
Routine cancer screenings (PAP test, mammogram, sigmoidoscopy, colonoscopy, PSA screening)	100%, not subject to deductible	100% of MAA, not subject to deductible	100%, not subject to deductible	100% of MAA, not subject to deductible	100%, not subject to deductible when using network providers; 80% of MAA after deductible when using out-of-network providers
Hospital emergency room					
No coverage in any medical option if not a true emergency	80% after deductible; precertification required if admitted	80% after deductible; precertification required if admitted	90% after deductible; precertification required if admitted	90% after deductible; precertification required if admitted	90% after deductible for doctor; 80% after deductible for hospital
Urgent care center					
	80% after deductible	80% after deductible	90% after deductible	90% after deductible	90% after deductible when using network providers; 80% after deductible when using out-of-network providers

Medical

	High Deductible Health Plan Administered by Aetna and Empire BlueCross BlueShield				Hawaii Health Plan administered by United HealthCare
	BASIC		PREMIER		
	Network	*Out-of-network*	*Network*	*Out-of-network*	
Hospital inpatient and outpatient					
Semiprivate room and board, doctor's charges, lab, radiology, and X-ray	80% after deductible; precertification required for hospitalization and certain outpatient procedures	70% of MAA after deductible; precertification required for hospitalization and certain outpatient procedures	90% after deductible; precertification required for hospitalization and certain outpatient procedures	70% of MAA after deductible; precertification required for hospitalization and certain outpatient procedures	90% after deductible when using network doctors, 80% of MAA after deductible when using out-of-network doctors; 80% after deductible when using network hospitals, 80% of MAA after a $100 confinement deductible and calendar-year deductible when using out-of-network hospitals; precertification required for hospitalization and certain outpatient procedures. Failure to precertify will result in a $400 penalty, up to $1,000 per year
Non-hospital outpatient					
Lab, radiology, and X-ray	80% after deductible; precertification required for certain outpatient procedures	70% of MAA after deductible; precertification required for certain outpatient procedures	90% after deductible; precertification required for certain outpatient procedures	70% of MAA after deductible; precertification required for certain outpatient procedures	90% after deductible when using network doctors, 80% of MAA after deductible when using out-of-network doctors; precertification required for certain outpatient procedures
Mental health and substance abuse					
Inpatient	80% after deductible, precertification required	70% of MAA after deductible; precertification required	90% after deductible, precertification required	70% of MAA after deductible; precertification required	90% after deductible when using network doctors, 80% of MAA after deductible when using out-of-network doctors; 80% after deductible when using network hospitals, 80% of MAA after a $100 confinement deductible and calendar-year deductible when using out-of-network hospitals; precertification required. Failure to precertify will result in a $400 penalty, up to $1,000 per year
Outpatient	80% after deductible; precertification recommended	70% of MAA after deductible; precertification recommended	90% after deductible; precertification recommended	70% of MAA after deductible; precertification recommended	90% after deductible when using network providers; 80% of MAA after deductible when using out-of-network providers; precertification recommended

	High Deductible Health Plan Administered by Aetna and Empire BlueCross BlueShield				Hawaii Health Plan administered by United HealthCare
	BASIC		PREMIER		
	Network	*Out-of-network*	*Network*	*Out-of-network*	
Therapies					
Physical/speech/occupational therapy (all therapies combined): Limited to 60 visits a year network and out-of-network combined (30 visits a year network and out-of-network combined for the Hawaii Health Plan; separate chronic/ developmental delay benefit of 24 visits a year network and out-of-network combined for the Hawaii Health Plan); you may be eligible for additional visits with Plan approval after a medical necessity review.	80% after deductible; 70% after deductible for approved visits over Plan limits	70% of MAA after deductible; 50% of MAA after deductible for approved visits over Plan limits	90% after deductible; 70% after deductible for approved visits over Plan limits	70% of MAA after deductible; 50% of MAA after deductible for approved visits over Plan limits	90% network after deductible; 80% of MAA out-of-network after deductible; 70% after deductible for approved visits over Plan limits; failure to precertify will result in a $400 penalty, up to $1,000 per year
Chiropractic therapy: Limited to 20 visits a year network and out-of-network combined (30 visits a year network and out-of-network combined for the Hawaii Health Plan)	80% after deductible	70% of MAA after deductible	90% after deductible	70% of MAA after deductible	90% after deductible when using network providers; 80% of MAA out-of-network after deductible

*Maximum allowed amount

Preventive care

Preventive care services are available in all plans. Both exams and immunizations are covered by network providers at 100% with no deductible to meet.

Preventive care services include but are not limited to:

- Routine physical exams and diagnostic tests, for example, CBC (complete blood count), cholesterol blood test, and urinalysis and immunizations;
- Well-child services and routine pediatric care and immunizations for children, excluding travel immunizations; and
- Routine well-woman exams.

Contact the Plan for details.

Patient Protection and Affordable Care Act (PPACA) Guidelines

The Patient Protection and Affordable Care Act (PPACA) requires that group health plans follow certain guidelines regarding how often certain preventive screenings should be covered. These guidelines are recommended by the U.S. Preventive Services Task Force, the Centers for Disease Control (CDC) and the Health Resources & Services Administration.

All of the Citi medical options follow these guidelines — or provide more generous benefits than what is required, however each of the plans may be administered differently. Contact your medical plan to confirm how these screenings are covered.

Screening recommendations include:

- ***Colorectal Cancer*** – covered for adults 50-75, using fecal occult blood testing, flexible sigmoidoscopy, or colonoscopy
- ***High Blood Pressure*** – covered every two years if below $^{120}/_{80}$, or every year if between 120-$^{139}/_{80}$-90
- ***Lipid Disorders*** – covered for men 20-35, women 20-40 if at high risk, or men over 35, women over 45 if normal risk
- ***Type 2 Diabetes*** – covered for asymptomatic adults with blood pressure higher than135/80
- ***HIV*** – covered for adolescents and adults at increased risk and all pregnant women
- ***Syphilis*** – covered for adults at increased risk and all pregnant women
- ***Abdominal Aorta Aneurysm*** – covered one time for men 65-75 who have ever smoked

Medical

- ***Breast Cancer*** – covered every 1 to 2 years starting at 50
- ***Genetic Testing Breast and Ovarian Cancer (BRCA)*** – covered for women with family history BRCA1 or BRCA2
- ***Cervical Cancer*** – covered for sexually active women, 21-65
- ***Osteoporosis*** – covered for post menopausal women 60-85, every other year
- ***Chlamydia*** – covered for sexually active women who are under age 24 or are pregnant
- ***Gonorrhea*** – covered for sexually active women who are under age 24 or are pregnant
- ***Asymptomatic Bacteriuria*** – covered during 12-16 weeks gestation
- ***Hepatitis B*** – covered during first prenatal visit
- ***Iron Deficiency Anemia*** – covered during first prenatal visit
- ***Rh (D) Incompatibility*** – covered for asymptomatic women
- ***Congenital Hypothyroidism*** – covered for newborns
- ***Phenylketonuria (PKU)*** – covered for newborns
- ***Sickle Cell Anemia (SSA)*** – covered for newborns
- ***Hearing Loss*** – covered for newborns
- ***Visual Impairment under age 5*** – covered to detect amblyopia, strabismus, and visual acuity defects.

Quick tip

Use the Health Care Spending Account (HCSA)/Limited Purpose Health Care Spending Account (LPSA) to save money on your out-of-pocket health care expenses. Since you forfeit any money remaining in the account that you do not use by the end of the plan year, estimate conservatively. See the *Spending Accounts* section for details.

Routine cancer screenings

In the ChoicePlan 500, Oxford Health Plans PPO, and High Deductible Health Plan – Basic and Premier, cancer-screening tests are covered 100% with no deductible to meet when performed by network providers.

Refer to the fact sheets for the ChoicePlan 500, Oxford Health Plans PPO, or High Deductible Plan – Basic and Premier for coverage details when screenings are performed by out-of-network providers.

See the *Hawaii Health Plan* section for information on how routine cancer screenings are covered in that plan.

Cancer screening tests are:

- Pap smear;
- Mammography;
- Sigmoidoscopy;
- Colonoscopy; and
- PSA test.

Using an emergency room

If you have a true medical emergency, you should go to the nearest emergency facility. If you are admitted, you must notify your Plan within 48 hours. If you are not able to do this, have a family member contact your Plan.

The Citi Plans do not cover non-emergency services provided in an emergency room.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed. Generally, urgent care centers have evening and weekend hours and do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, or the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, or seizures).

Genetic Information Nondiscrimination Act of 2008

Under the Genetic Information Nondiscrimination Act of 2008 (GINA), genetic information cannot be requested, required, or purchased for underwriting purposes or before enrollment. You and your dependents cannot be required to undergo genetic testing. Genetic information cannot be used to adjust premiums or contributions. The Plan may use the minimum necessary amount of genetic testing results to make determinations about claims payments.

Newborns' and Mothers' Health Protection Act notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours/96 hours.

Women's Health and Cancer Rights Act notice

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to cover reconstructive surgery and prostheses following mastectomies. All medical plans and HMOs provide this coverage, subject to applicable deductibles and coinsurance.

If you receive benefits for a medically necessary mastectomy, and if you elect breast reconstruction after the mastectomy, you will also be covered for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy including lymphedema.

The Mental Health Parity and Addiction Equity Act of 2008

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

It is important to note that MHPAEA does not mandate that a plan provide MH/SUD benefits. Rather, if a plan provides medical/surgical and MH/SUD benefits, it must comply with the MHPAEA's parity provisions.

Precertification/ notification

Precertification/notification helps ensure that you obtain the most appropriate care for your condition in the most appropriate setting, and that your health care costs and Citi's costs are kept under control. The following sections describe the precertification/notification features of each Plan. Be sure to read the sections that apply to the Plan in which you enroll.

Precertification requirements for Aetna plans

If you are enrolled in Aetna ChoicePlan 500 or the High Deductible Health Plan – Basic or High Deductible Health Plan – Premier you must call Aetna to precertify any inpatient surgery or hospitalization and certain outpatient diagnostic/surgical procedures. Scheduled inpatient services must be precertified at least 14 days in advance. Outpatient procedures must be precertified at least five days in advance. Aetna must be notified of emergency admissions within 48 hours of the admission.

You are not required to notify Aetna of emergency hospitalization or other emergency services occurring outside the United States.

Inpatient confinements

For inpatient confinement, you must call Aetna for precertification at least 14 days prior to the scheduled admission date. An admission date may not have been set when the confinement was planned. You must call Aetna again as soon as the admission date is set.

You must obtain precertification for:

- A scheduled hospital admission, including to a mental health or chemical dependency treatment facility;
- A scheduled admission to a skilled-nursing facility or hospice care facility;
- Home health care; and
- Private-duty nursing.

In case of an unscheduled or emergency admission, you or your doctor must call Aetna within 48 hours after the admission.

Mental health/chemical dependency

You must call Aetna for precertification before you obtain covered inpatient mental health and/or chemical dependency treatment.

Organ/tissue transplants

You must notify Aetna before the scheduled date of any of the following:

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant.

See Organ/tissue transplants in "Covered services and supplies" on page 94 for information about precertification requirements. Aetna will then complete the utilization review. You, the physician, and the facility will receive a letter confirming the results of the utilization review.

Pregnancy

Pregnancy is subject to the following notification time periods:

- Aetna should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in a prenatal program;
- You must notify the Plan to certify inpatient confinement for delivery of a child. This is to certify a length of stay that exceeds:
  - 48 hours following a normal vaginal delivery; or
  - 96 hours following a cesarean section.
- For inpatient care (for either the mother or child) that continues beyond the 48/96-hour limits stated above, Aetna must be notified before the end of these time periods; and
- Non-emergency inpatient confinement during pregnancy but before the admission for delivery requires notification as a scheduled confinement.

If you or your physician does not agree with Aetna's determination, you may appeal the decision. For information about the claims appeal process, see "Claims and appeals for Aetna medical plans" on page 112.

Precertification for ChoicePlan 500 and the High Deductible Health Plan administered by Empire BlueCross BlueShield

You are required to obtain precertification for both network and out-of-network services. Your network doctor does *not* obtain precertification on your behalf.

Your Plan reviews and determines whether hospitalization and non-emergency surgery are medically necessary.

In case of an unscheduled or emergency admission, you or your doctor must call your Plan within two business days after the admission.

When traveling outside the United States, you are not required to obtain precertification for emergency hospitalization or other emergency services.

No benefits are payable unless Empire BlueCross BlueShield determines that the services and supplies are covered under the Plan.

You are required to obtain precertification for the following services:

- Admission to a skilled nursing facility;
- Air ambulance;
- Certain outpatient procedures;
- Gender reassignment surgeries;
- Home health care services, including private-duty nursing;
- Inpatient facility admissions, including emergency admissions and inpatient physical rehabilitation;
- Outpatient surgery; call at least fourteen working days prior to the service being provided;
- Inpatient mental health/chemical dependency;
- Organ/tissue transplants; call Empire BlueCross BlueShield before the scheduled date of any of the following:
  - The evaluation;
  - The donor search;
  - The organ procurement/tissue harvest; and
  - The transplant.

  See Organ/tissue transplants in "Covered services and supplies" on page 94 for information about precertification requirements. Empire BlueCross BlueShield will then complete the utilization review. You, the physician, and the facility will receive a letter confirming the results of the utilization review.
- Pregnancy; call Empire's Maternity Care program to ensure you receive pregnancy-related materials and the maximum benefits.
  - Pregnancy is subject to the following notification time periods:
    - For inpatient confinement for delivery of child, you should certify a length of stay in excess of:
      - 48 hours following a normal vaginal delivery; or
      - 96 hours following a cesarean section.
    - For inpatient care (for either the mother or child) that continues beyond the 48/96 hour limits stated above, Empire BlueCross BlueShield should be notified before the end of these time periods.

  If you or your physician does not agree with Empire BlueCross BlueShield's determination, you may appeal the decision. For more information about the claims appeal process, see "Claims and appeals for Empire BlueCross BlueShield medical plans" on page 114 or call **1-866-290-9098**.

Precertification for Oxford Health Plans PPO

The following services require precertification:

- Chiropractic services;
- Dental services (accident only);
- Durable medical equipment with a retail cost of more than $1,000 whether for purchase or rental;
- Hospital and other facility admissions, including emergency admissions;
- Home health care services, including private-duty nursing;
- Reconstructive procedures;
- Hospice care;
- Maternity admissions exceeding 48 hours for normal delivery/96 hours for cesarean section;
- Short-term rehabilitation (PT, OT & ST); and
- Transplant services.

Medical

Network services: Your PCP or other network provider will handle the precertification process for you when you receive any network services.

Out-of-network services: When you receive care from an out-of-network provider, you must obtain precertification before receiving any of the listed services. (Your out-of-network provider does not obtain precertification for you.)

Inpatient confinements

For inpatient confinement in a hospital or other facility, you must precertify the scheduled admission date at least five days before the start of the confinement. An admission date may not have been set when the confinement was planned. You must call Oxford again as soon as the admission date is set. You must receive precertification for:

- A scheduled hospital admission, including to a mental health or chemical dependency treatment facility;
- A scheduled admission to a skilled-nursing facility or hospice care facility;
- Home health care; and
- Private-duty nursing.

In case of an unscheduled or emergency admission, you or your doctor must call within 48 hours after the admission. If you are not able to call, have a family member contact United HealthCare.

Outpatient surgery/diagnostic testing/other services

When you receive care from an out-of-network provider, you must obtain precertification before receiving the following services:

- Diagnostic tests for organ or tissue transplants;
- Reconstructive procedures;
- Home health care;
- Private-duty nursing;
- Hospice;
- Dental services (accident only); and
- Durable medical equipment with a purchase or cumulative rental cost of $500 or more.

For outpatient services that require precertification, you must receive precertification at least fourteen working days before the service is given.

Mental health/chemical dependency

You must obtain precertification before you obtain covered inpatient mental health and/or chemical dependency treatment.

Organ/tissue transplants

You must obtain precertification at least fourteen working days before the scheduled date of any of the following, or as soon as reasonably possible:

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant.

Pregnancy

Pregnancy is subject to the following precertification time periods:

- Precertification should be requested through Oxford during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in a prenatal program;
- For inpatient care (for either the mother or child) that continues beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, Oxford must receive a precertification request before the end of these time periods; and
- Non-emergency inpatient confinement during pregnancy but before the admission for delivery requires precertification as a scheduled confinement.

If you or your physician does not agree with Oxford's determination, you may appeal the decision. For information about the claims appeal process, see "Claims and appeals for Oxford Health Plans medical plans" on page 118.

Precertification requirements for Hawaii Health Plan

When you receive care from any provider, whether network or out of network, you must notify United HealthCare before receiving any of the listed services. If you do not notify United HealthCare, you will be subject to a penalty of $400 per admission (to a maximum penalty, in the aggregate, of $1,000 per calendar year).

Inpatient confinements

For inpatient confinement in a hospital or other facility, you must notify United HealthCare of the scheduled admission date at least five days before the start of the confinement. An admission date may not have been set when the confinement was planned. You must call United HealthCare again as soon as the admission date is set. You must notify United HealthCare for:

- A scheduled hospital admission, including to a mental health or chemical dependency treatment facility;
- A scheduled admission to a skilled-nursing facility or hospice care facility;
- Home health care; and
- Private-duty nursing.

In case of an unscheduled or emergency admission, you or your doctor must call United HealthCare *within* 48 hours after the admission.

Outpatient surgery/diagnostic testing/other services

When you receive care from an out-of-network provider, you must notify United HealthCare before receiving the following services:

- Diagnostic tests for organ or tissue transplants;
- Reconstructive procedures;
- Home health care;
- Private-duty nursing;
- Hospice;
- Dental services (accident only); and
- Durable medical equipment with a purchase or cumulative rental cost of $1,000 or more.

For outpatient services that require notification, you must notify United HealthCare at least five working days before the service is given.

Mental health/chemical dependency

You must notify United HealthCare before you obtain covered inpatient mental health and/or chemical dependency treatment.

Organ/tissue transplants

You must notify United HealthCare at least seven working days before the scheduled date of any of the following, or as soon as reasonably possible:

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant.

Pregnancy

Pregnancy is subject to the following notification time periods:

- United HealthCare should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in a prenatal program.
- For inpatient care (for either the mother or child) that continues beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, United HealthCare must be notified before the end of these time periods; and
- Non-emergency inpatient confinement during pregnancy but before the admission for delivery requires notification as a scheduled confinement.

If you or your physician does not agree with United HealthCare's determination, you may appeal the decision. For information about the claims appeal process, see "Claims and appeals for United HealthCare medical plans" on page 116.

ChoicePlan 500

ChoicePlan 500 at a glance

Type of service	*Network*	*Out-of-network*
Annual deductible		
• Individual	• $500	• $1,500
• Maximum per family	• $1,000	• $3,000
Annual out-of-pocket maximum (includes deductible)		
• Individual	• $3,000	• $6,000
• Maximum per family	• $6,000	• $12,000
Lifetime maximum	• None	• None
Professional care (in office)		
• PCP visits	• 90% after deductible	• 70% of MAA* after deductible
• Specialist visits	• 90% after deductible (Aetna: 95% after deductible for Aexcel specialist)	• 70% of MAA after deductible
• Allergy treatment	• 90% after deductible for the first office visit; 100% for each additional injection if office visit fee is not charged	• 70% of MAA after deductible
Preventive care (subject to frequency limits)		
• Well-adult visits and routine immunizations	• 100%, not subject to deductible	• 100%, not subject to deductible up to $250 maximum, then covered at 70% of MAA, immunizations covered at 70% of MAA, not subject to deductible
• Well-child visits and routine immunizations	• 100%, not subject to deductible	• 100%, not subject to deductible up to $250 maximum, then covered at 70% of MAA, immunizations covered at 70% of MAA, not subject to deductible
• Cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening)	• 100%, not subject to deductible	• 100%, not subject to deductible up to $250 maximum, then covered at 70% of MAA
Routine care (subject to frequency limits)		
• Routine vision exams	• 100%, not subject to deductible, limited to one exam every 12 months	• 100%, not subject to deductible, up to $250 maximum (annually), then covered at 70% of MAA, limited to one exam every 12 months
• Routine hearing exams	• 100%, not subject to deductible, limited to one exam every 12 months	• 100%, not subject to deductible, up to $250 maximum (annually), then covered at 70% of MAA, limited to one exam every 12 months
Hospital inpatient and outpatient		
• Semiprivate room and board, doctor's charges, lab, X-ray, radiology, and surgical care	• 90% after deductible; precertification is required for hospitalization and certain outpatient procedures	• 70% of MAA after deductible; precertification required for hospitalization and certain outpatient procedures
Non-Hospital outpatient		
• Lab, X-ray, and radiology	• 90% after deductible; precertification is required for certain outpatient procedures	• 70% of MAA after deductible; precertification is required for certain outpatient procedures
Maternity care		
• Physician office visit	• 90% after deductible	• 70% of MAA after deductible
• Hospital delivery	• 90% after deductible • Precertification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery	• 70% of MAA after deductible • Pre-notification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery

Type of service	*Network*	*Out-of-network*
Emergency care (no coverage if not a true emergency)		
• Hospital emergency room • (includes emergency room facility and professional services provided in the emergency room)	• $100 copayment (waived if admitted within 24 hours, precertification required for hospitalization)	• $100 copayment (waived if admitted within 24 hours, precertification required for hospitalization)
• Urgent care facility	• 90% after deductible	• 90% after deductible
Non-routine outpatient lab, radiology, and X-ray services	• 90% after deductible	• 70% of MAA after deductible
Outpatient short-term rehabilitation		
• Physical, speech, or occupational therapy. (All therapy visits are reviewed for medical necessity. PT/ST/OT therapy visits are combined with a 60-visit maximum. Additional visits over the maximum are reviewed on a case-by-case basis for medical necessity.)	• 90% after deductible • 60 visits per year for physical, speech, developmental, and occupational therapy combined. This limit applies to network and out-of-network services combined • 70% after deductible for visits approved for medical necessity over plan limit	• 70% of MAA after deductible • 60 visits per year for physical, speech, developmental, and occupational therapy combined. This limit applies to network and out-of-network services combined • 50% of MAA after deductible for visits approved for medical necessity over plan limit
• Chiropractic therapy (medically necessary)	• 90% after deductible, up to 20 visits per year for network and out-of-network services combined	• 70% of MAA after deductible, up to 20 visits per year for network and out-of-network services combined
Durable medical equipment (includes orthotics/prosthetics and appliances)	• 90% after deductible	• 70% of MAA after deductible
Private-duty nursing and home health care	• 90% after deductible, limited to 200 visits annually for network and out-of-network services combined; precertification required	• 70% of MAA after deductible, limited to 200 visits annually for network and out-of-network services combined; precertification required
Hospice	• 90% after deductible; precertification required	• 70% of MAA after deductible; precertification required
Skilled nursing facility	• 90% after deductible (limited to 120 days annually for network and out-of-network services combined); precertification required	• 70% of MAA after deductible (limited to 120 days annually for network and out-of-network services combined); precertification required
Infertility treatment	• Covered up to a $24,000 family lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. • Network: 90% after deductible up to the family lifetime maximum network • Out-of-network: 70% of MAA after deductible up to the family lifetime maximum • Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum per family • Contact the Claims Administrator for specific coverage.	• Covered up to a $24,000 family lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. • Network: 90% after deductible up to the family lifetime maximum network • Out-of-network: 70% of MAA after deductible up to the family lifetime maximum • Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum per family • Contact the Claims Administrator for specific coverage.
Prescription drugs (see the *Prescription Drugs* section)		
Mental health and chemical dependency (see "Mental health/chemical dependency in and out-of-network" on page 68)		

*Maximum allowed amount

These tables are intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see "Covered services and supplies" on page 94 and "Exclusions and limitations" on page 105.

You have the freedom to choose your doctor or health care facility when you need health care. How that care is covered and how much you pay for your care out of your own pocket depends on whether the expense is covered by the Plan and whether you choose a preferred provider or a non-preferred provider. Using preferred providers (network) saves you money in two ways. First, preferred providers charge special, negotiated rates, which are generally lower than the maximum allowed amounts (MAA). Second, the level of reimbursement for many services is higher when using preferred providers. *Citi plans only cover services that are deemed medically necessary.*

You must meet a deductible both in and out of the network before the Plan will pay benefits. Precertification is required before any inpatient hospital stay and certain outpatient procedures.

ChoicePlan 500 network features

Deductible

If you elect to use physicians or other providers in the network, you will need to meet an annual network deductible of $500 individual/$1,000 family before any benefit will be paid. Once you meet your deductible, the Plan will pay 90% of covered network expenses.

The individual deductibles apply to all covered expenses, except preventive care, and must be met each calendar year before any benefits will be paid.

The family deductible represents the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible can be applied toward the family deductible. The family deductible can be met as follows:

- **Two in a family**: Each member must meet the $500 individual deductible; or
- **Three or more in a family**: Expenses can be combined to meet the $1,000 family deductible, but no one person can apply more than the individual deductible ($500) toward the family deductible amounts.

Coinsurance

Coinsurance refers to the portion of a covered expense that you pay after you have met the deductible. For example, if the Plan pays 90% of certain covered expenses, your coinsurance for these expenses is 10%.

Out-of-pocket maximum

The out-of-pocket maximum for services rendered in the network is $3,000 (individual)/$6,000 (family). This amount represents the most you will have to pay out of your own pocket in a calendar year for network services. This amount does not include network copayments, penalties, or services not covered under ChoicePlan 500. Once this out-of-pocket maximum is met, covered expenses are payable at 100% of the negotiated rate contracted with the Claims Administrator for the remainder of the calendar year. However, network copayments still apply even after the out-of-pocket maximums are met.

Eligible expenses within a family can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount ($3,000) to the family out-of-pocket maximum ($6,000).

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are:

- Charges above MAA;
- Copayments, including emergency room, office visit and urgent care;
- Penalties;
- Prescription drug expenses; and
- Charges for services not covered under ChoicePlan 500.

Expenses incurred when using out-of-network services count toward your network out-of-pocket maximum. Network and out-of-network, out-of-pocket maximums cross-accumulate.

Primary care physician (PCP)

When seeking primary care services, you should choose a provider from the PCPs in the directory of network providers. You may choose a pediatrician as the PCP for your covered child. Women may also select an OB/GYN without referral from their PCP. A directory of the providers who participate in the ChoicePlan 500 network is available from the Claims Administrator. You may call or visit the Claims Administrator's website:

- Aetna: **www.aetna.com**; select the Aetna Open Access, Choice POSII Open Access Plan or call **1-800-545-5862**
- Empire BlueCross BlueShield: **www.empireblue.com/citi**; to access a network provider through the BlueCross BlueShield Association BlueCard® PPO Program, select "Find a Doctor," and then choose "Across the Country (National Provider Search)." Enter your identification prefix (which is the first three letters of your member ID located on your ID card). If you do not have your member ID card handy, select PPO/EPO on the right side of the screen and click on "Next." You will have a variety of search options to help you find a provider who meets your needs. You may also call Empire at **1-866-290-9098**.
- Once you meet your deductible, the Plan will pay 90% of covered network expenses.

Specialists

If you need the services of a specialist, you may seek care from a specialist directly without a referral. Once you meet your deductible, the Plan will pay 90% of covered network expenses.

Aetna Aexcel specialists

Aexcel is a designation within Aetna's network that includes specialists who have demonstrated effectiveness in the delivery of care based on defined measures of clinical performance and cost-efficiency. Currently, there are Aexcel-designated physicians in 12 medical specialty categories: Cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics and gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, urology, and vascular surgery.

Aexcel-designated specialists are currently available to members in AZ, CA, CO, CT, DC, DE, FL, GA, IL, IN, KS, KY, MD, MA, ME, MI, MO, NJ, NV, NY, OH, OK, PA, TX, VA, and WA.

When you visit an Aexcel specialist you do not need a referral. The Plan will pay 95% of covered expenses after your deductible for Aexcel specialists. To find an Aexcel specialist visit, **www.aetna.com/docfind**; select the Aetna Standard Plans, Aetna Select, and look for the providers listed with the blue star. This blue star identifies the Aexcel specialists.

Allergist

When you see a network allergist, once you meet your deductible, you will be expected to pay 10% of the first office visit. If you receive an allergy injection only (without a physician's office visit charge), benefits will be covered at 100%. If services are for other than an allergy injection, coinsurance will apply.

Preventive care

Preventive care services are covered at 100%, no deductible to meet for the ChoicePlan 500.

Preventive care services include:

- Routine physical exams: Well-child care and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines. For frequency guidelines, contact your Claims Administrator;
- Routine diagnostic tests. For example, CBC (complete blood count), cholesterol blood test, urinalysis;
- Well-child services and routine pediatric care; and
- Routine well-woman exams.
- **Note:** For employees who are covered under **Aetna**, out-of-pocket maximum for preventive care is combined across all preventive care services.

In addition, ChoicePlan 500 will cover both cancer-screening tests and well-adult and well-child immunizations performed by network providers at 100%, not subject to deductible. Routine cancer screenings are:

- Pap smear performed by a network provider annually;
- Mammogram at a frequency based on age:
  - Ages 35–39: Baseline mammogram; or
  - Age 40 and older: Annual mammogram;
- Sigmoidoscopy annually for persons age 50 and older;
- Colonoscopy; and
- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older.

Preventive care services covered in the network at 100% will be reviewed annually and updated prospectively to comply with recommendations of the:

- American Medical Association;
- United States Preventive Care Task Force;
- Advisory Committee on Immunization Practices that have been adopted by the Director of the Centers for Disease Control and Prevention; and
- Comprehensive Guidelines Supported by the Health Resources and Services Administration.

Routine care

ChoicePlan 500 offers additional coverage for routine care services to help in the early detection of health problems.

- Routine eye exam:
  - **Network:** Covered at 100%, not subject to deductible; one exam every 12 months, performed by a network ophthalmologist or optometrist;
  - **Out-of-network:** Covered at 100%, not subject to deductible up to $250, then covered at 70% of MAA; limited to one exam every 12 months.

Medical

- Routine hearing exam:
  - **Network:** Covered at 100%, not subject to deductible; one exam every 12 months, performed by a network otolaryngologist or otologist.
  - **Out-of-Network:** Covered at 100%, not subject to deductible up to $250, then covered at 70% of MAA; limited to one exam every 12 months.

Hospital

Hospital care (inpatient and outpatient) received through a preferred provider is covered at 90% for covered services after the deductible has been met. Services provided by a network physician in an out-of-network hospital are covered at the network benefit level.

Note: Any charges submitted by an out-of-network hospital would be treated as out-of-network claims. Notification of an inpatient admission is required. Notification is required for certain outpatient procedures and services.

Emergency care

The emergency room copayment is $100 per visit. If you are admitted to the hospital within 24 hours of the emergency room visit for any condition, the copayment is waived.

Urgent care

Urgent care centers are listed in the provider directory available on the Claims Administrators' websites. You do not need a referral or any prior authorization to use an urgent care center. Services provided by an urgent care center are covered at 90% for covered services after the deductible has been met.

Charges not covered

A network provider contracts with the ChoicePlan 500 Claims Administrator to participate in the network. Under the terms of this contract, a network provider may not charge you or the Claims Administrator for the balance of the charges above the contracted negotiated rate for covered services.

You may agree with the network provider to pay any charges for services or supplies not covered under ChoicePlan 500 or not approved by ChoicePlan 500. In that case, the network provider may bill charges to you. However, these charges are not covered expenses under ChoicePlan 500 and are not payable by the Claims Administrator.

For information about how to file a claim or appeal a denied claim, see "Claims and appeals for Aetna medical plans" on page 112 or "Claims and appeals for Empire BlueCross BlueShield medical plans" on page 114.

Paying your bill at your network doctor's office

After you meet your annual deductible, the Plan will pay 90% for most covered services, while you will pay 10% of the Plan's negotiated rate. In most cases, your doctor will bill you for the 10%. Generally, you will not pay your network doctor on the day of your visit because you will have to wait for your portion of the charge to be calculated.

Choosing network providers

ChoicePlan 500 is administered by Aetna and Empire BlueCross BlueShield. When you enroll in ChoicePlan 500, you may request a provider directory that lists doctors and other providers who belong to the network.

- Aetna: **www.aetna.com**; select the Aetna Open Access, Choice POSII Open Access Plan or call **1-800-545-5862**.
- Empire BlueCross BlueShield: **www.empireblue.com/citi**; to access a network provider through the BlueCross BlueShield Association BlueCard ® PPO Program, select "Find a Doctor," and then choose "Across the Country (National Provider Search)." Enter your identification prefix (which is the first three letters of your member ID located on your ID card). If you do not have your member ID card handy, select PPO/EPO on the right side of the screen and click on "Next." You will have a variety of search options to help you find a provider who meets your needs. You may also call **1-866-290-9098**.

Note: Before visiting a network provider, contact him or her to confirm participation in your Plan's network. Provider lists are kept as current as possible, but changes can occur between the time you review the list of providers and the start of your coverage.

Out-of-network features

You can use an out-of-network provider for medical services and still be reimbursed under ChoicePlan 500. These expenses generally are reimbursed at a lower level than network expenses, after you have met the out-of-network deductible.

For information about how to file a claim for out-of-network services or appeal a denied claim, see "Claims and appeals for Aetna medical plans" on page 112, or "Claims and appeals for Empire BlueCross BlueShield medical plans" on page 114.

Deductible and coinsurance

If you elect to use physicians or other providers outside the network, you will need to meet an annual deductible of $1,500 individual/$3,000 family maximum before any benefit will be paid. Once you meet your deductible, you must submit a claim form accompanied by your itemized bill to be reimbursed for covered expenses.

The individual deductibles apply to all covered expenses except routine preventive care and must be met each calendar year before any benefits will be paid.

The family deductibles represent the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible can be applied toward the family deductible. The family deductible can be met as follows:

- **Two in a family:** Each member must meet the $500 network/$1,500 out-of-network individual deductible; or
- **Three or more in a family:** Expenses can be combined to meet the $1,000 network/$3,000 out-of-network family deductible, but no one person can apply more than the individual deductible ($500/$1,500) toward the family deductible amount.

Once you have met the deductible, ChoicePlan 500 normally pays 70% of maximum allowed amount (MAA) for covered expenses that are received out-of-network.

Out-of-pocket maximum

The out-of-pocket maximum for services rendered outside of the network is $6,000 (individual)/$12,000 (family). This amount includes the $1,500 individual/$3,000 family deductible and represents the most you will have to pay out of your own pocket in a calendar year for services received outside the network, excluding charges that exceed MAA expenses, penalties, or services not covered under ChoicePlan 500. Once this out-of-pocket maximum is met, covered expenses are payable at 100% of MAA for the remainder of the calendar year.

Eligible expenses within a family can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount of $6,000 to the family out-of-pocket maximum of $12,000.

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are:

- Expenses that exceed MAA;
- Emergency room copayment;
- Penalties;
- Prescription drug expenses; and
- Charges for services not covered under the Plan.

In addition, expenses incurred when using network services count toward your out-of-network, out-of-pocket maximum.

Preventive care

Each participant has a $250 annual credit toward all wellness services out-of-network. Thereafter, covered expenses are not subject to the deductible and expenses that exceed the $250 credit are covered at 70% of MAA. Preventive care services include:

- Routine physical exams: Well-child care and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines. For frequency guidelines, contact your Claims Administrator;
- Routine diagnostic tests: For example, CBC (complete blood count), cholesterol blood test, urinalysis;
- Well-child services and routine pediatric care; and
- Routine well-woman exams.

Medical

In addition, ChoicePlan 500 will cover both cancer-screening tests and well-adult and well-child immunizations performed by non-network providers. Well-adult and child immunizations are covered 70% of MAA, with no deductible to meet. Routine cancer screenings are covered at 100% with no deductible to meet up to a maximum benefit of $250; thereafter such screenings are covered at 70% of MAA. Routine cancer screenings are the same as provided under network coverage.

Hospital

Hospital care (inpatient and outpatient) will be reimbursed at 70% of MAA, after you meet your annual deductible. Coverage for room and board is limited to expenses for the regular daily charge made by the hospital for a semi-private room (or private room when medically appropriate or if it is the only room type available). Notification of an inpatient admission is required. Notification is required for certain outpatient procedures and services.

Emergency care

The emergency room copayment is $100 per visit. If you are admitted to the hospital within 24 hours of the emergency room visit for any condition, the copayment is waived.

Urgent care

Services provided by an urgent care center are covered at 90% for covered services after the deductible has been met.

Multiple surgical procedure guidelines

If you are using an out-of-network provider for a surgical procedure, the following multiple surgical procedure guidelines will apply.

If more than one procedure will be performed during one operation — through the same incision or operative field — the Plan will pay according to the following guidelines:

- **First procedure:** The Plan will allow 100% of the negotiated or MAA.
- **Second procedure:** The Plan will allow 50% of the negotiated or MAA.
- **Additional procedures:** The Plan will allow 50% of the negotiated or MAA for each additional procedure.
- **Bilateral and separate operative areas**: The Plan will allow 100% of the negotiated or MAA for the primary procedure and 50% of the secondary procedure and 50% of the negotiated or MAA for tertiary/additional procedures.

If billed separately, incidental surgeries will not be covered. An incidental surgery is a procedure performed at the same time as a primary procedure and requires few additional physician resources and/or is clinically an integral part of the performance of the primary procedure.

Mental health/chemical dependency in and out-of-network

ChoicePlan 500 provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call the Claims Administrator at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help find the right provider for you. In an emergency, the intake coordinator will also provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call your Claims Administrator before seeking treatment for mental health or chemical dependency treatment.

Action (all visits are reviewed for medical necessity)	Inpatient	Outpatient
If you call the Plan and use its network provider/facility	After the deductible, eligible expenses covered at 90% of the negotiated rate; precertification required	After the deductible, eligible expenses covered at 90% of the negotiated rate; precertification recommended
If you call the Plan but do not use its network provider/facility	After the deductible, eligible expenses covered at 70% of MAA; precertification required	After the deductible, eligible expenses covered at 70% of MAA; precertification recommended

Coverage levels

Mental health and chemical dependency treatment benefits are subject to the same medical necessity requirements, coverage limitations, and deductibles that are required under ChoicePlan 500.

Mental health benefits include, but are not limited to:

- Assessment, diagnosis, and treatment;
- Medication management;
- Individual, family, and group psychotherapy;
- Acute inpatient care;
- Partial hospitalization programs;
- Facility based intensive outpatient program services; and
- Psychological testing that is not primarily educational in nature.

No benefit will be paid for services that are not considered to be medically necessary.

Inpatient services

ChoicePlan 500 pays benefits at the network level (90% of the negotiated rate contracted with the Claims Administrator) if you call the Plan, use a network provider, and the treatment is medically necessary, and in the appropriate level-of-care setting. If you do not use a network provider, you will be reimbursed at 70% of MAA after the deductible is met provided that the treatment is medically necessary and in the appropriate level-of-care setting.

In general, inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by the Claims Administrator in advance of the admission.

Outpatient services

If you use a network provider, you will be reimbursed at 90% of covered expenses after the deductible is met. If you do not use a network provider, you will be reimbursed at 70% of MAA for covered services after the deductible is met.

Emergency care

Emergency care for mental health or chemical dependency treatment does not require a referral. However you are encouraged to call the Claims Administrator within 48 hours after an emergency admission. ChoicePlan 500's behavioral health providers are available 24/7 to accept calls.

Medically necessary

The Claims Administrator will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The Claims Administrator will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless the Claims Administrator determines that the covered services and supplies are medically necessary. Please refer to the "Glossary" for the definition of medical necessity.

For more information about what your Plan covers, see "Covered services and supplies" on page 94. You may also contact your Plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Concurrent review and discharge planning

The following items apply if ChoicePlan 500 requires certification of any confinement, services, supplies, procedures, or treatments:

- **Concurrent review.** The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.
- **Discharge planning.** Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be used by the member upon discharge from an inpatient stay.

Oxford Health Plans Preferred Provider Organization (PPO) (CT, NJ, and NY only)

The Oxford Health Plans Preferred Provider Organization (PPO) is administered by Oxford Health Plans and is available in the Connecticut, New Jersey, and New York tri-state area. The Plan is self-insured, that is, it is not subject to state laws.

Under the Plans, you have the freedom to choose your doctor or health care facility when you need health care. How that care is covered and how much you pay for your care out of your own pocket depends on whether the expense is covered by the Plan and whether you choose a preferred provider or a non-preferred provider. Using preferred (network) providers saves you money in two ways. First, preferred providers charge special, negotiated rates, which are generally lower than the maximum allowed amounts (MAA). Second, the level of reimbursement for many services is higher when using preferred providers. For a list of providers, visit the Oxford website at **www.oxhp.com** or call Oxford Member Services at **1-800-760-4566** (if you are not currently participating in the Plans) or **1-800-396-1909** (if you are currently participating in the Plans).

The Oxford Health Plans PPO at a glance

Type of service	Network	Out-of-network
Annual deductible		
• Individual	• $500	• $1,500
• Maximum per family	• $1,000	• $3,000
Annual out-of-pocket maximum (includes deductible)		
• Individual	• $3,000	• $6,000
• Maximum per family	• $6,000	• $12,000
Lifetime maximum	• None	• None
Professional care (in office)		
• PCP visits	• 90% after deductible	• 70% of MAA* after deductible
• Specialist visits	• 90% after deductible	• 70% of MAA after deductible
• Allergy treatment	• 90% after deductible for the first office visit; 100% for each additional injection if office visit fee is not charged	• 70% of MAA after deductible
Preventive care (subject to frequency limits)		
• Well-adult visits and routine immunizations	• 100%, not subject to deductible	• 100%, not subject to deductible, up to $250 maximum, then covered at 70% of MAA • Immunizations covered at 70% of MAA, not subject to deductible
• Well-child visits and routine immunizations	• 100%, not subject to deductible	• 100%, not subject to deductible, up to $250 maximum, then covered at 70% of MAA • Immunizations covered at 70% of MAA, not subject to deductible
• Routine cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening)	• 100%, not subject to deductible	• 100%, not subject to deductible, up to $250 maximum, then covered at 70% of MAA
Routine care (subject to frequency limits)		
• Routine vision exams – In- and out-of-network combined limit: one exam every 12 months	• 100%, not subject to deductible	• 100%, not subject to deductible, up to $250 maximum annually, then covered at 70% of MAA
• Routine hearing exams – In- and out-of-network combined limit: one exam every 12 months	• 100%, not subject to deductible	• 100%, not subject to deductible, up to $250 maximum annually, then covered at 70% of MAA

Type of service	Network	Out-of-network
Hospital inpatient and outpatient		
• Semiprivate room and board, doctor's charges, radiology, lab, X-ray, and surgical care	• 90% after deductible; precertification required for hospitalization and certain outpatient procedures	• 70% of MAA after deductible; precertification required for hospitalization and certain outpatient procedures
Non-hospital outpatient		
• Radiology, lab, and X-ray	• 100%, not subject to deductible; precertification is required for certain outpatient procedures	• 70% of MAA after deductible; precertification is required for certain outpatient procedures
Maternity care		
• Physician office visit	• 90% after deductible	• 70% of MAA after deductible
• Hospital delivery	• 90% after deductible • Precertification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery	• 70% of MAA after deductible • Precertification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery
Emergency care (no coverage if not a true emergency)		
• Hospital emergency room (includes emergency room facility and professional services provided in the emergency room)	• $100 copayment (waived if admitted within 24 hours; precertification required for hospitalization; 90% after deductible)	• $100 copayment (waived if admitted within 24 hours; precertification required for hospitalization)
• Urgent care facility	• 90% after deductible	• 90% after deductible
Non-routine outpatient lab and X-ray services	• 90% after deductible	• 70% of MAA after deductible
Outpatient short-term rehabilitation		
• Physical, speech, or occupational therapy	• 90% after deductible • 60 visits per year for physical, speech, and occupational therapy combined. This limit applies to network and out-of-network services combined • 70% after deductible for visits approved for medical necessity over Plan limits	• 70% of MAA after deductible, • 60 visits per year for physical, speech, and occupational therapy combined. This limit applies to network and out-of-network services combined • 50% of MAA after deductible for visits approved for medical necessity over Plan limits
• Chiropractic therapy	• 90% after deductible, up to 20 visits per year for network and out-of-network services combined; precertification required	• 70% of MAA after deductible, up to 20 visits per year for network and out-of-network services combined; precertification required
Durable medical equipment (includes orthotics/prosthetics and appliances)	• 90% after deductible	• 70% of MAA after deductible
Private-duty nursing and home health care	• 90% after deductible, limited to 200 visits annually for network and out-of-network services combined; precertification required	• 70% of MAA after deductible, limited to 200 visits annually for network and out-of-network services combined; precertification required
Hospice	• 90% after deductible; precertification required	• 70% of MAA after deductible; precertification required
Skilled nursing facility	• 90% after deductible (limited to 120 days annually for network and out-of-network services combined); precertification required	• 70% of MAA after deductible (limited to 120 days annually for network and out-of-network services combined); precertification required

Medical

Type of service	Network	Out-of-network
Infertility treatments	• CT: Deductible and coinsurance apply to covered services up to a $10,000 lifetime maximum for network and out-of-network services combined; 1 cycle of infertility treatment • NJ: Deductible and coinsurance apply to covered services up to 4 egg retrievals per lifetime for network and out-of-network services combined. Precertification required • NY: Covered at 100% for services up to a $10,000 lifetime maximum for network and out-of-network services combined • Contact Oxford for specific coverage details	• CT: Deductible and coinsurance apply to covered services up to a $10,000 lifetime maximum for network and out-of-network services combined; 1 cycle of infertility treatment • NJ: Deductible and coinsurance apply to covered services up to 4 egg retrievals per lifetime for network and out-of-network services combined. Precertification required • NY: Covered at 100% for services up to a $10,000 lifetime maximum for network and out-of-network services combined • Contact Oxford for specific coverage details
Prescription Drugs		
Retail	• $10 copayment (tier 1); $20 copayment (tier 2); $40 copayment (tier 3) per prescription up to a 30-day supply	• 50% covered
Mail order	• $20 copayment (tier 1); $40 copayment(tier 2); $80 copayment (tier 3) per prescription up to a 90-day supply	• Not available
Mental health and chemical dependency (refer to "Mental health/chemical dependency: in and out-of-network" on page 75)		

*Maximum allowed amount

These tables are intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see "Covered services and supplies" on page 94 and "Exclusions and limitations" on page 105.

How the Plan Works

Network coverage

To receive the highest level of benefits, referred to as the network level of benefits, from the Oxford PPO, you must receive care from a preferred provider.

Deductible

If you use physicians or other providers in the network, you will need to meet an annual deductible ($500 individual/$1,000 family) before any benefits will be paid. Once you meet your deductible, the Plan will generally pay 90% of covered network expenses.

The individual deductibles apply to all covered expenses except preventive care and must be met each calendar year before any benefits will be paid.

The family deductible represents the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible can be applied toward the family deductibles. The family deductible can be met as follows:

- **Two in a family:** Each member must meet the $500 individual deductible; or
- **Three or more in a family:** Expenses can be combined to meet the $1,000 family deductible, but no one person can apply more than the individual deductible ($500) toward the family deductible amounts

Coinsurance

Coinsurance refers to the portion of a covered expense that you pay after you have met the deductible. For example, if the Plan pays 90% of certain covered expenses, your coinsurance for these expenses is 10%.

Out-of-pocket maximum

The out-of-pocket maximums for services rendered in the network are $3,000 individual/$6,000 family. This amount represents the most you will have to pay out of your own pocket in a calendar year for services received in the network. This amount does not include network copayments, penalties, or services not covered under the

Oxford PPO. Once this out-of-pocket maximum is met, covered expenses are payable at 100% of the negotiated rate contracted with the Claims Administrator for the remainder of the calendar year. However, network copayments still apply even after the out-of-pocket maximum is met.

Eligible expenses within a family can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount ($3,000) to the family out-of-pocket maximum ($6,000).

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are:

- Prescription drug expenses; and
- Charges for services not covered under the Oxford PPO

Expenses incurred when using out-of-network services count toward your network out-of-pocket maximum. Network and out-of-network out-of-pocket maximums do not cross-accumulate.

Primary care physician (PCP)

When seeking primary care services, you should choose a provider from primary care physicians in the directory of network providers. You may choose a pediatrician as a PCP for your covered child. Women may also select an OB/GYN without a referral from their PCP. A directory of the network providers who participate in the Oxford PPO is available from the Claims Administrator. You may call or visit the Claims Administrator's website at **www.oxhp.com** or **1-800-760-4566** (if you are not currently participating in the Plans) or **1-800-396-1909** (if you are currently participating in the Plans).

Once you meet your deductible, the Plan will pay 90% of covered network expenses.

Specialists

If you need the services of a specialist, you may seek care from a specialist directly without a referral. Once you meet your deductible, the Plan will pay 90% of covered network expenses.

Allergist

When you see a network allergist, once you meet your deductible, you will be expected to pay 10% of the first office visit. If you receive an allergy injection only (without a physician office visit charge), benefits will be covered at 100%. If services are for other than an allergy injection and you are charged for an office visit, coinsurance will apply.

Preventive care

Preventive care services are covered at 100%, not subject to deductible.

Preventive care services include:

- Routine physical exams: well-child care and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines. For frequency guidelines, contact your Claims Administrator;
- Routine diagnostic tests. For example: CBC (complete blood count), cholesterol blood test, urinalysis;
- Well-child-care services and routine pediatric care; and
- Routine well-woman exams.

In addition, the Oxford PPO will cover both routine cancer-screening tests and well-adult and well-child immunizations performed by network providers at 100%, not subject to deductible. Routine cancer screenings are:

- Pap smear performed by a network provider annually;
- Mammogram at a frequency based on age:
  - Ages 35-39: Baseline mammogram; or
  - Age 40 and older: Annual mammogram;
- Sigmoidoscopy annually for persons age 50 and older;
- Colonoscopy; and
- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older.

Preventive care services covered in the network at 100% will be reviewed annually and updated prospectively to comply with recommendations of the:

- United States Preventive Care Task Force;
- Advisory Committee on Immunization Practices that have been adopted by the director of the Centers for Disease Control and Prevention; and
- Comprehensive Guidelines Supported by the Health Resources and Services Administration.

Medical

Routine care

The Oxford PPO offer additional coverage for routine care services to help in the early detection of health problems.

- **Routine eye exam:** Covered at 100%, not subject to deductible, one exam every 12 months, performed by a network ophthalmologist or optometrist; and
- **Routine hearing exam:** Covered at 100%, not subject to deductible, one exam every 12 months, performed by a network otolaryngologist or otologist.

Infertility

The Oxford PPO covers expenses associated with infertility treatment. Since infertility coverage varies by state, please contact the Plan for details.

Emergency care

The emergency room copayment is $100 per visit. If you are admitted to the hospital within 24 hours of the emergency room visit for any condition, the copayment is waived and 90% after deductible.

Charges not covered

A network provider contracts with the Oxford PPO Claims Administrator to participate in the network. Under the terms of this contract, a network provider may not charge you or the Claims Administrator for the balance of the charges above the contracted negotiated rate for covered services.

You may agree with the network provider to pay any charges for services or supplies not covered under the Oxford PPO or not approved by the Oxford PPO. In that case, the network provider may bill charges to you. However, these charges are not covered expenses under Oxford PPO and are not payable by the Claims Administrator.

For information about how to file a claim or appeal a denied claim, see "Claims and appeals for Oxford Health Plans medical plans" on page 118.

Out-of-network coverage

You can use an out-of-network provider for medical services and still receive reimbursement under the Oxford PPO. These expenses generally are reimbursed at a lower level than network expenses, and you will have to meet a deductible.

For information about how to file a claim for out-of-network services or appeal a denied claim, see "Claims and appeals for Oxford Health Plans medical plans" on page 118.

Deductible and coinsurance

If you use physicians or other providers outside the network, you will need to meet an annual deductible ($1,500 individual/$3,000 family) before any benefit will be paid. Once you meet your deductible, you must submit a claim form accompanied by your itemized bill to be reimbursed for covered expenses.

The individual deductibles apply to all covered expenses except routine preventive care and must be met each calendar year before any benefits will be paid.

The family deductibles represent the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible can be applied toward the family deductible. The family deductible can be met as follows:

- **Two in a family:** Each member must meet the $1,500 individual deductible or
- **Three or more in a family:** Expenses can be combined to meet the $3,000 family deductible, but no one person can apply more than the individual deductible ($1,500) toward the family deductible amount.

Once you have met the deductible, Oxford PPO normally pays 70% of maximum allowed amount (MAA) charges for covered expenses that are received out-of-network.

Out-of-pocket maximum

The out-of-pocket maximum for services rendered outside of the network is $6,000 individual/$12,000 family. This amount includes the ($1,500 individual and $3,000 family) deductible and represents the most you will have to pay out of your own pocket in a calendar year for services received outside the network, excluding charges that exceed MAA, penalties, or services not covered under the Oxford PPO. Once this out-of-pocket maximum is met, covered expenses are payable at 100% of MAA for the remainder of the calendar year.

Eligible expenses within a family can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount ($6,000) to the family out-of-pocket maximum ($12,000).

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are:

- Expenses that exceed MAA;
- Prescription drug expenses; and
- Charges for services not covered under the Plan.

In addition, expenses incurred when using network services count toward your out-of-network, out-of-pocket maximum.

Preventive care

Each participant has a $250 annual credit toward all wellness services out-of-network. Thereafter, covered expenses are not subject to the deductible and expenses that exceed the $250 credit are covered at 70% of MAA. Preventive care services include:

- Routine physical exams: Well-child care and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines. For frequency guidelines, contact your Claims Administrator;
- Routine diagnostic tests: For example, CBC (complete blood count), cholesterol blood test, urinalysis;
- Well-child services and routine pediatric care; and
- Routine well-woman exams.

In addition, the Oxford PPO will cover both cancer-screening tests and well-adult and well-child immunizations performed by non-network providers. Well adult and child immunizations are covered 70% of MAA, with no deductible to meet. Routine cancer screenings are covered at 100% with no deductible to meet up to a maximum benefit of $250; thereafter such screenings are covered at 70% of MAA. Routine cancer screenings are the same as provided under network coverage.

Infertility

The Oxford PPO covers expenses associated with infertility treatment. Since infertility coverage varies by state, contact the Plan for details.

Hospital

Hospital care (inpatient and outpatient) will be reimbursed at 70% of MAA, after you meet your annual deductible. Coverage for room and board is limited to expenses for the regular daily charge made by the hospital for a semi-private room (or private room when medically appropriate or if it is the only room type available). Notification of an inpatient admission is required. Notification is recommended for certain outpatient procedures and services.

Emergency care

The emergency room copayment is $100 per visit. If you are admitted to the hospital for any condition, the copayment is waived.

Urgent care

Services provided by an urgent care center are covered at 90% for covered services after the deductible has been met.

Mental health/chemical dependency: in and out-of-network

The Oxford PPO provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call the customer service telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help find the right provider for you. In an emergency, the intake coordinator will also provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

Medical

You must call your Plan before seeking treatment for mental health or chemical dependency treatment.

Action (all visits are reviewed for medical necessity)	Inpatient	Outpatient
If you call the Plan and use its network provider/facility	After the deductible, eligible expenses are covered at 90% of the negotiated rate; precertification required	After the deductible, eligible expenses are covered at 90% of the negotiated rate; precertification recommended
If you call the Plan but do not use its network provider/ facility	After the deductible, eligible expenses covered at 70% of MAA; precertification required	After the deductible, eligible expenses covered at 70% of MAA; precertification recommended

Coverage levels

Mental health and chemical dependency treatment benefits are subject to the Plan's medical necessity requirements, coverage limitations, and deductibles.

Mental health benefits include, but are not limited to:

- Assessment, diagnosis, and treatment;
- Medication management;
- Individual, family, and group psychotherapy;
- Acute inpatient care;
- Partial hospitalization programs;
- Facility based intensive outpatient program services; and
- Psychological testing that is not primarily educational in nature.

No benefit will be paid for services that are not considered to be medically necessary.

Inpatient services

The Oxford PPO pays benefits at the network level (90% of the negotiated rate contracted with the Claims Administrator) if you call the Plan, use a network provider, and the treatment is medically necessary and in the appropriate level-of-care setting. If you do not use a network provider, you will be reimbursed at 70% of MAA after the deductible is met provided that the treatment is medically necessary and in the appropriate level-of-care setting.

In general, inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless precertified in advance of the admission.

Outpatient services

You are encouraged to call the Oxford PPO for outpatient referrals. If you call and use the recommended provider, you will be reimbursed at 90% of covered expenses after the deductible is met. If you do not use the recommended provider, you will be reimbursed at 70% of MAA for covered services after the deductible is met.

Emergency care

Emergency care for mental health or chemical dependency treatment does not require a referral. However you are required to call the Oxford PPO within 48 hours after an emergency admission. The Oxford PPO behavioral health providers are available 24/7 to accept calls.

Medically necessary

Oxford PPO will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The Behavioral Health department will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless the Behavioral Health department determines that the covered services and supplies are medically necessary. Please refer to the "Glossary" for the definition of medical necessity.

For more information about what your Plan covers, see "Covered services and supplies" on page 94. You may also contact the Plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Concurrent review and discharge planning

The following items apply if the Oxford PPO requires certification of any confinement, services, supplies, procedures, or treatments:

- **Concurrent review:** The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.
- **Discharge planning:** Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be used by the member upon discharge from an inpatient stay.

Fully insured health maintenance organizations (HMOs)

Citi has entered into fully insured arrangements with numerous HMOs to provide health benefits to eligible employees. Although HMOs generally deliver benefits in the same way, the coverage that each HMO provides differs from the others.

This section provides a description of the medical benefit information available to HMO participants and should be read together with the *Eligibility and participation* section, the *Administrative information* section, and the HMO fact sheets, and HMO Certificate of Insurance listed under "2012 insured HMOs" on page 79. There is a separate HMO fact sheet and HMO Certificate of Insurance for each fully insured HMO.

- *Eligibility and participation* and *Administrative information* provide information about eligibility and enrollment for you and your dependents, coordination of benefits, your legal rights, your contributions, and other administrative details.
- HMO fact sheets summarize the benefits available through each HMO.
- HMO Certificates of Insurance provide detailed information about the benefits and coverage available through each HMO. For example, the Certificate of Insurance will generally provide you with information concerning:
  - The nature of services provided to members, including all benefits and limitations;
  - Conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility to participate in the HMO) and circumstances under which services may be denied; and
  - The procedures to be followed when obtaining services and the procedures available for the review of claims for services that are denied in whole or in part.

The HMO will send a Certificate of Insurance and a provider directory to you at your home upon enrollment in the HMO. If you do not receive your Certificate of Insurance, call your HMO at the telephone number on the HMO fact sheet or on your ID card.

For a list of the HMOs offered by Citi, HMO fact sheets, and the Certificate of Insurance for each HMO, see "2012 insured HMOs" on page 79. The HMOs available to you will depend on your home zip code.

Note: Citi offers the opportunity to join an insured HMO. The actual coverage provided by the HMO is the HMO's responsibility. Citi does not guarantee or have any responsibility for the quality of health care or service provided or arranged by the HMO. Citi is not responsible for medical expenses that are not covered services under the HMO. HMO participants have the right to choose their own health care professionals and the services they receive under the HMO.

Be sure to check directly with the HMO prior to enrolling to ensure that you fully understand the provisions of the HMO.

If you have questions about coverage, providers, or using an HMO, call the HMO directly at the telephone number on the HMO fact sheet. This number can also be found on your HMO ID card, if you are a member of that HMO.

All the materials described above make up the Plan document for Citi's fully insured HMOs. The Plan document is intended to comply with the requirements of ERISA and other applicable laws and regulations. This HMO Plan document does not create a contract or guarantee of employment between Citi and any individual.

Typical plan design features of an HMO offered by Citi

You must use network providers. If you do not use participating providers — except in an emergency — the HMO will not cover that care, and you will be responsible for paying the full cost of that care.

You must choose a primary care physician (PCP) from the list of providers before obtaining any medical services. You may also choose a pediatrician as the PCP for your child. Women may also select an OB/GYN without a referral from their PCP.

Your deductible is $500/individual and $1,000/family maximum. After meeting your deductible, the HMO will pay covered services at 90% while you will pay 10% (your coinsurance). Your annual out–of-pocket maximum is $3,000/individual and $6,000/family maximum.

Each HMO offers prescription drug coverage. Contact the HMO for the name of the prescription drug benefits manager.

Preventive care is covered at 100% without having to meet the deductible.

Routine vision exams are covered at 100% in all HMOs except Coventry Health Care of Iowa, Health Plan Hawaii Plus (HMSA), and Kaiser Hawaii.

As a reminder, benefits vary depending on the HMO.

For more information, review the HMO fact sheet and the Certificate of Insurance or call your HMO.

If you have questions or concerns about specific covered services, call the HMO in which you are enrolled directly. Visit **www.benefitsbookonline.com/enrollment/plans.html** for information HMO contact information.

Primary care physician (PCPs)

In general, as a participant in an HMO, your PCP provides and coordinates all of your network care. In most cases, if you need to visit a specialist, your PCP will refer you to network specialists and facilities. Consult your PCP whenever you have questions about your health.

Many HMOs will require each covered family member to select a PCP. You will find PCPs listed in the HMO's provider directory, which you can access by linking to the HMO fact sheet available under "Fully insured health maintenance organizations (HMOs)" on page 77. Generally, if you do not choose a PCP, one will be selected for you until you select one.

Your options for choosing a PCP depend on the HMO you select. For instance, your PCP could be a general practitioner, an internist, or a family practitioner. You may choose a pediatrician as your child's PCP. In addition to choosing a PCP for other health care needs, women may select a gynecologist without a referral from their PCP for their routine gynecological checkups.

Specialists

When you need a specialist, most HMOs will require you to obtain a referral from your HMO or the services will not be covered. With most HMOs, your PCP is responsible for providing these specialist referrals. Certain services may require both a referral from your PCP and prior authorization from your HMO. Your PCP may help to coordinate any required authorizations.

If your HMO requires a referral and you visit a specialist without one, you may be responsible for the full cost of your care. Generally, you cannot request referrals after you have received the care, except in emergencies. You should contact the HMO directly or see the HMO's Certificate of Insurance for a detailed explanation of the referral procedures.

Routine care

Most HMOs cover preventive care services and health screenings. Such services may include:

- Routine physical exams, including well-child care and adult care;
- Routine health screenings, including gynecological exams, mammograms, sigmoidoscopy, colonoscopy, and PSA (prostatic-specific antigen) screenings;
- Routine eye exams; and
- Routine hearing exams.

Hospital care

Generally, hospital care — both inpatient and outpatient — requires a copayment or coinsurance. If you use a network provider or lab, but are not referred by your HMO, you may be required to pay for the services. Generally, hospital services require advance approval from the HMO. Your PCP may help to coordinate the approval.

See the HMO fact sheet and Certificate of Insurance for more information about hospital coverage.

Maternity care

Most HMOs cover physician and hospital care for both the mother and the newborn child, including prenatal care, delivery, and post-natal care. Generally, you will need a referral for your first visit to a participating obstetrician. However, you will not need a referral for the remaining visits during your pregnancy.

The mother and the newborn child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery and 96 hours following a cesarean section. Some HMOs provide coverage for home health care visits if your doctor determines that you and your child may be safely discharged after a shorter stay.

The 48/96-hour minimum stay after childbirth is required by federal law. State laws may provide additional requirements for maternity coverage. See the HMO fact sheet and Certificate of Insurance for more information about maternity coverage.

Call the Citi Benefits Center through ConnectOne within 31 days of the child's birth to add your newborn child to your coverage. The health plans will not cover the child after 31 days. Call **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Emergency care

Benefits are always available in a medical emergency, whether you use network or out-of-network providers. A medical emergency is generally defined as a sickness or injury that, without immediate medical attention, could place a person's life in danger or cause serious harm to bodily functions.

If you have a true medical emergency, you should go to the nearest emergency facility. Most HMOs require you to contact your PCP or the HMO within certain time limits, generally 48 hours. If you are unable to do this, you should have a family member contact your HMO.

Most HMOs require a copayment for each emergency room visit. If you are admitted to the hospital, the copayment is generally waived. Non-emergency services provided in an emergency room are not covered.

See the HMO fact sheet and Certificate of Insurance for more information, including your HMO's definition of a true medical emergency.

Benefit limits

Covered services, exclusion, and limitations vary by HMO. Check with the HMO prior to enrolling to ensure that you fully understand the provisions of the HMO.

2012 insured HMOs

The following fully insured HMOs are offered by Citi for 2012 in each state. The inclusion of an HMO in a state list does not mean that the option is available throughout the state. Your eligibility to participate in one of the HMOs offered is based on your home zip code. You can determine whether the HMO is available where you live by calling the telephone number on the HMO fact sheet.

State	HMO
California	Kaiser FHP of California — Southern — Fact Sheet, Certificate of Insurance Kaiser FHP of California — Northern — Fact Sheet, Certificate of Insurance
Colorado	Kaiser FHP of Colorado — Fact Sheet, Certificate of Insurance
District of Columbia	Kaiser FHP of the Mid-Atlantic States — Fact Sheet, Certificate of Insurance
Georgia	Kaiser FHP of Georgia — Fact Sheet, Certificate of Insurance
Hawaii	Health Plan Hawaii Plus (HMSA) – Fact Sheet, Certificate of Insurance Kaiser FHP of Hawaii — Fact Sheet, Certificate of Insurance
Idaho	SelectHealth — Fact Sheet, Certificate of Insurance
Iowa	Coventry Health Care of Iowa — Fact Sheet, Certificate of Insurance Sanford Health Plan — Fact Sheet, Certificate of Insurance
Maryland	Kaiser FHP of the Mid-Atlantic States — Fact Sheet, Certificate of Insurance
Minnesota	Sanford Health Plan — Fact Sheet, Certificate of Insurance
New Mexico	Presbyterian Health Plan - NM — Fact Sheet, Certificate of Insurance
New York	Independent Health — Fact Sheet, Certificate of Insurance
Pennsylvania	Geisinger Health Plan — Fact Sheet, Certificate of Insurance
South Dakota	Sanford Health Plan — Fact Sheet, Certificate of Insurance
Utah	SelectHealth — Fact Sheet, Certificate of Insurance
Virginia	Kaiser FHP of the Mid-Atlantic States — Fact Sheet, Certificate of Insurance

High Deductible Health Plan – Basic and Premier

HIGH DEDUCTIBLE HEALTH PLAN AT A GLANCE				
	HIGH DEDUCTIBLE HEALTH PLAN – BASIC		HIGH DEDUCTIBLE HEALTH PLAN – PREMIER	
	Network	Out-of-network	Network	Out-of-network
Company contribution to your HSA	$500 Employee Only/ $1,000 all other coverage categories		$500 Employee Only/ $1,000 all other coverage categories	
Deductible	$2,100/$4,200	$3,100/$6,200	$1,200/$2,400	$2,400/$4,800
Out-of-pocket maximum (including deductible)	$5,000/$10,000	$7,500/$15,000*	$2,500/$5,000	$5,000/$10,000*
Coinsurance	80%	70%	90%	70%
Prescription drugs (see the *Prescription Drugs* section)				

* Only the amount paid by the Plan — not the amount billed by the doctor/facility — is applied to your out-of-pocket maximum.

The High Deductible Health Plan (HDHP), administered by Aetna and Empire BlueCross BlueShield, covers the same services as ChoicePlan 500. However, there are certain major differences between the Plans.

- The HDHP provides what is referred to as "catastrophic" medical coverage. It is *not* intended for individuals who want to be reimbursed for almost all their health care expenses.
- The HDHP is designed to be used in conjunction with a Health Savings Account (HSA) in which you contribute before-tax dollars to pay for your deductible and other eligible out-of-pocket expenses. HDHP participants are permitted to enroll in the Limited Purpose Health Care Spending Account (LPSA). Participants cannot enroll in the Health Care Spending Account (HCSA). *Enrollment in an HCSA during the plan year disqualifies participants from making HSA contributions.*
- Prescription drugs count toward the individual/family deductible and out-of-pocket maximum. You do not need to meet a separate prescription drug deductible.

When you enroll in an HDHP, you must be prepared to spend up to several thousand dollars out of pocket before the Plan will pay benefits, other than for certain preventive services/medications and routine cancer screenings. Generally, benefits cannot be paid from the HDHP until you meet the deductible.

Note: If enrolled in any of the family coverage categories (any category other than employee only), the entire family deductible amount must be met before the Plan will pay benefits. The out-of-pocket maximum also applies to all covered participants, not to any individual.

The HDHP – Basic has a higher deductible but costs less per pay period than the HDHP – Premier. Since the Premier option has a lower deductible, it will reimburse you for eligible expenses sooner.

High Deductible Health Plan features

- Most covered network expenses are reimbursed at 80% (Basic) and 90% (Premier) of negotiated charges after the annual deductible has been met. Claims submitted by an out-of-network provider generally are reimbursed at 70% of maximum allowed amount (MAA) after the deductible has been met. **Note:** Only the amount paid by the Plan — not the amount billed by the doctor/facility — is applied to your out-of-pocket maximum.
- Routine physical exams for adults and children and well-woman exams are covered at 100% when using network providers and 100% of MAA when using out-of-network providers with no deductible to meet.
- Cancer screenings are covered at 100% when using network providers and 100% of MAA when using out-of-network providers with no deductible to meet. Cancer screening tests are the Pap smear, mammography, sigmoidoscopy, colonoscopy, and PSA test.
- Other recommended preventive care services are covered at 100% when using network providers and 100% of MAA when using out-of-network providers with no deductible to meet.

- Prescription drugs are covered by the Citigroup Prescription Drug Program administered by Express Scripts. You first must meet your combined medical and prescription drug deductible before you can purchase prescription drugs at a retail network pharmacy and through the Express Scripts Home Delivery program for the Plan's copayment or coinsurance, except as described in the bullet immediately following.
- You can purchase certain preventive care medications for a copayment or coinsurance *before* the deductible is met. Copayments/coinsurance count toward your out-of-pocket maximum. For a list of preventive medications, visit the Express Scripts' website. If you are a participant in a medical plan with prescription drug coverage through Express Scripts, visit **www.express-scripts.com**. If not, visit **https://member.express-scripts.com/preview/citigroup2012**.
- The Plan has no lifetime maximum benefit other than for infertility coverage.

Citi has determined that the HDHP does not constitute "creditable coverage" under Medicare. If you enroll in the HDHP and become eligible for Medicare in the same plan year, you may pay more for Medicare Part D prescription drug coverage if you later choose to elect it. For information about creditable coverage, see the Non-Creditable Coverage Disclosure Notice.

High Deductible Health Plan – Basic

Type of service	Network	Out-of-network
Annual deductible (includes prescription drug expenses)		
• Single	• $2,100	• $3,100
• Family	• $4,200	• $6,200
Annual out-of-pocket maximum (includes deductible)		
• Single	• $5,000	• $7,500
• Family	• $10,000	• $15,000
Lifetime maximum	• None	• None
Professional care (in office)		
• PCP or specialist visits	• 80% after deductible	• 70% of MAA* after deductible
• Allergy treatment	• 80% after deductible for the first office visit; 100% after deductible for each additional injection if office visit fee is not charged, after deductible	• 70% of MAA after deductible
Preventive care (subject to frequency limits)		
• Well-adult visits and routine immunizations • Well-child visits and routine immunizations • Routine cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening)	• 100%, not subject to deductible	• 100% of MAA, not subject to deductible
Routine care (subject to frequency limits)		
• Routine vision exam	• 100%, not subject to deductible; limit one exam per 12 months	• 100% of MAA, not subject to deductible; limit one exam per 12 months
• Routine hearing exam	• 100%, not subject to deductible; limit one exam per 12 months	• 100% of MAA, not subject to deductible; limit one exam per 12 months
Hospital inpatient and outpatient		
• Semiprivate room and board, doctor's charges, lab, X-ray, radiology, and surgical care	• 80% after deductible; precertification required for hospitalization and certain outpatient procedures and services	• 70% of MAA after deductible; precertification required for hospitalization and certain outpatient procedures and services
Non-hospital outpatient		
• Lab, X-ray, and radiology	• 80% after deductible; precertification is required for certain outpatient procedures	• 70% of MAA after deductible; precertification is required for certain outpatient procedures

Medical

Type of service	Network	Out-of-network
Maternity care		
• Physician office visit	• 80% after deductible	• 70% of MAA after deductible
• Hospital delivery	• 80% after deductible	• 70% of MAA after deductible
Emergency care (no coverage if not a true emergency)		
• Hospital emergency room (includes emergency room facility and professional services provided in the emergency room)	• 80% of covered services after deductible; precertification required if admitted	• 80% of covered services after deductible; precertification required if admitted
• Urgent care facility	• 80% of covered services after deductible	• 80% of covered services after deductible
• Non-routine outpatient lab, X-ray, and radiology services	• 80% of covered services after deductible	• 70% of covered services after deductible
Outpatient short-term rehabilitation		
• Physical, speech, or occupational therapy	• 80% after deductible • 60 visits per year for physical, speech, developmental, and occupational therapy • 70% after deductible for visits approved for medical necessity above Plan limits	• 70% of covered services after deductible • 60 visits per year for physical, speech, developmental, and occupational therapy • 50% of MAA after deductible for visits approved for medical necessity above Plan limits
Prescription drugs (see the *Prescription Drugs* section)		
Mental health and chemical dependency (see "Mental health/chemical dependency" on page 84)		

*Maximum allowed amount

This table is intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see "Covered services and supplies" on page 94 and "Exclusions and limitations" on page 105.

How the Plan works

This section contains more detailed information about HDHP's provisions and how this medical plan works.

You have a choice of using network providers or out-of-network providers. Using network providers saves you money in two ways. First, network providers charge special, negotiated rates, which are generally lower than the MAA. Second, the level of reimbursement for many services is higher when you use a network provider.

A directory of network providers is available directly from the Claims Administrator.

- Aetna: **www.aetna.com**; select the Aetna Open Access, Choice POSII Open Access Plan or call **1-800-545-5862**
- Empire BlueCross BlueShield: **www.empireblue.com/citi**; select the PPO/EPO or call **1-866-290-9098**

Deductible and coinsurance

You must meet an annual deductible of $2,100 for individual (employee only) coverage or $4,200 for family (two or more in a family) before the Plan pays any benefits, unless the service is covered at 100%, such as preventive care.

The deductible applies to all covered expenses except preventive care and must be met each calendar year before any benefits will be paid.

Other than for services not subject to the deductible, any one or a combination of family members must meet the full family deductible before the Plan pays any benefits. There is no individual limit within the family deductible limit. The deductible can be met as follows:

- **Network**
  - **Employee only:** The individual deductible of $2,100 applies.
  - **Two or more in a family:** The $4,200 family deductible applies, one or a combination of all family members must meet the full family deductible before the Plan pays any benefits.
  - **Note:** Once you have met the deductible, the Plan normally pays 80% of the negotiated rate for covered health services if you or your covered dependent uses a network hospital/provider.
- **Out-of-Network**
  - **Employee only:** The individual deductible of $3,100 applies.
  - **Two or more in a family:** The $6,200 family deductible applies, one or a combination of all family members must meet the full family deductible before the Plan pays any benefits.
  - **Note:** Expenses are normally reimbursed at 70% of MAA for claims for covered services submitted for an out-of-network provider.

Out-of-pocket maximum

Your out-of-pocket maximum is $5,000 individual/$10,000 family (out-of-network $7,500/individual and $15,000/family). The amount includes the $2,100/individual and $4,200/family (out-of-network $3,100/$6,200) deductible. This represents the most you will have to pay out of your own pocket in a calendar year.

Only covered expenses count toward the individual or family out-of-pocket maximum. There is no individual out-of-pocket maximum within the family out-of-pocket maximum. One family member or a combination of family members must meet the full family out-of-pocket maximum. The maximum can be met as follows:

- **Employee only**: $5,000 (out-of-network $7,500)
- **Two or more in a family:** The $10,000 (out-of-network $15,000) family out-of-pocket maximum applies; one or a combination of all family members must meet the full family out-of-pocket maximum

Once this out-of-pocket maximum is met, covered expenses are payable at 100% of the negotiated rate (or of MAA) for the remainder of the calendar year. However, the Plan does not cover the amount over MAA. You can still be billed for that amount and are responsible for paying that portion.

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are:

- Expenses that exceed MAA,
- Charges for services not covered under the Plan, and
- Any expense that would have been reimbursed if you had followed the notification requirements for care.

Preventive care

Covered expenses are not subject to the deductible and are covered at 100% when using network providers or 100% of MAA when using out-of-network providers.

Preventive care services include:

- Routine physical exams: Well-child care and adult care, performed by the patient's provider at a frequency based on American Medical Association guidelines or as directed by the provider. For frequency guidelines, call the Claims Administrator;
- Routine diagnostic tests: For example, CBC (complete blood count), cholesterol blood test, urinalysis; and
- Routine well-woman exams.

In addition, the Plan will cover cancer-screening tests, well-adult immunizations and well-child care and immunizations at 100%. Cancer screenings are:

- Pap smear performed annually;
- Mammogram at a frequency based on age:
  - Ages 35-39: baseline mammogram; or
  - Age 40 and older: annual mammogram;
- Sigmoidoscopy annually for persons age 50 and older;
- Colonoscopy; and
- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older.

Preventive care services covered in the network at 100% will be reviewed annually and updated prospectively to comply with recommendations of the:

- United States Preventive Care Task Force;
- Advisory Committee on Immunization Practices that have been adopted by the director of the Centers for Disease Control and Prevention; and
- Comprehensive Guidelines Supported by the Health Resources and Services Administration.

Routine care

Routine health screenings are covered at:

- 100%, not subject to deductible; and
- 100% of the MAA, not subject to deductible (for care received from an out-of-network provider)

The annual deductible does not apply to routine care. However, routine care is subject to the following limits:

- **Routine vision exam:** Limited to one exam per 12 months; and
- **Routine hearing exam:** Limited to one exam per 12 months

To be sure your claim for a routine exam is paid properly, ask your physician to indicate "routine exam" on the bill. If a medical condition is diagnosed during a routine exam, your claim for a routine exam still will be paid as explained above, provided the bill is marked "routine exam."

Medical

Hospital

After you meet your annual deductible, hospital care (inpatient and outpatient) will be reimbursed at:

- 80% for care received from a network provider; or
- 70% for care received from an out-of-network provider.

Notification of an inpatient admission is required. Notification is recommended for certain outpatient procedures and services.

Emergency care

After you meet your annual deductible, emergency care will be reimbursed at 80% for care received from both network and out-of-network providers.

Non-emergency services provided in an emergency room are not covered.

Urgent care

Urgent care centers will be reimbursed at:

- 80% of the negotiated rate (after the deductible is met) for care received from a network provider; or
- 80% of MAA (after the deductible is met) for care received from an out-of-network provider

Mental health/chemical dependency

The Aetna HDHP – Basic provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call the Claims Administrator at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help find the right provider for you. In an emergency, the intake coordinator will also provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call before seeking treatment for mental health or chemical dependency treatment.

Action (all visits are reviewed for medical necessity)	Inpatient	Outpatient
If you call the Plan and use its network provider/facility	After the deductible, eligible expenses covered at 80% of the negotiated rate; precertification required	After the deductible, eligible expenses covered at 80% of negotiated rate; precertification recommended
If you call the Plan but do not use its network provider/facility	After the deductible, eligible expenses covered at 70% of MAA; precertification required	After the deductible, eligible expenses covered at 70% of MAA; precertification recommended

Coverage levels

Mental health and chemical dependency treatment benefits are subject to the same medical necessity requirements, coverage limitations, and deductibles that are required under the HDHP Premier.

Mental health benefits include, but are not limited to:

- Assessment, diagnosis, and treatment:
- Medication management;
- Individual, family, and group psychotherapy;
- Acute inpatient care;
- Partial hospitalization programs;
- Facility-based intensive outpatient program services; and
- Psychological testing that is not primarily educational in nature.

No benefit will be paid for services that are not considered to be medically necessary.

Inpatient services

You *must* call the Claims Administrator to give notification of inpatient services. Inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. After you meet your deductible, inpatient stays are covered at 80% of the negotiated rate when you use a network provider or 70% of MAA if you use an out-of-network provider. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by the Claims Administrator in advance of the admission.

Outpatient services

You are encouraged to call the Claims Administrator for outpatient referrals. If you call and use the recommended provider, you will be reimbursed at 80% of covered expenses after the deductible is met. If you do not use the recommended provider, you will be reimbursed at 70% of MAA for covered services after the deductible is met.

Emergency care

Emergency care for mental health or chemical dependency treatment does not require a referral. However you are encouraged to call the Claims Administrator within 48 hours after an emergency admission. The behavioral health provider is available 24/7 to accept calls.

Medically necessary

The Claims Administrator will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The Claims Administrator will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless the Claims Administrator determines that the covered services and supplies are medically necessary. See the "Glossary" for the definition of medical necessity.

For more information about what your Plan covers, see "Covered services and supplies" on page 94. You may also contact your Plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

High Deductible Health Plan – Premier

Type of service	Network	Out-of-network
Annual deductible (includes prescription drug expenses)		
• Single • Family	• $1,200 • $2,400	• $2,400 • $4,800
Annual out-of-pocket maximum (includes deductible)		
• Single • Family	• $2,500 • $5,000	• $5,000 • $10,000
Lifetime maximum	• None	• None
Professional care (in office)		
• PCP or specialist visits	• 90% after deductible	• 70% of MAA* after deductible
• Allergy treatment	• 90% after deductible for the first office visit; 100% after deductible for each additional injection if office visit fee is not charged	• 70% of MAA after deductible
Preventive care (subject to frequency limits)		
• Well-adult visits and routine immunizations • Well-child visits and routine immunizations • Routine cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening)	• 100%, not subject to deductible	• 100% of MAA, not subject to deductible
Routine care (subject to frequency limits)		
• Routine vision exam	• 100%, not subject to deductible; limit 1 exam per 12 months	• 100% of MAA, not subject to deductible; limit 1 exam per 12 months
• Routine hearing exam	• 100%, not subject to deductible; limit 1 exam per 12 months	• 100% of MAA, not subject to deductible; limit 1 exam per 12 months
Hospital inpatient and outpatient		
• Semiprivate room and board, doctor's charges, lab, X-ray, radiology, and surgical care	• 90% after deductible; precertification required for hospitalization and certain outpatient procedures and services	• 70% of MAA after deductible; precertification required for hospitalization and certain outpatient procedures and services

Medical

Type of service	Network	Out-of-network
Non-hospital outpatient		
• Lab, X-ray, and radiology	• 90% after deductible; precertification is required for certain outpatient procedures	• 70% of MAA after deductible; precertification is required for certain outpatient procedures
Maternity care		
• Physician office visit	• 90% after deductible	• 70% of MAA after deductible
• Hospital delivery	• 90% after deductible	• 70% of MAA after deductible
Emergency care (no coverage if not a true emergency)		
• Hospital emergency room (includes emergency room facility and professional services provided in the emergency room)	• 90% of covered services after deductible; precertification required if admitted	• 90% of covered services after deductible; precertification if admitted
• Urgent care facility	• 90% of covered services after deductible	• 90% of MAA of covered services after deductible
Non-routine outpatient lab, radiology, and X-ray services	• 90% of covered services after deductible	• 70% of MAA of covered services after deductible
Outpatient short-term rehabilitation		
• Physical, speech, or occupational therapy	• 90% after deductible • 60 visits per year for physical, speech, developmental and occupational • 70% after deductible for visits approved for medical necessity above the limit	• 70% of MAA covered services after deductible • 60 visits per year for physical, speech, developmental and occupational • 50% of MAA after deductible for visits approved for medical necessity above the limit
Prescription drugs (see the *Prescription Drugs* section)		
Mental health and chemical dependency (see "Mental health/chemical dependency" on page 88)		

*Maximum allowed amount

This table is intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see "Covered services and supplies" on page 94 and "Exclusions and limitations" on page 105.

How the Plan works

This section contains more detailed information about HDHP's provisions and how this medical plan works. These provisions apply whether the Plan is administered by Aetna or Empire BlueCross BlueShield.

You have a choice of using network providers or out-of-network providers. Using network providers saves you money in two ways. First, network providers charge special, negotiated rates, which are generally lower than the MAA. Second, the level of reimbursement for many services is higher when you use a network provider.

A directory of network providers is available directly from the Claims Administrator.

- Aetna: **www.aetna.com**, select the Aetna Open Access, Choice POSII Open Access Plan or call **1-800-545-5862**
- Empire BlueCross BlueShield: **www.empireblue.com/citi**; select the PPO/EPO, or call **1-866-290-9098**

Deductible and coinsurance

You must meet an annual deductible of $1,200 for individual (employee only) coverage or $2,400 for family (two or more in a family) before the HDHP – Premier pays any benefits, unless the service is covered at 100%, such as preventive care.

The deductible applies to all covered expenses except preventive care and must be met each calendar year before any benefits will be paid.

Other than for services not subject to the deductible, any one or a combination of family members must meet the full family deductible before the Plan pays any benefits. There is no individual limit within the family deductible limit. The deductible can be met as follows:

- **Network**
  - **Employee only:** The individual deductible of $1,200 applies.

  - **Two or more in a family:** The $2,400 family deductible applies, one or a combination of all family members must meet the full family deductible before the Plan pays any benefits.
  - **Note:** Once you have met the deductible, the Plan normally pays 90% of the negotiated rate for covered health services if you or your covered dependent uses a network hospital/provider.
- **Out-of-Network**
  - **Employee only:** The individual deductible of $2,400 applies.
  - **Two or more in a family:** The $4,800 family deductible applies, one or a combination of all family members must meet the full family deductible before the Plan pays any benefits.
  - **Note:** Expenses are normally reimbursed at 70% of MAA for claims for covered services submitted for an out-of-network provider.

Out-of-pocket maximum

Your out-of-pocket maximum is $2,500 individual/$5,000 family (out-of-network $5,000 individual/$10,000 family). The amount includes the $1,200 individual/$2,400 family (out-of-network $2,400 individual/$4,800 family) deductible. This represents the most you will have to pay out of your own pocket in a calendar year.

Eligible expenses can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount ($2,500/5,000 out-of-network) to the family out-of-pocket maximum ($5,000/10,000 out-of-network).

Only covered expenses count toward the individual or family out-of-pocket maximum. There is no individual within the family out-of-pocket maximum. One family member or a combination of family members must meet the full family out-of-pocket maximum and the maximum can be met as follows:

- **Employee only:** $2,500 (out-of-network $5,000);
- **Two or more in a family:** The $5,000 (out-of-network $10,000) family out-of-pocket maximum applies; one or a combination of all family members must meet the full family out-of-pocket maximum.

Example: If there are two or more family members, one family member or a combination of family members must meet the full family out-of-pocket maximum ($10,000) before the Plan pays 100% of any benefits.

Once this out-of-pocket maximum is met, covered expenses are payable at 100% of the negotiated rate (or of MAA) for the remainder of the calendar year.

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are expenses that exceed MAA, charges for services not covered under the Plan, and any expense that would have been reimbursed if you had followed the notification requirements for care.

Preventive care

Covered expenses are not subject to the deductible and are covered at 100% of negotiated rates when using network providers or 100% of MAA when using out-of-network providers.

Preventive care services include:

- Routine physical exams: Well-child care and adult care, performed by the patient's provider at a frequency based on American Medical Association guidelines or as directed by the provider. For frequency guidelines, call the Claims Administrator;
- Routine diagnostic tests: For example, CBC (complete blood count), cholesterol blood test, urinalysis; and
- Routine well-woman exams.

In addition, the Plan will cover cancer-screening tests and well-adult and well-child care and immunizations at 100%. Cancer screenings are:

- Pap smear performed annually;
- Mammogram at a frequency based on age:
  - Ages 35-39: baseline mammogram; or
  - Age 40 and older: annual mammogram;
- Sigmoidoscopy annually for persons age 50 and older;
- Colonoscopy; and
- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older.

Medical

Preventive care services covered in the network at 100% will be reviewed annually and updated prospectively to comply with recommendations of the:

- United States Preventive Care Task Force;
- Advisory Committee on Immunization Practices that have been adopted by the director of the Centers for Disease Control and Prevention; and
- Comprehensive Guidelines Supported by the Health Resources and Services Administration.

Routine care

Routine health screenings are covered at:

- 100%, not subject to deductible, and
- 100% of MAA, no deductible to meet for care received from an out-of-network provider.

The annual deductible does not apply to routine care. However, routine care is subject to the following limits:

- **Routine vision exam:** Limited to one exam per 12 months
- **Routine hearing exam:** Limited to one exam per 12 months

To be sure your claim for a routine exam is paid properly, ask your physician to indicate "routine exam" on the bill. If a medical condition is diagnosed during a routine exam, your claim for a routine exam still will be paid as explained above, provided the bill is marked "routine exam."

Mental health/chemical dependency

The HDHP – Premier provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call the Claims Administrator at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help find the right provider for you. In an emergency, the intake coordinator will also provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call before seeking treatment for mental health or chemical dependency treatment.

Action (all visits are reviewed for medical necessity)	Inpatient	Outpatient
If you call the Plan and use its network provider/facility	After the deductible, eligible expenses covered at 90% of the negotiated rate; precertification required	After the deductible, eligible expenses covered at 90% of negotiated rate; precertification recommended
If you call the Plan but do not use its network provider/facility	After the deductible, eligible expenses covered at 70% of MAA; precertification required	After the deductible, eligible expenses covered at 70% of MAA; precertification recommended

Coverage levels

Mental health and chemical dependency treatment benefits are subject to the same medical necessity requirements, coverage limitations, and deductibles that are required under the HDHP – Premier.

Mental health benefits include, but are not limited to:

- Assessment, diagnosis, and treatment;
- Medication management;
- Individual, family, and group psychotherapy;
- Acute inpatient care;
- Partial hospitalization programs;
- Facility-based intensive outpatient program services; and
- Psychological testing that is not primarily educational in nature.

No benefit will be paid for services that are not considered to be medically necessary.

Inpatient services

You *must* call the Claims Administrator to give notification of inpatient services. Inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. After you meet your deductible, inpatient stays are covered at 90% when you use a network provider or 70% of MAA if you use an out-of-network provider. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by the Claims Administrator in advance of the admission.

Outpatient services

You are encouraged to call the Claims Administrator for outpatient referrals. If you call and use the recommended provider, you will be reimbursed at 90% of covered expenses after the deductible is met. If you do not use the recommended provider, you will be reimbursed at 70% of MAA for covered services after the deductible is met.

Emergency care

Emergency care for mental health or chemical dependency treatment does not require a referral. However you are encouraged to call the Claims Administrator within 48 hours after an emergency admission. The behavioral health provider is available 24/7 to accept calls.

Medically necessary

The Claims Administrator will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The Claims Administrator will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless the Claims Administrator determines that the covered services and supplies are medically necessary. See the "Glossary" section for the definition of medical necessity.

For more information about what your Plan covers, see "Covered services and supplies" on page 94. You may also contact your Plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Health Savings Accounts (HSAs)

A Health Savings Account (HSA) is used in conjunction with a qualified High Deductible Health Plan (HDHP), such as the Basic and Premier Plans offered by Citi.

When you enroll in either HDHP, you are eligible to open an HSA through any bank or institution that offers one. HSAs were designed to work with HDHPs to help you:

- Pay for expenses incurred before you meet your deductible;
- Pay for qualified medical expenses that are not otherwise reimbursable by the HDHP; and
- Save for future qualified medical and retiree health expenses on a tax-free basis.

To establish an HSA, you must:

- Be covered under a High Deductible Health Plan (HDHP);
- Have no other health coverage except what is permitted under Other health coverage;
- Not be enrolled in Medicare part A & B or Medicaid; and
- Not be claimed as a dependent on someone else's tax return.

You may visit Citi's on-site medical clinics for preventive care and allergy injections (if you supply the allergy medication)/visits; to obtain non-prescription pain relievers; and as a result of an accident at work. If enrolled in a HSA, you may *not* use Citi's on-site medical clinics for treatment when sick. Use of on-site medical clinics for other reasons, such as sick care, would be considered "impermissible medical coverage."

If you enroll in the HDHP – Basic or Premier for the first time 2012, open a Citi HSA administered by ConnectYourCare, and accept the terms of an HSA through Your Benefits Resources™, Citi will contribute to your account. The annual contribution amounts are based on your medical plan coverage category. Amounts paid are up to $500 for employee only coverage and up to $1,000 for any other coverage category. Citi's contribution is paid on a quarterly basis.

Details of the deadlines to receive Citi's contribution to your HSA are below:

Deadline to receive Citi's contribution		Employee Only	Employee + Spouse/ Children/Family
Q1	4:00 p.m. EST on 12/31/11	$125	$250
Q2	4:00 p.m. EST on 3/31/12	$125	$250
Q3	4:00 p.m. EST on 6/30/12	$125	$250
Q4	4:00 p.m. EST on 9/30/12	$125	$250

The maximums that can be contributed to an HSA for 2012 are:

- $3,100 for an eligible individual with employee only coverage and
- $6,250 for an eligible individual enrolling in any other coverage category.

Under federal law, individuals who are 55 or older by December 31, 2012, can make a catch-up contribution of an additional $1,000 for 2012 and each year going forward.

If you do not enroll in a HDHP, by law you cannot establish a HSA.

Funds are available in the HSA once they have been contributed, not sooner like with an HCSA.

Health Savings Account features

- You "own" your HSA; your account is portable.
- Contributions to an HSA can be made by individuals, employers, or both.
- Contributions (subject to limits) and earnings are tax-free under federal and many state income tax laws.
- Withdrawals (to pay for qualified medical expenses, as determined by the IRS) are tax-free under federal and many state income tax laws.
- You do not forfeit funds that you do not use by year-end. Instead, HSA funds remaining in your account will roll over to the following year.
- However, you will pay a penalty of 20% of the disbursed amount for disbursements that are not used for qualified medical expenses.

Note: The HSA is not part of the Citigroup Medical Plans or any other employee benefit plan sponsored by Citi.

The HSA and the LPSA

If you enroll in a HDHP and make tax-free contributions to an HSA you cannot participate in a HCSA. *HCSA enrollment is considered "impermissible medical care coverage" and disqualifies your contributions to an HSA.*

According to IRS regulations, if you enroll in a HDHP you can enroll in the Limited Purpose Health Care Spending Account (LPSA) to reimburse yourself for eligible expenses such as those for vision, dental, and preventive medical care. You may also enroll in an LPSA if you enrolled in an HDHP but are not enrolled in an HSA.

An LPSA works like an HCSA, except only certain types of expenses are eligible for reimbursement. See the "LPSA" section in the *Spending Accounts* section for more information.

For more information about the LPSA, contact your tax adviser or visit the IRS website at **www.irs.gov**. From the home page, go to the search feature at the top of the page and enter "Ruling 2004-45."

Hawaii Health Plan (Hawaii only)

The Hawaii Health Plan is available in Hawaii only and is administered by United HealthCare. You can save money by using United HealthCare's preferred providers. This Plan is in compliance with the Prepaid Health Care Act and is effective on your date of hire. Eligible employees are all employees (including, but not limited to, full-time, part-time, temporary, on-call, and seasonal workers) who work at least 20 hours each week for four consecutive weeks. Full medical coverage will be continued for a disabled employee for three months following the month of disability.

For the names of network providers, visit **www.myuhc.com/groups/citi** or call United HealthCare at **1-877-311-7845**. When prompted to choose a network, choose "Choice Plus Plan."

Hawaii Health Plan at a glance

Type of service	Hawaii Health Plan (United HealthCare available in Hawaii only)
Annual deductible	
• Individual	• $200
• Maximum per family	• $600
Annual out-of-pocket maximum (includes deductible)	
• Individual	• $1,000
• Maximum per family	• $2,000
Lifetime maximum	• None
Professional care (in office)	
• PCP or specialist visits	• 90% after deductible when using network providers; 80% of MAA* after deductible when using out-of-network providers
Routine care (subject to frequency limits)	
• Well-adult visits and routine immunizations	• 100%, not subject to deductible
• Well-child visits and routine immunizations	• 100%, not subject to deductible
Hospital inpatient and outpatient	
• Semiprivate room and board, doctor's charges, lab, X-ray, radiology, and surgical care	• Inpatient: 90% after deductible when using network physicians; 80% of MAA after deductible when using network hospital; 80% after deductible when using out-of-network physicians; 80% of MAA after $100 confinement deductible and calendar-year deductible when using out-of-network hospitals; notification required for hospitalization and certain outpatient procedures; $400 penalty for failure to precertify, to a maximum of $1,000 per year • Outpatient: 90% after deductible when using network physician; 80% of MAA after deductible when using out-of-network physician; 80% of MAA after deductible for hospital
Non-hospital outpatient	
• Lab, X-ray, and radiology	• 90% after deductible when using network physician; 80% of MAA after deductible when using out-of-network physician; precertification is required for certain outpatient procedures
Emergency care	
• No coverage if not a true emergency	• 90% after deductible for physician; 80% after deductible for hospital
Urgent care center	• 90% after deductible when using network providers; 80% after deductible when using out-of-network providers
Prescription drugs (see the *Prescription Drugs* section)	
Mental health and chemical dependency (see "Mental health/chemical dependency" on page 93)	

*Maximum allowed amount

This table is intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see "Covered services and supplies" on page 94 and "Exclusions and limitations" on page 105**.**

A directory of preferred providers is available directly from United HealthCare at **1-877-311-7845** or online at **www.myuhc.com/groups/citi**.

For information about how to file a claim or appeal a denied claim, see "Claims and appeals for United HealthCare medical plans" on page 116.

How the Plan works

This section contains more detailed information about Hawaii Health Plan's provisions and how the Plan works.

You have a choice of using preferred providers or non-preferred providers. Using preferred providers saves you money in two ways. First, preferred providers charge negotiated rates, which are generally lower than the MAA. Second, the level of benefits is generally higher when you use a preferred provider.

Medical

Deductibles and coinsurance

You must meet an annual deductible of $200 individual ($600 family maximum) before the Hawaii Health Plan pays any benefits. There is no annual deductible for routine preventive care.

The individual deductible applies to all covered expenses except routine preventive care and must be met each calendar year before any benefits will be paid.

The family deductible is the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible count toward the family deductible. The family deductible can be met as follows:

- **Up to two in a family:** Each member must meet the $200 individual deductible; or
- **Three or more in a family:** Expenses can be combined to meet the $600 family deductible, but no one person can apply more than the $200 individual deductible toward the family deductible amount.

Once you have met the deductible, Hawaii Health Plan normally pays 90% of the negotiated rate for covered health services if you or your covered dependent uses a United HealthCare preferred physician, and pays 80% of MAA if you use a United HealthCare preferred hospital.

Out-of-pocket maximum

Your individual out-of-pocket maximum is $1,000 ($2,000 family maximum). The amount includes the $200 individual ($600 family) deductible. Once this out-of-pocket maximum is met, covered expenses are payable for the remainder of the calendar year at 100% of the negotiated rate when you use a preferred provider or at 100% of MAA when you use a non-preferred provider.

Eligible expenses can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount ($1,000) to the family out-of-pocket maximum ($2,000).

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are expenses that exceed MAA, prescription drug copayments, and penalties applied for failure to notify United HealthCare. Mental health/chemical dependency treatment expenses, including copayments, count toward your calendar-year, out-of-pocket maximum.

Routine care

Well-child care, adult routine physical exams, and routine health screenings are covered at:

- 100% of the negotiated rate (for care received from a United HealthCare preferred provider); and
- 80% of MAA (for care received from a non-preferred provider).

The annual deductible does not apply to routine care. However, routine care is subject to the following limits:

- **Routine physical exam:** Well-child care and adult care at a frequency based on American Medical Association (AMA) guidelines. For frequency guidelines, call United HealthCare at **1-877-311-7845**;
- **Routine cancer screenings,** limited to**:**
  - Annual Pap smear;
  - Mammogram at a frequency based on age:
    - Ages 35-39: baseline mammogram; or
    - Age 40 and older: annual mammogram;
  - Sigmoidoscopy annually for persons age 50 and older;
  - Colonoscopy (covered as part of a routine physical); and
  - Prostatic-specific antigen (PSA) screening.

All routine care is covered at 80% of the negotiated rate for preferred providers or 80% of MAA for non-preferred providers. There is no deductible or annual maximum for routine physicals.

To be sure your claim for a routine exam is paid properly, ask your physician to indicate "routine exam" on the bill. If a medical condition is diagnosed during a routine exam, your claim for a routine exam still will be paid as explained above, provided the bill is marked "routine exam."

For more specific information, contact United HealthCare directly.

Hospital

After you meet your annual deductible, hospital care (inpatient and outpatient) will be reimbursed at:

- 80% of the negotiated rate for claims incurred at a United HealthCare preferred hospital; and
- 80% of MAA after the $100 per confinement deductible for claims incurred at a non-preferred hospital in an area where one was available.

Emergency care

After you meet the deductible, emergency care is covered at 80% for covered hospital services and 90% for covered physician services. Non-emergency services provided in an emergency room are not covered.

See the *Glossary* for the definition and examples of emergency care as defined and determined by the Plan.

If you have a true medical emergency, you should go to the nearest emergency facility. If you are admitted, you must contact United HealthCare within 48 hours. See "Precertification/ notification" on page 57. If you are not able to do this, have a family member contact United HealthCare. Penalty for non-compliance is $400 per admission (to a maximum penalty, in the aggregate, of $1,000 per calendar year).

Mental health/chemical dependency

Hawaii Health Plan provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call United HealthCare at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help find the right care provider for you. In an emergency, the intake coordinator will also provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call United HealthCare before seeking treatment for mental health or chemical dependency treatment. For more information, see "Precertification/ notification" on page 57.

Information regarding participating providers is available directly from United HealthCare at **1-877-311-7845** or online at **www.liveandworkwell.com**; access code Citi.

Action	Inpatient	Outpatient
If you call United HealthCare and use its network provider/facility	After the deductible, eligible physician expenses covered at 90% of the negotiated rate and eligible hospital expenses covered at 80% of the negotiated rate	After the deductible, eligible expenses covered at 90% of *MAA
If you call United HealthCare but do not use its network provider/facility	After a $100 confinement deductible and after the $200 individual deductible is met, eligible expenses covered at 80% of MAA	After the deductible, eligible expenses covered at 80% of MAA
If you do not call and do not use United HealthCare's network provider/facility	$400 non-notification penalty per admission, up to a maximum penalty of $1,000 per calendar year; after a $100 confinement deductible and the $200 deductible is met, eligible expenses covered at 80% of MAA	After the deductible, eligible expenses covered at 80% of MAA

*Maximum allowed amount

Coverage levels

Unlike the medical benefits under Hawaii Health Plan, mental health and chemical dependency treatment benefits are subject to medical necessity requirements, as well as being subject to the same coverage guidelines and deductibles that are required under Hawaii Health Plan.

Mental Health benefits include, but are not limited to:

- Assessment, diagnosis, treatment;
- Medication management;
- Individual, family, and group psychotherapy;
- Acute inpatient care;
- Partial hospitalization programs;
- Facility based intensive outpatient program services; and
- Psychological testing that is not primarily educational in nature.

No benefit will be paid for services that are not considered to be medically necessary.

Medical

Inpatient services

Inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. Inpatient mental health/substance abuse treatment is covered at least 80%. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state is which the patient resides, unless approved by United HealthCare in advance of the admission.

Outpatient services

You are encouraged to call United HealthCare for outpatient referrals, although a referral is not required. If you call United HealthCare and use network providers, you will be reimbursed for 80% of the negotiated rates per visit after the deductible is met. If you do not use United HealthCare's recommended providers, you will be reimbursed for 80% of MAA for covered services after the deductible is met.

Emergency care

Emergency care does not require a referral from United HealthCare. When emergency care is required for mental health or chemical dependency treatment, you (or your representative or physician) must call United HealthCare within 48 hours after the emergency care is given. United HealthCare's behavioral health provider is available 24/7 to accept calls.

When emergency care has ended, you should call United HealthCare for any additional inpatient services. Otherwise, benefits may be reduced. All benefits, as long as they are deemed medically necessary, are payable as shown in the highlights table.

Medically necessary - mental health/chemical dependency benefits

United HealthCare's behavioral health provider will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. United HealthCare's behavioral health provider will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless United HealthCare's behavioral health provider determines that the covered services and supplies are medically necessary. See the "Glossary" for the definition of medical necessity.

For more information about coverage for a particular service or supply or limits that may apply, see "Covered services and supplies" on page 94 or call United HealthCare at **1-877-311-7845**.

Note: Benefits details in the Hawaii Health Plan section are subject to approval by the Hawaii Department of Labor.

Covered services and supplies

This list of covered services and supplies applies to all non-HMO and Oxford PPO medical plans sponsored by Citi, except where noted.

Covered services and supplies must be medically necessary and related to the diagnosis or treatment of an accidental injury, sickness, or pregnancy. Reimbursement for all covered services and supplies listed in this section are subject to maximum allowed amount (MAA) or, for network services, the negotiated rates of the Plan.

You and your physician decide which services and supplies are required, but the Plan pays only for the following covered services and supplies that are medically necessary as determined by the Claims Administrators.

Covered services and supplies also include services and supplies that are part of a case management program. A case management program is a course of treatment developed by the Claims Administrator as an alternative to the services and supplies that would otherwise have been considered covered services and supplies. Unless the case management program specifies otherwise, the provisions of the Plan related to benefit amounts, maximum amounts, copayments, and deductibles will apply to these services.

Acupuncture

Must be administered by a medical doctor or a licensed acupuncturist.

Adult immunizations

The following are the guidelines for covered adult immunizations:

- **Tetanus, diphtheria (Td):** Booster every 10 years;
- **Influenza (flu):** Annual for adults under age 50 and at risk; annual for adults age 50 plus;
- **Pneumococcal vaccine (PPV):** Once for adults under age 50 with risk factors with booster after five years for adults at highest risk and those most likely to lose their immunity; once at age 65 with booster after five years if less than 65 at the time of primary vaccination;
- **Varicella (chicken pox):** Persons under age 50 with no history of varicella and who test negative for immunity. Persons over age 50 are assumed to be immune. **Note:** Women who are pregnant (or planning to become pregnant in the four weeks following vaccination) should NOT be vaccinated;
- **Measles, mumps, rubella (MMR):** For people born after 1956 - two doses measles with additional doses as MMR; people born before 1957 can be considered immune. **Note:** Women who are pregnant (or planning to become pregnant in the four weeks following vaccination) and people whose immune system is not working properly should NOT be vaccinated;
- **Hepatitis A:** Only those at risk; those at risk, two doses at least six months apart;
- **Hepatitis B:** Immunize if age 46 or under; if over age 45, only those at high risk; if at risk, three doses (second dose one to two months after the first dose, and the third dose no earlier than two months after the first dose and four months after the second dose);
- **Meningococcal:** Meningitis (only those at risk); if at increased risk, one dose (an additional dose may be recommended for those who remain at high risk);
- **Tuberculin skin test:** Annual testing for high-risk group (method: Five tuberculin units of PPD);
- **Gardasil vaccine for HPV:** Females age 9 years to 26 years; and
- **Zostavax vaccine for shingles:** Adults age 60 or older.

Ambulatory surgical center

A center's services given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

Anesthetics

Drugs that produce loss of feeling or sensation either generally or locally, except when done for dental care not covered by the Plan. When administered as part of a medical procedure, anesthesia must be administered by a board-certified anesthesiologist. Anesthesia is not covered when rendered in the doctor's office or when administered by the operating surgeon, unless it is administered by a dentist for dental care that is covered by the Plan.

Note: The Oxford PPO will cover this service when medically necessary and appropriate.

Baby care

The following services and supplies given during an eligible newborn child's initial hospital confinement:

- Hospital services for nursery care;
- Other services and supplies given by the hospital;
- Services of a surgeon for circumcision in the hospital; and
- Physician services.

Birth center

Room and board and other services, supplies, and anesthetics.

Cancer detection

Diagnostic screenings not subject to precertification or notification include:

- Mammogram;
- Pap smear;
- Prostatic-specific antigen (PSA);
- Sigmoidoscopy; and
- Colonoscopy.

Medical

Chemotherapy

For cancer treatment.

Contraceptive services/devices

Contraceptive services and devices including, but not limited to:

- Diaphragm and intrauterine device and related physician services;
- Voluntary sterilization by either vasectomy or tubal ligation;
- Injectables such as Depo-Provera; and
- Surgical implants for contraception, such as Norplant.

Dietitian/nutritionist

Nutritional counseling is covered by a licensed dietitian and/or licensed nutritionist for diabetes, bulimia, anorexia nervosa, and morbid obesity.

Durable medical equipment

Durable medical equipment means equipment that meets all of the following:

- It is for repeated use and is not a consumable or disposable item;
- It is used primarily for a medical purpose; and
- It is appropriate for use in the home.

Some examples of durable medical equipment are:

- Appliances that replace a lost body part or organ or help an impaired organ or part;
- Orthotic devices such as arm, leg, neck, and back braces;
- Hospital-type beds;
- Equipment needed to increase mobility, such as a wheelchair;
- Respirators or other equipment for the use of oxygen; and
- Monitoring devices (e.g., blood glucose monitor).

Each Claims Administrator decides whether to cover the purchase or rental of the equipment based on coverage guidelines. Changes made to your home, automobile, or personal property are not covered. Rental coverage is limited to the purchase price of the durable medical equipment. Replacement, repair, and maintenance are covered only if:

- They are needed due to a change in your physical condition or
- It is likely to cost less to buy a replacement than to repair the existing equipment or rent similar equipment.

Foot care

Care and treatment of the feet, if afflicted by severe systemic disease. Routine care such as removal of warts, corns, or calluses; the cutting and trimming of toenails; and foot care for flat feet, fallen arches, and chronic foot strain is covered only if needed due to severe systemic disease.

- **Aetna and Empire BlueCross BlueShield ChoicePlan 500** cover the services of a podiatrist for the treatment of a disease or injury, including the treatment of corns, calluses, keratoses, bunions, and ingrown toenails.

Hearing aids

Hearing aids are covered, regardless of the reason for hearing loss.

- Adults: once every 36 months; and
- Children: every 24 months.

Home health care (combined with private-duty nursing)

The following covered services must be given by a home health care agency:

- Temporary or part-time skilled nursing care by or supervised by a registered nurse (RN) or licensed practical nurse (LPN)
- Medical social services provided by, or supervised by, a qualified physician or social worker if your physician certifies with the Plan that the medical social services are necessary for the treatment of your medical condition.

Covered services are limited to 200 visits each calendar year (combined visits with private-duty nursing), and you must notify the Plan in advance. Each period of home health aide care of up to eight hours given in the same day counts as one visit. Each visit by any other member of the home health team will count as one visit. Multiple services provided on the same day count as one visit and are billed by the same provider on the same bill. Visits may be increased with prior approval from your health Plan.

Hospice care

Hospice services for a participant who is terminally ill include:

- Room and board coverage limited to expenses for the regular daily charge made by the hospital for a semiprivate room (or private room when medically appropriate or if it is the only room type available);
- Other services and supplies;
- Part-time nursing care by or supervised by a RN or LPN;
- Home health care services as shown under home health care; the limit on the number of visits shown under home health care does not apply to hospice patients;
- Counseling for the patient and covered dependents;
- Pain management and symptom control; and
- Bereavement counseling for covered dependents; services must be given within six months after the patient's death, and covered services are limited to a total of 15 visits for each family member.
  - For **Aetna ChoicePlan 500, Empire BlueCross BlueShield ChoicePlan 500 and Oxford Health Plans**, bereavement counseling is covered under the mental health benefit.

Bereavement counseling must be provided by a licensed counselor. Services for the patient must be given in an inpatient hospice facility or in the patient's home. The physician must certify that the patient is terminally ill with six months or less to live. Any counseling services given in connection with a terminal illness will not be considered as mental health and chemical dependency treatment for purposes of applying the mental health/chemical dependency maximum visit limit.

Hospital services

Hospital services include:

- Room and board: Covered expenses are limited to the regular daily charge made by the hospital for a semiprivate room (or private room when medically appropriate);
- Other services and supplies, including:
  - Intensive or special care facilities when medically appropriate;
  - Visits by your physician while you are confined;
  - General nursing care;
  - Surgical, medical, and obstetrical services;
  - Use of operating rooms and related facilities;
  - Medical and surgical dressings, supplies, casts, and splints;
  - Drugs and medications;
  - Intravenous injections and solutions;
  - Nuclear medicine;
  - Preoperative care and post-operative care:
    - Administration and processing of blood;
    - Anesthesia and anesthesia services;
    - Oxygen and oxygen therapy;
    - Inpatient physical and rehabilitative therapy, including cardiac and pulmonary rehabilitation;
    - X-rays, laboratory tests, and diagnostic services; and
    - Magnetic resonance imaging (MRI).

Emergency room services are covered only if determined to be medically appropriate and there is not a less intensive or more appropriate place of service, diagnostic, or treatment alternative that could have been used. If your health plan, at its discretion, determines that a less intensive or more appropriate treatment could have been given, then no benefits are payable.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law

generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, to discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable). Authorizations are required for longer stays.

Infertility treatment

Infertility benefits are provided under the following Plans: ChoicePlan 500, High Deductible Health Plan – Basic and Premier, and Hawaii Health Plan.

Diagnosis of infertility and surgical correction of a medical condition causing infertility are covered subject to the Plan's copayment or deductible and coinsurance.

Covered services include:

- Services for diagnosis and treatment of the underlying medical condition:
  - Initial evaluation, including history, physical exam, and laboratory studies;
  - Physical lab work including genetic testing, psychological evaluations, medications to synchronize the cycle of the donor with the cycle of the recipient and to stimulate the ovarian function of the donor;
  - Evaluation of ovulation function;
  - Ultrasound of ovaries;
  - Post-coital test;
  - Hysterosalpingogram;
  - Endometrial biopsy;
  - Hysteroscopy; and
  - Semen analysis for male participants.
- Advanced reproductive services:
  - Ovulation induction cycle with menotropins;
  - Harvesting of Plan participant's eggs;
  - Artificial insemination;
  - Infertility surgery (diagnostic or therapeutic);
  - ART services and treatment, including in-vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), and cryopreserved embryo transfer and Frozen Embryo Transfer (FET);
- Medical expenses for infertility treatment are covered up to a family lifetime maximum of $24,000.
- Prescription drug expenses associated with infertility treatment are covered up to a lifetime maximum of $7,500, through the *Prescription Drugs* section.
- Covered services do not include the costs associated with surrogate mothers and the costs of donating donor eggs.

The Hawaii Health Plan covers medical *and* prescription drug expenses associated with infertility treatment. The infertility benefit covers:

- Medical expenses up to a $24,000 family lifetime maximum and
- Prescription drug expenses associated with infertility treatment up to a $7,500 lifetime maximum

The Plan deductible does not apply.

Oxford Health Plans: Coverage varies by state. Contact your Plan for details.

HMOs: Each HMO offers different infertility coverage and limits, if at all. Check with your HMO for details of infertility coverage.

Laboratory tests/X-rays

X-rays or tests for diagnosis or treatment.

Licensed counselor services

Services of a licensed counselor for mental health and chemical dependency treatment.

Medical care

- Hospital, office, and home visits; and
- Emergency room services.

Medical supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure; and
- Blood or blood derivatives only if not donated or replaced. This means:
  - Autologous blood donation: The donation of your own blood for use during a scheduled covered surgical procedure;

- Directed blood donation: The donation of blood by a person chosen by the patient to donate blood for the patient's use during a scheduled covered surgical procedure; and
- Autologous or directed blood donation prior to a scheduled surgery when it generally requires blood transfusions and the provider/organization that obtains and processes the blood makes a charge that the patient is legally obligated to pay.

Medical transportation services

Transportation by professional ambulance or air ambulance to and from the nearest medical facility qualified to give the required treatment. These services must be given within the United States, Puerto Rico, and Canada.

- **Aetna ChoicePlan 500** and **Empire BlueCross BlueShield ChoicePlan 500** cover medical transportation services outside of these geographic areas to and from the nearest medical facility.
- **Oxford Health Plans:** When a member has traveled out of the country, emergency or 911 transportation to the nearest hospital and/or hospital emergency facility does not require notification, precertification, or certification. However, Oxford Medical Management should be notified of an admission within 48 hours or as soon as possible, consistent with the member's certificate. All requests for other out-of-the-country transportation require precertification and Medical Director review.

The Health Plans cover professional ambulance service on a standard basis to transport the individual from the place where he/she is injured or stricken by disease to the first hospital where treatment is given. Ambulettes are not covered.

Morbid obesity expenses (non-HMO/PPO plans)

Covered medical expenses include charges made on an inpatient or outpatient basis by a hospital or a physician for the surgical treatment of morbid obesity of a covered person. Limitations apply. For more information, contact your Plan directly.

Dietician/nutritionist coverage is also available for morbid obesity. See "Dietitian/nutritionist" on page 96.

Nurse-midwife

Services of a licensed or certified nurse-midwife. Maternity-related benefits are payable on the same basis as services given by a physician.

Nurse-practitioner

Services of a licensed or certified nurse-practitioner acting within the scope of that license or certification. Benefits are payable on the same basis as covered services given by a physician.

Oral surgery/dental services

The Plan pays first (the primary plan) for oral surgery if needed as a necessary, but incidental, part of a larger service in treatment of an underlying medical condition.

The following oral surgeries are considered medical in nature and covered under the medical plan as necessary:

- Treat a fracture, dislocation, or wound;
- Cut out:
  - Teeth partly or completely impacted in the bone of the jaw;
  - Teeth that will not erupt through the gum;
  - Other teeth that cannot be removed without cutting into bone;
  - The roots of a tooth without removing the entire tooth; and
  - Cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is covered only when not done in connection with the removal, replacement, or repair of teeth; and
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement
- **Empire BlueCross BlueShield** accepts the following oral surgeries as medical in nature and covered under the medical plan as necessary:
  - Extraction of impacted wisdom teeth;
  - Services to treat an injury to sound natural teeth that are given within 12 months of accident/injury;
  - TMJ surgery; and
  - Anesthesia for dental services only when the dental service itself is covered, is administered by an anesthesiologist and is done outside of the doctor's office.

Corrective surgery is covered if medically necessary for purposes of chewing and speaking.

The following services and supplies are covered only if needed because of accidental injury to sound and natural teeth that happened to you or your dependent while covered under this Plan. Treatment must be received within 12 months of the accident/injury.

- Oral surgery;
- Full or partial dentures;
- Fixed bridgework;
- Prompt repair to sound and natural teeth; and
- Crowns.

Oxford Health Plans accepts the following oral surgeries as medical in nature and covered under the medical plan as necessary:

- Extraction of impacted wisdom teeth;
- Services to treat an injury to sound natural teeth; and
- TMJ surgery.

Organ/tissue transplants

Your Claims Administrator must be notified at least 17 business days (10 business days for **Empire BlueCross BlueShield**; **Aetna** does not have day requirement, but you must precertify) before the scheduled date of any of the following (or as soon as reasonably possible):

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant procedure.

Donor charges for organ/tissue transplants

- In the case of an organ or tissue transplant, donor charges are considered covered expenses only if the recipient is a covered person under the Plan. If the recipient is not a covered person, no benefits are payable for donor charges.
- The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a covered service unless the search is made in connection with a transplant procedure arranged by a designated transplant facility.
  - **Aetna** covers donor search fees through the National Marrow Donor Program.

Qualified procedures

If a qualified procedure, listed in this section, is medically necessary and performed at a designated transplant facility, the "medical care and treatment" and "transportation and lodging" provisions described in this section apply.

- Heart transplants;
- Lung transplants;
- Heart/lung transplants;
- Liver transplants;
- Kidney transplants;
- Pancreas transplants;
- Kidney/pancreas transplants;
- Bone marrow/stem cell transplants;
- Cornea transplants (Hawaii Health Plan only); and
- Other transplant procedures when your Claims Administrator determines that they are medically necessary to perform the procedure as a designated transplant.

For **Aetna**, transplant services are covered as long as the transplant is not experimental or investigational and has been approved in advance. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluations and follow-up care. Each facility has been selected to perform only certain types of transplants, based on its quality of care and successful clinical outcomes.

For **Aetna** plans (ChoicePlan 500 and High Deductible Health Plan (both Basic and Premiere), a transplant will be covered as a network service only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered a non-participating facility for transplant-related services, even if the facility is considered a participating facility for other types of services.

Members must receive precertification for transplant procedures. When a member or physician calls Aetna to precertify a transplant evaluation, a case nurse will direct him or her to an IOE facility.

For **Empire BlueCross BlueShield**, there is tiered coverage based on the facility used for the transplant. If a Blue Distinction Center for Transplants (BDCT) is used, the transplant will be covered at 100% with access to the travel and lodging benefit. Blue Distinction Centers for Transplants meet stringent clinical criteria, established in collaboration with expert physician panels and national medical societies, including the Center for International Blood and Marrow Transplant Research (CIBMTR), the Scientific Registry of Transplant Recipients (SRTR), and the Foundation for the Accreditation of Cellular Therapy (FACT), and are subject to periodic re-evaluation as criteria continue to evolve. Call Empire at **1-866-290-9098** for additional coverage information as well as assistance in locating a BDCT facility.

Transplants performed at participating, non-BDCT facilities are covered at 90% with access to the travel and lodging benefit; all other facilities are covered at 70% with no access to the travel and lodging benefit. Travel and lodging is covered only if a BDCT facility is used.

Medical care and treatment

Covered expenses for services provided in connection with the transplant procedure include:

- Pretransplant evaluation for one of the procedures listed above;
- Organ acquisition and procurement;
- Hospital and physician fees;
- Transplant procedures;
- Follow-up care for a period of up to one year after the transplant;
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search. **Note**: Coverage of donor costs, is generally limited to medically necessary procedures, inpatient confinement (e.g., semi-private room and board in an acute hospital setting) and a postoperative global period not to exceed 180 calendar days. (This maximum applies to the **Oxford PPO**. It does not apply to the **Aetna and Empire BlueCross BlueShield** plans); and
- Transportation and lodging.

When available, the Plan will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging for the transplant recipient and a companion are available as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for an evaluation, the transplant procedure, or necessary post-discharge follow-up;
- Reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per-diem rate of $50 for one person or $100 a day for two people (a maximum of $50 per person — $100 for patient and companion combined — per night is paid toward lodging expenses; meals are not covered);
- Travel and lodging expenses are available only if the transplant recipient resides more than:
  - 100 miles from the designated transplant facility for **Aetna** plans;
  - **Empire BlueCross BlueShield** plans do not have a mileage requirement.
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered; lodging expenses will be reimbursed at the $100 per-diem rate;
- A combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the transplant recipient and companion (companions, if the covered dependent is a minor) and reimbursed under the Plan in connection with all transplant procedures. (For **Aetna** plans, a $10,000 maximum [per occurrence] will apply to all non-health benefits in connection with any one type of procedure. These benefits are available until one year following the date of the procedure.)

If the covered person chooses not to receive his or her care in connection with a qualified procedure pursuant to this organ/tissue transplant section, the services and supplies received by the covered person in connection with that qualified procedure will be paid under the Plan if and to the extent covered by the Plan without regard to this organ/tissue transplant section.

- There may be some differences in coverage for transportation and lodging.

Oxford Health Plans covers only those solid organ transplants that are non-experimental and non-investigational. All transplants must be performed by a UNOS (United Network for Sharing Organs)-participating academic transplant center. All solid organ transplants must be performed in facilities that Oxford has specifically contracted and designated to perform these procedures to be eligible for Plan coverage.

The following types of solid organ transplants will be covered when performed by a UNOS-participating academic transplant center:

- Heart transplant;
- Lung transplant;
- Heart-lung transplant;
- Liver transplant;
- Kidney transplant;
- Intestinal and multi-visceral transplants; and
- Pancreas transplant.

For more information, contact your Claims Administrator directly.

Orthoptic training

Training by a licensed optometrist or an orthoptic technician. The Plan covers a hidden ocular muscle condition where the eyes have a tendency to underconverge or overconverge. Manifest conditions of exotropia (turning out) or esotropia (turning in) are covered. Coverage is limited to 32 visits per calendar year.

Outpatient occupational therapy

See "Rehabilitation therapy" on page 102.

Outpatient physical therapy

See "Rehabilitation therapy" on page 102.

Prescribed drugs

Prescribed drugs and medicines for inpatient services.

Private-duty nursing care (combined with home health care)

Private-duty nursing care is given on an outpatient basis by a RN, LPN, or licensed vocational nurse (LVN). This service must be approved by your Claims Administrator.

- **Aetna ChoicePlan 500 and Empire BlueCross BlueShield ChoicePlan 500:** A combined network and out-of-network maximum benefit of 200 visits per calendar year (combined with home health care visits) applies. One visit is equal to one eight-hour shift. Inpatient private-duty nursing is not covered. Precertification is required. Additional visits may be covered if approved in advance by your Plan.
- **Oxford Health Plans PPO:** Private-duty nursing services are covered as medically necessary. A combined network and out-of-network maximum benefit of 200 visits per calendar year (combined with home health care visits) applies. One visit is equal to one eight-hour shift. Inpatient private-duty nursing is not covered.
- **United HealthCare Hawaii Plan:** At least 60 home heath visits are covered each year.

Psychologist services

Services of a psychologist for psychological testing and psychotherapy.

Rehabilitation therapy

Defined as short-term occupational therapy, physical therapy, speech therapy, and spinal manipulation:

- Services of a licensed occupational or physical therapist, provided the following conditions are met:
  - The therapy must be ordered and monitored by a licensed physician; and
  - The therapy must be given according to a written treatment plan approved by a licensed physician. The therapist must submit progress reports at the intervals stated in the treatment plan;
- Services of a licensed speech therapist. These services must be given to restore speech lost or impaired due to one of the following:
  - Surgery, radiation therapy, or other treatment that affects the vocal chords;

- Cerebral thrombosis (cerebral vascular accident);
- Brain damage due to accidental injury or organic brain lesion (aphasia);
- Accidental injury that happens while the person is covered under the Plan;
- Chronic conditions (such as cerebral palsy or multiple sclerosis); or
- Developmental delay.

Inpatient

- Services of a hospital or rehabilitation facility for room, board, care, and treatment during a confinement. Coverage for room and board is limited to expenses for the regular daily charge made by the hospital for a semiprivate room (or private room when medically appropriate or if it is the only room type available).
- Inpatient rehabilitative therapy is a covered service only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.

Outpatient

- Services of a hospital, comprehensive outpatient rehabilitative facility (CORF), or licensed therapist as described above.
- Coverage includes short-term cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure, or myocardial infarction.
- Coverage includes short-term pulmonary rehabilitation for the treatment of reversible pulmonary disease.
- All visit limits apply for both network and out-of-network, wherever the services are being provided, for example, at home, at a therapist's office, or in a free-standing therapy facility.
- **ChoicePlan 500 and High Deductible Health Plans (both Basic and Premiere):** Spinal manipulation therapy limited to 20 visits per calendar year. All other therapies combined are limited to 60 visits per calendar year.
- **Hawaii Health Plan:** Covers at least 30 days of each type of therapy each calendar year for restorative care with a separate chronic/developmental speech delay benefit of 24 visits per calendar year.

Skilled nursing facility services

- Room and board: Covered expenses for room and board are limited to the facility's regular daily charge for a semiprivate room.
- Other services and supplies.

Covered services are limited to the first 120 days of confinement each calendar year.

Speech therapy

See "Rehabilitation therapy" on page 102.

Spinal manipulations

Services of a physician given for the detection or correction (manipulation) by manual or mechanical means or structural imbalance or distortion of the spine. Routine maintenance and adjustments are not a covered service under this Plan.

Surgery

Services for surgical procedures. (**Oxford Health Plans PPO:** All surgical procedures must be precertified in advance.)

Reconstructive surgery

- Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:
  - Birth defect;
  - Sickness;
  - Surgery to treat a sickness or accidental injury; or
  - Accidental injury that happens while the person is covered under the Plan,

- Reconstructive breast surgery following a mastectomy including areolar reconstruction and the insertion of a breast implant. The Plan covers expenses associated with reconstructive surgery following a mastectomy, expenses for reconstructive surgery on the other breast to achieve symmetry, the cost of prostheses, and the cost for treatment of physical complications at any stage of the mastectomy including lymphedemas. Normal Plan deductibles, coinsurance, and copayments will apply; and
- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to sickness or accidental injury that happens while the person is covered under the Plan.

Assistant-surgeon services

Covered expenses for assistant-surgeon services are limited to 20% of the amount of covered expenses for the primary surgeon's charge for the surgery for non-HMO/PPO Plans. An assistant-surgeon generally must be a licensed physician. Physician's-assistant services are not covered if billed on his or her own behalf. (**Aetna and Empire BlueCross BlueShield** cover assistant surgeon services for certain surgeries. **Aetna** covers registered nurses acting as assistant surgeons for certain surgeries. Contact Empire BlueCross BlueShield for information about which providers qualify as assistant surgeons.)

Multiple surgical procedure guidelines

If you are using an out-of-network provider for a surgical procedure, the following multiple surgical procedure guidelines will apply.

If more than one procedure will be performed during one operation — through the same incision or operative field — the Plan will pay according to the following guidelines:

- First procedure: The Plan will allow 100% of the negotiated or maximum allowed amount (MAA).
- Second procedure: The Plan will allow 50% of the negotiated or MAA.
- Third and additional procedures: The Plan will allow 50% of the negotiated or MAA for each additional procedure.
- Bilateral and separate operative areas: The Plan will allow 100% of the negotiated or MAA for the primary procedure and 50% of the secondary procedure and 50% of the negotiated or MMA for tertiary/additional procedures.

If billed separately, incidental surgeries will not be covered. An incidental surgery is a procedure performed at the same time as a primary procedure and requires few additional physician resources and/or is clinically an integral part of the performance of the primary procedure.

Transsexual surgery, sex change, or transformation

The plan does cover procedures, treatments and related services designed to alter a participant's physical characteristics from his or her biologically determined sex to those of another sex.

Termination of pregnancy

- Voluntary (i.e., abortion) and
- Involuntary (i.e., miscarriage).

Temporomandibular Joint Syndrome (TMJ)

Surgical treatment of TMJ does not include treatment performed by prosthesis placed directly on the teeth or physical therapy for TMJ.

Treatment centers

- Room and board; and
- Other services and supplies.

Voluntary sterilization

- Vasectomy; and
- Tubal ligation.

Reversals are not covered.

Well-child care

Office visit charges for routine well-child care exams and immunizations based on guidelines from the American Medical Association.

Wellness benefit

Covered expenses include:

- Routine physical exam (including a well-woman exam) is covered once per calendar year;
- Routine immunizations;
- Vision exam once every 24 months;
- Smoking cessation; and
- Weight control.

A $250 calendar year maximum applies to out-of-network services per covered family member. This maximum does not apply to wellness visits to network providers, for well-child care visits and immunizations, or for routine care under the Hawaii Health Plan.

Exclusions and limitations

There are services and expenses that are not covered under the non-HMO/PPO Plans. The following list of exclusions and limitations applies to your Plan benefits unless otherwise provided under your HMO:

- Acupuncture and acupuncture therapy, except as described under "Covered services and supplies" on page 94;
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services;
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan;
- Any services or supplies that are not medically necessary, as determined by the Claims Administrator;
- BEAM (brain electrical activity mapping) neurologic testing;
- Biofeedback, except as specifically approved by the Claims Administrator;
- Blood, blood plasma, or other blood derivatives or substitutes, except as described under under "Covered services and supplies" on page 94;
- Breast augmentation and otoplasties, including treatment of gynecomastia. Reduction mammoplasty is not covered unless medically appropriate, as determined by the Claims Administrator;
- Charges for canceled office visits or missed appointments; boutique, access, or concierge fees to doctors;
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments. **Hawaii Health Plan:** Treatment in a state facility, including care and treatment in a non-participating hospital owned or operated by any state government agency is covered;
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury;
- Charges made by a hospital for confinement in a special area of the hospital that provides non-acute care, by whatever name called, including, but not limited to, the type of care given by the facilities listed below:
  - Adult or child day care center;
  - Ambulatory surgical center;
  - Birth center;
  - Halfway house;
  - Hospice;
  - Skilled nursing facility;
  - Treatment center;
  - Vocational rehabilitation center; and
  - Any other area of a hospital that renders services on an inpatient basis for other than acute care of sick, or injured persons, or pregnant women. If that type of facility is otherwise covered under the Plan, then benefits for that covered facility, which is part of a hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a hospital;
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. Cosmetic procedures including, but not limited to, pharmacological regimens, nutritional procedures or treatments, plastic surgery, salabrasion, chemosurgery, and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes, and/or that are performed as a treatment for acne. However, the Plan covers reconstructive surgery as described under "Covered services and supplies" on page 94;

- Court-ordered services and services required by court order as a condition of parole or probation, unless medically appropriate and provided by participating providers upon referral from your PCP (no referral required for Aetna, Empire BlueCross BlueShield, or United HealthCare);
- Coverage for an otherwise eligible person or a dependent who is on active military duty, including health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
- Custodial care made up of services and supplies that meets one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment; or
  - Care that can safely and adequately be provided by persons who do not have the technical skills of a health care professional;
- Care that meets one of the above conditions is custodial care regardless of any of the following:
  - Who recommends, provides, or directs the care;
  - Where the care is provided; and
  - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself;
- Dental care or treatment to the mouth, teeth, gums, or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, and implants. See "Covered services and supplies" on page 94 for limited coverage of oral surgery and dental services;
- Devices used specifically as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs, such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation;
- Ecological or environmental medicine, diagnosis, and/or treatment;
- Educational services, special education, remedial education, or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems and learning disabilities are not covered by the Plan; See "Covered services and supplies" on page 94 for limited coverage of cognitive services.
- Education, training, and bed and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged, or a nursing home;
- Enteral feedings and other nutritional and electrolyte supplements, unless it is the sole source of sustenance;
- Expenses that are the legal responsibility of a third-party payer, such as Workers' Compensation or as a result of a claim;
- Expenses incurred by a dependent if the dependent is covered as an employee, under the Plan for the same services;
- Experimental, investigational, or unproven services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by the Claims Administrator, unless approved by the Claims Administrator in advance. This exclusion will not apply to drugs:
  - That have been granted investigational new drug (IND) treatment or Group treatment IND status;
  - That are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;
  - That the Claims Administrator has determined, based on scientific evidence, demonstrate effectiveness or show promise of being effective for the disease. See the "Glossary" for the definition of experimental, investigational or unproven services;
- Eyeglasses and contact lenses (**Empire BlueCross BlueShield** will cover eyeglasses or contact lenses within 12 months following cataract surgery);
- False teeth;
- Hair analysis;
- Hair transplants, hair weaving, or any drug used in connection with baldness. Wigs and hairpieces are not covered unless the hair loss is due to chemotherapy or radiation therapy. Wigs and hairpieces needed for

endocrine, metabolic diseases, psychological disorders (such as stress or depression), burns, or acute traumatic scalp injury associated with hair loss must be evaluated and preauthorized by the Claims Administrator;

- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated;
- Herbal medicine, holistic, or homeopathic care, including drugs;
  - **Aetna:** Not covered; however, discounts are available through the Aetna Natural Products and Services Discount Program;
  - **Empire BlueCross BlueShield:** Not covered; however, discounts on alternative medicine and treatment are available through the Empire SpecialOffers Program. Visit Empire's website at **www.empireblue.com/citi** for information about the Empire SpecialOffers Program;
  - **Oxford:** Not covered; however, discounts are available for some services under the Oxford Healthy Bonus Program;
- Household equipment including, but not limited to, the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, are not covered. Improvements to your home or place of work, including, but not limited to, ramps, elevators, handrails, stair glides, and swimming pools, are not covered;
- Hypnotherapy, except when approved in advance by the Claims Administrator;
- Implantable drugs (other than contraceptive implants);
- Infertility services, except as described under "Covered services and supplies" on page 94. The Plan does not cover charges for the freezing and storage of cryopreserved embryos and charges for storage of sperm or surrogate mothers or any charges associated with them.
- Inpatient private-duty or special nursing care. Outpatient private-duty nursing services must be preauthorized by the Claims Administrator
- Membership costs for health clubs, personal trainers, massages, weight loss clinics, and similar programs; (**Oxford Health Plans** offers a $200 reimbursement every six months for employees who can prove they have had 50 gym visits in that time period and $100 every six months for spouses who can prove they have had 50 gym visits in that time period).
- Naturopathy;
- Nutritional counseling and nutritionists except as described under "Covered services and supplies" on page 94;
- Occupational injury or sickness. An occupational injury or sickness is an injury or sickness that is covered under a Workers' Compensation act or similar law. For persons for whom coverage under a Workers' Compensation act or similar law is optional because they could elect it, or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the Workers' Compensation act or similar law had that coverage been elected;
- Outpatient supplies, including, but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips; contact the Plan for details. (These may not always be excluded.);
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services;
- Physical, psychiatric, or psychological exams, testing, or treatments not otherwise covered, when such services are:
  - For purposes of obtaining, maintaining, or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage, or adoption;
  - Relating to judicial or administrative proceedings or orders;
  - Conducted for purposes of medical research; or
  - To obtain or maintain a license of any type;
- Radial keratotomy or any other related procedures designed to surgically correct refractive errors, such as LASIK, PRK, or ALK;
- Recreational, educational, and sleep therapy, including any related diagnostic testing;

Medical

- Religious, marital, and sex counseling, including related services and treatment;
- Reversal of voluntary sterilizations, including related follow-up care;
- Routine hand and foot care services, including routine reduction of nails, calluses, and corns;
- Services not covered by the Plan;
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation;
- Services provided by your close relative (your spouse, child, brother, sister, or your or your spouse's parent or grandparent) for which, in the absence of coverage, no charge would be made; the **Hawaii Health Plan** excludes services provided by a parent, child, or spouse for which, in the absence of coverage, no charge would be made);
- Services given by volunteers or persons who do not normally charge for their services;
- Services required by a third party including, but not limited to, physical exams and diagnostic services in connection with:
  - Obtaining or continuing employment;
  - Obtaining or maintaining any license issued by a municipality, state, or federal government;
  - Securing insurance coverage;
  - Travel; and
  - School admissions or attendance, including exams required to participate in athletics unless the service is considered to be part of an appropriate schedule of wellness services;
- Services you are not legally obligated to pay for in the absence of this coverage;
- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a covered person under the Plan and is undergoing a covered transplant. Services for, or related to, transplants involving mechanical or animal organs are not covered;
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability;
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation;
- Specific non-standard allergy services and supplies, including, but not limited to:
  - Skin titration (wrinkle method);
  - Cytotoxicity testing (Bryan's Test);
  - Treatment of non-specific candida sensitivity;
  - Urine autoinjections;
- Stand-by services: Boutique, concierge, or on-call fees required by a physician;
- Surgical operations, procedures, or treatment of obesity, except when approved in advance by the Claims Administrator;
- Telephone consultations;
- Therapy or rehabilitation including, but not limited to:
  - Primal therapy;
  - Chelation therapy (except to treat heavy metal poisoning);
  - Rolfing;
  - Psychodrama;
  - Megavitamin therapy;
  - Purging;
  - Bioenergetic therapy;
  - Vision perception training; and
  - Carbon dioxide therapy;
- Thermograms and thermography;
- Treatment in a federal, state, or governmental facility, including care and treatment provided in a non-participating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws; this exclusion does not apply to the **Hawaii Health Plan**;
- Treatment of injuries sustained while committing a felony or an assault or during a riot or insurrection; this exclusion does not apply to the **Hawaii Health Plan**;
- Treatment of diseases, injuries, or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you;

- Treatment, including therapy, supplies, and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis;
- Treatment of spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or dislocation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or dislocation of or in the vertebral column; and
- Weight reduction or control (unless there is a diagnosis of morbid obesity), special foods, food supplements, liquid diets, diet plans, or any related products.

Additional medical plan information

These features apply to ChoicePlan 500, the High Deductible Health Plan – Basic and Premier, the Hawaii Health Plan, and Oxford Health Plans PPO, as noted.

Infertility

The ChoicePlan 500, the Hawaii Health Plan, and the High Deductible Health Plan – Basic and Premier cover the medical and prescription drug expenses associated with infertility treatment such as in-vitro fertilization, artificial insemination, GIFT, ZIFT, and other non-experimental/ investigational treatments. Infertility treatment is also covered for any condition or treatment of a condition that would destroy the function of the ovaries or testes.

If both you and your spouse (same or opposite sex)/civil union partner/domestic partner are enrolled in Citi coverage, both of you together are eligible for the lifetime maximum benefits under the infertility provision (medical and prescription drug as listed in the bullets below). *Each of you is not eligible for a separate lifetime maximum benefit.*

The infertility benefit covers:

- Prescription drug expenses (managed by Express Scripts) associated with infertility treatment up to a $7,500 lifetime infertility prescription drug maximum for participants; and
- Medical expenses up to a $24,000 lifetime infertility medical maximum across the ChoicePlan 500 and the High Deductible Health Plan – Basic and Premier (network and out-of-network) combined and the Hawaii Health Plan.

For the donor, the Plan covers the cost of physical lab work including genetic testing, psychological evaluations, medications to synchronize the cycle of the donor with the cycle of the recipient and to stimulate the ovarian function of the donor; all office visits; ultrasound; lab work normally done on the Plan participant; and the harvesting of her eggs. The Plan does not cover surrogates or surrogate charges.

The lifetime maximum per family can be spent in one year or over a number of years. If you change medical options, the Claims Administrators will keep track of the amount you have remaining toward this benefit. *Expenses for your donor are counted toward your lifetime family maximum.*

Call your Plan if you have questions about specific procedures or treatments.

For Oxford Health Plans and HMO participants: Your Plan may offer different infertility coverage, if any. Contact your Plan for details.

Mental health and substance abuse benefits

All visits for both inpatient and outpatient mental health and substance abuse treatment are reimbursed at the same coinsurance level as other medical services, according to your Plan, subject to medical necessity.

The plans administered by Aetna, Empire BlueCross BlueShield, and Oxford Health Plans provide confidential mental health and substance abuse services through a network of counselors and specialized practitioners.

Medical

When you call your Plan at the toll-free number on your medical plan ID card, you will speak with an intake coordinator who will help find the right network care provider. In an emergency, the intake coordinator will also provide immediate assistance and, if necessary, arrange for treatment at an appropriate facility.

You must call your Plan before seeking treatment for inpatient mental health or chemical dependency treatment. Call your Plan for the names of network providers.

Programs available to Aetna participants

Aetna offers the National Medical Excellence Program® (NME), which can arrange for care when appropriate care is not available in your local service area. Specifically, NME may coordinate the care for participants who need:

- Bone marrow or organ transplantation;
- "Investigational" or new technology (when standard care is not available);
- Preauthorized care that is not available within 100 miles of a participant's home; or
- Emergency care while temporarily traveling outside the United States.

In addition, the program will cover the cost of transportation and lodging for you and a companion if the facility to which you are directed is more than 100 miles from your home. The lodging expense maximum is $50 per night, and the travel and lodging maximum is $10,000. For details, contact the Member Services number on your medical plan ID card.

National Advantage Program (NAP)

Available to Aetna participants using out-of-network services.

By using NAP, you have access to discounted rates for many hospital and doctor's claims that would otherwise be paid as billed or for emergency/medically necessary services that are not provided in the Aetna network. For more information, call Aetna at **1-800-545-5862.**

Aetna tools

Aetna offers the following tools to help you manage your health care expenses. For a preview of these tools, visit the Aetna website for participants, Aetna Navigator, at **www.aetna.com**. If you are not a participant, you can tour the Aetna website at **www.aetna.com/members/tour/index.html**.

- **Aetna Navigator Hospital Comparison Tool:** Provides a report that compares hospitals in your area for more than 160 diagnoses and procedures. This information can help you decide where to obtain care.
- **Estimate the cost of care:** Allows you to compare the estimated average costs for 200 different health care services in your area. You can see the potential for savings by choosing a doctor who participates in the Aetna network.
- **Cost and quality transparency:** This tool is designed to help you make informed health care decisions based on the actual costs of care and the clinical quality of physicians in selected areas.

  In the cost-only markets, doctor-specific charges for health care services are displayed. These markets are Anchorage and Fairbanks, AK; Eastern Washington; El Paso, TX; New Jersey; West Virginia; Charlotte, NC; Detroit and East Midland, MI; Las Vegas, NV; Massachusetts; Milwaukee, WI; and Utah.

  In the cost and quality transparency markets, information is taken from Aetna's Aexcel evaluation process, which is used to evaluate a specific panel of specialists based on defined measures of clinical performance and cost-efficiency. These markets are Arizona; Atlanta, GA; Cincinnati, Cleveland, and Columbus, OH; Central Valley, Los Angeles, San Diego, and Northern, CA; Colorado; Delaware; Connecticut; Metropolitan Washington, DC; Jacksonville, Tampa, Orlando, and South FL; Austin, Dallas, Houston, and San Antonio, TX; Maine; Metro New York; Seattle, WA; Chicago, IL; Indianapolis, IN; Pittsburgh, PA; Kansas City, MO and KS; Richmond, VA; and Oklahoma City and Tulsa, OK.

Programs available to Empire BlueCross BlueShield participants

Blue Distinction Centers for Specialty Care℠ are facilities recognized for their distinguished clinical care and processes in the areas of transplant surgery, bariatric surgery, cardiac care, and complex and rare cancers.

To identify a Blue Distinction facility, visit **www.empireblue.com/citi**. Click on "Find a Doctor," "Across the Country," and, in the upper right, "Blue Distinction Centers for Specialty Care."

Blue Distinction Centers for Transplants

The Blue Distinction Centers for Transplants (BDCT) is a bone marrow and organ transplant program offered through participating BlueCross BlueShield Plans. All institutions selected as BDCT centers of excellence must meet stringent criteria. BDCT provides a range of services for the following types of transplants:

- Heart;
- Lung;
- Liver;
- Simultaneous pancreas kidney (SPK); and
- Bone marrow/stem cell.

In addition, travel and lodging benefits are available to participants approved for transplant services. Benefits include the cost of airline, bus, rail, or taxi fare necessary for the patient and one companion (two companions if the patient is under age 19). A $50-per-day maximum for one person and $100-per-day maximum for two people for charges related to lodging and a $10,000 lifetime maximum for all travel and lodging services combined applies.

For specific coverage and additional information about these benefits, call Member Services at the telephone number on your medical plan ID card.

Blue Distinction Centers for bariatric surgery, cardiac care, and complex and rare cancers

The national Blue Distinction Centers offer specialty care in bariatric surgery, cardiac care, and complex and rare cancer. These specialty center networks help members identify facilities that have met high efficiency and quality standards.

Online member tools

Make more informed choices about the medical care you and your family receive — and better understand your options — with Empire BlueCross BlueShield's decision-support tools at **www.empireblue.com/citi**.

- **Care Comparison:** An innovative collection of online decision-support tools to help you make more informed choices about the medical care that you and your family receive. You will find the data you need to evaluate hospitals based on clinical quality measures and other key quality indicators, such as hospital reputation and characteristics (within a given radius of the area you choose); estimate the costs of specific health care services and procedures; and more.
- **Surgical Procedures:** If you are thinking about surgery, you should have as much information as possible. The Surgical Procedures tool gives fast and easy access to reliable medical information along with graphic animation that demonstrates different types of surgery. It can help you protect your most valuable asset: Your health.

Programs available to Oxford Health Plans PPO participants

Cancer Resource Services

To use Cancer Resource Services, you must enroll before receiving any treatment. If you are receiving treatment at the time you are hired or newly eligible for benefits, call Cancer Resource Services immediately to enroll. Call Cancer Resource Services at **1-866-936-6002** from 8 a.m. to 8 p.m. ET on weekdays, excluding holidays.

Medical

Cancer Resource Services can assist when you or a covered dependent is diagnosed with cancer and must make difficult and important decisions such as what kind of treatment to get and where to get treatment.

In addition to helping you answer these questions, Cancer Resource Services can also arrange for and coordinate access to a full range of comprehensive cancer treatment services through "centers of excellence." Centers of excellence cancer centers provide:

- Comprehensive, highly specialized teams of experts with extensive experience in cancer diagnosis and treatment, including rare cancers;
- Second-opinion services if you are unsure about your diagnosis or what treatment is right for you;
- Experience in performing a large number of cancer surgeries and other complex procedures; and
- Access to new experimental treatments that may be an option for some patients.

To learn more about Cancer Resource Services or to enroll, call **1-866-936-6002** or visit the Cancer Resource Services website at **www.myoptumhealthcomplexmedical.com**. You are not charged for this service, and you have no obligation to use a Cancer Resource Services center.

Claims and appeals

Claims and appeals for Aetna medical plans

The amount of time Aetna will take to make a decision on a claim will depend on the type of claim.

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Preservice claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

* The time period allowed to make a decision is suspended pending receipt of additional information.

Contact your medical plan Claims Administrator to obtain a claims appeal form. For claims regarding eligibility or enrollment in a plan, call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

The form explains how and when to file a claim.

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

- The specific reasons for the denial;
- The specific references in the Plan documentation on which the denial is based;
- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review;
- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the Plan's appeals procedure.

Appeals for Aetna medical plans

You will have two levels of appeal for both administrative and clinical appeals in accordance with the definitions below.

Administrative appeals are defined as appeals in response to denials based on contractual or benefit exclusion, limitation, or exhaustion not requiring clinical judgment. Administrative denials do not require a clinician to interpret the contractual limitation or apply clinical judgment to the limitation.

Clinical appeals are defined as appeals in response to denials based on clinical judgment for the determination and application the terms of the Plan to the member's medical circumstances.

You will have 180 days following receipt of a claim denial to appeal the decision. You will be notified of the decision no later than 15 days (for preservice claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Claims Administrator provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator.

For preservice and post-service claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claims Administrator's decisions are conclusive and binding. The Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services (the telephone number is on your ID card). You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you and your authorized representative and the Claims Administrator by telephone, fax, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received. If you are not satisfied with the appeal decision, you may file a second-level appeal within 60 days of receipt of the level one appeal decision. The appeal will be handled in the same timeframes as the first-level appeal and a notice will be sent to you explaining the decision.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

You must exhaust the applicable level one and level two processes of the appeal procedure before you contact the Department of Insurance to request an investigation of a complaint or appeal; file a complaint of appeal with the Department of Insurance; or establish any litigation, arbitration or administrative proceeding regarding an alleged breach of the policy terms by Aetna Life Insurance Company or any matter within the scope of the appeals procedure.

External review

An "external review" is a review by an independent physician, with appropriate expertise in the area at issue, of claim denials based on lack of medical necessity or the experimental or investigational nature of a proposed service or treatment.

You may, at your option, obtain external review of a claim denial provided the following are met:

- You have exhausted the Aetna appeal process for denied claims, as described under this "Claims and appeals for Aetna medical plans" section and you have received a final denial;
- The appeal is made by the member or the member's authorized representative;
- The final denial was based on a lack of medical necessity or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment at issue for which the member is financially responsible exceeds $500.

If you meet the eligibility requirements listed above, you will receive written notice of your right to request an external review at the time the final decision on your internal appeal has been rendered. Either you or an individual acting on your behalf will be required to submit to Aetna the external review Request Form (except under expedited review as described below), a copy of the Plan denial of coverage letter, and all other information you wish to be reviewed in support of your request. Your request for an external review must be submitted in writing to Aetna within 60 calendar days after you receive the final decision on your internal appeal.

Aetna will contact the external review organization that will conduct your external review. The external review organization will then select an independent physician with appropriate expertise in the area at issue for the purpose of performing the external review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the external review Request Form and must follow the applicable Plan's contractual documents and Plan criteria governing the benefits.

The external review organization will generally notify you of the decision within 30 calendar days of Aetna's receipt of a properly completed External Review Request Form. The notice will state whether the prior determination was upheld or reversed and briefly explain the basis for the determination. The decision of the external reviewer will be binding on the Plan, except where Aetna or the Plan can show reviewer conflict of interest, bias, or fraud. In such cases, notice will be given to you and the matter will be promptly resubmitted for consideration by a different reviewer.

An expedited review is available when your treating physician certifies on a separate Request for Expedited external review Form (or by telephone with prompt written follow-up) the clinical urgency of the situation. "Clinical urgency" means that a delay (waiting the full 30-calendar-day period) in receipt of the service or treatment would jeopardize your health. Expedited reviews will be decided within five calendar days of receipt of the request. In the case of such expedited reviews, you will initially be notified of the determination by telephone, followed immediately by a written notice delivered by expedited mail or fax.

You will be responsible for the cost of compiling and sending the information that you wish to be reviewed by the external review organization to Aetna. Aetna is responsible for the cost of sending this information to the external review organization. The professional fee for the external review will be paid by Aetna.

For an individual to act on your behalf in connection with an external review, you will need to specifically consent to the representation by signing the appropriate line on the External Review Request Form.

Your may obtain more information about the external review process by calling the toll-free Member Services telephone number on your ID card.

Claims and appeals for Empire BlueCross BlueShield medical plans

Timing of initial claim approval or denial

The time within which your claim will be approved or denied will depend on the type of claim you file.

- **For claims involving urgent care**: You will be notified of the approval or denial no later than 72 hours after your claim is received. If your claim did not include enough information to determine whether it should be approved or denied, you will be notified within 24 hours after receiving your claim of the specific information that is necessary. You will have at least 48 hours to provide the specified information. You will be notified of the approval or denial no later than 48 hours after Empire BlueCross BlueShield receives the information or 48 hours after the deadline for providing the information, if earlier. For purposes of these claims procedures, urgent care means medical care or treatment that must be provided without delay to avoid seriously jeopardizing life health or the ability to regain maximum function or that must, in the opinion of a physician, be provided without delay to adequately manage severe pain.
- **For medical care requiring precertification approval (called a "precertification claim")**: You will be notified of the approval or denial of your claim no later than 15 calendar days after your claim is received. Empire BlueCross BlueShield may extend this 15-calendar day period to 30 calendar days if it needs more time to review your claim due to matters outside of its control. If a longer period of time is required, you will be notified within the initial 15-calendar day period of the reasons for the extension and the date by which a decision will be made. You will be notified if your claim did not include enough information to reach a decision. You will have at least 45 calendar days from receipt of the notice to provide the specified information.

- **For care involving an ongoing course of treatment to be provided over a period of time or through a number of treatments (called "concurrent care decisions"): Y**ou will be notified in advance of any decision by Empire BlueCross BlueShield to reduce or terminate the course of treatment that would be covered, so that you will have enough time to appeal the decision and receive a determination before the treatment is reduced or terminated. If you wish to extend the course of treatment and the treatment involves urgent care, you will be notified within 24 hours after your claim is received, as long as you make your claim at least 24 hours before the approved course of treatment is scheduled to end.
- **For all other care (e.g., reimbursement for medical services already received)**: You will be notified of the approval or denial of your claim no later than 30 calendar days after your claim is received. Empire BlueCross BlueShield may extend this 30-calendar day period to 45 calendar days if it needs more time to review your claim due to matters outside of its control. If a longer period of time is required, you will be notified within the initial 30-calendar day period of the reasons for the extension and the date by which a decision will be made. You will be notified if your claim did not include enough information to make a decision. You will have at least 45 calendar days from receipt of the notice to provide the specified information.
- **Contents of claim denial notice:** If you receive notice that your claim has been denied, either in full or in part, the claim denial notice will include:
  - The specific reasons for the denial;
  - Reference to the specific Plan provisions on which the denial is based;
  - A description of any additional material or information Empire BlueCross BlueShield requires and an explanation of why it is necessary;
  - A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement that you have the right to bring a civil action under Section 502(a) of ERISA but only after you have followed the Plan's claims procedures;
  - If an internal rule, guideline, or protocol was relied on in making the adverse determination, either a copy of the specific rule, guideline, or protocol or a statement that it will be provided on request, free of charge; and
  - If the denial is based on a medical necessity exclusion, experimental treatment exclusion, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination or a statement that an explanation of the scientific or clinical judgment for the determination will be provided on request, free of charge.

Appeal filing deadlines

Action	Expedited appeal	Prospective standard appeal	Retrospective appeal
You may appeal to Empire BlueCross BlueShield in writing (for an urgent care claim, orally or in writing)	Within 180 calendar days after the date you were notified	Within 180 calendar days after the date you were notified	Within 180 calendar days after the date you were notified
Empire BlueCross BlueShield will notify you about the appeal decision	Within 72 hours after appeal is received	Within 15 calendar days after the appeal is received	Within 30 calendar days after the appeal is received
You can make a second appeal to Empire BlueCross BlueShield in writing	N/A	Within 60 calendar days after the appeal denial is received	Within 60 calendar days after the appeal denial is received
Empire BlueCross BlueShield will notify you about the second appeal decision	N/A	Within 15 calendar days after the appeal is received	Within 30 calendar days after the appeal is received

First appeal to Empire BlueCross BlueShield: You have 180 calendar days after receipt of the denial to file an appeal with Empire BlueCross BlueShield. Your appeal must be in writing, except that an appeal of an urgent care claim may be made orally or in writing. Be sure to explain why you think you are entitled to benefits, and attach any documentation that will support your claim.

Approval or denial of appeal: Empire BlueCross BlueShield will send you its decision within the following deadlines: 72 hours for urgent care claims; 15 calendar days for precertification claims; and 30 calendar days for all other claims.

Medical

If your claim is based on a medical judgment, in reviewing your appeal, Empire BlueCross BlueShield will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and will provide you with the name of the health care professional, upon request.

If Empire BlueCross BlueShield denies your appeal, the denial notice will include:

- The specific reasons for the denial;
- Reference to the specific Plan provisions on which the denial is based;
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA after you have followed the Plan's claims procedures and received an adverse decision on your first appeal (in the case of an urgent care claim) or on your second appeal (in the case of all other claims);
- If an internal rule, guideline, or protocol was relied on in making the adverse determination, either a copy of the specific rule, guideline, or protocol or a statement that it will be provided on request, free of charge; and
- If the denial is based on a medical necessity exclusion, experimental treatment exclusion, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination or a statement that an explanation of the scientific or clinical judgment for the determination will be provided on request, free of charge.

Second appeal to Empire BlueCross BlueShield: For claims other than urgent care claims, if Empire BlueCross BlueShield denies your appeal, you have 60 calendar days from receiving the appeal denial to send a second appeal to Empire BlueCross BlueShield. Your appeal must be in writing. Empire BlueCross BlueShield will send you its written decision within 15 calendar days for precertification claims and 30 calendar days for all other claims.

If you are appealing an urgent care claim, Empire BlueCross BlueShield's decision on your first appeal will be final.

Authorized representative: If you appeal an adverse decision to Empire BlueCross BlueShield, you may have an authorized person represent you (at your own expense). You have the right to examine the relevant portions of any documents that Empire BlueCross BlueShield referred to in its review.

Legal action: You must follow these claims procedures completely; they require one appeal to Empire BlueCross BlueShield for urgent care claims and two appeals to Empire BlueCross BlueShield for all other claims, before you can take legal action. After you receive the final decision from Empire BlueCross BlueShield, you can take legal action.

Claims and appeals for United HealthCare medical plans

The amount of time United HealthCare will take to make a decision on a claim will depend on the type of claim.

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Preservice claims (for services requiring notification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that the claim was improperly filed and how to correct the filing must be given within five days Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring notification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision for all other claims made within 15 days for preservice claims and 30 days for post-service claims

* The time period allowed to make a decision is suspended pending receipt of additional information.

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

- The specific reasons for the denial;
- The specific references in the Plan documentation on which the denial is based;

- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review;
- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the Plan's appeals procedure.

If you have a question or concern about a benefit determination, you may informally call Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the telephone, you may submit your question in writing. However, if you are not met with a benefit determination, you may appeal it as described here, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide the address of the Claims Administrator.

The Customer Service telephone number is on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday. If you are appealing an urgent care claim denial, contact Customer Service immediately.

United HealthCare level-one appeal

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the ID number from the ID card;
- The date(s) of medical service(s);
- The provider's name;
- The reason you believe the claim should be paid; and
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

During the 180-day period, you may review any pertinent documents and information relevant to your claim, if you make a request in writing. This material includes all information that was relied on in making the benefit determination; that was submitted to, considered, or generated by the Claims Administrator in considering the claim; and that demonstrates the Claims Administrator's processes for ensuring proper, consistent decisions.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of preservice claims, the first-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim.
- For appeals of post-service claims, the first-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

United HealthCare level-two appeal

If you are not satisfied with the first-level appeal decision of the Claims Administrator, you have the right to request a second-level appeal from the Claims Administrator. Your second-level appeal request must be submitted to the Claims Administrator within 60 days from receipt of first-level appeal decision.

For appeals of preservice claims, the second-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first-level appeal decision.

For appeals of post-service claims, the second-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first-level appeal decision.

For preservice and post-service claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claims Administrator's decisions are conclusive and binding. **Note:** The Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

United HealthCare urgent claim appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claims Administrator's decisions are conclusive and binding.

Claims and appeals for Oxford Health Plans medical plans

The amount of time Oxford Health Plans will take to make a decision on a claim will depend on the type of claim.

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Preservice claims (for services requiring notification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that the claim was improperly filed and how to correct the filing must be given within five days Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring notification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision for all other claims made within 15 days for preservice claims and 30 days for post-service claims

* The time period allowed to make a decision is suspended pending receipt of additional information.

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

- The specific reasons for the denial;
- The specific references in the Plan documentation on which the denial is based;
- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review;

- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the Plan's appeals procedure.

If you have a question or concern about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the telephone, you may submit your question in writing. However, if you are not met with a benefit determination, you may appeal it as described here, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the address of the Claims Administrator.

The Customer Service telephone number is on your ID card. Customer Service representatives are available during regular business hours Monday through Friday. If you are appealing an urgent care claim denial, contact Customer Service immediately.

Oxford Health Plans level-one appeal

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the ID number from the ID card;
- The date(s) of medical service(s);
- The provider's name;
- The reason you believe the claim should be paid; and
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

During the 180-day period, you may review any pertinent documents and information relevant to your claim, if you make a request in writing. This material includes all information that was relied on in making the benefit determination; that was submitted to, considered, or generated by the Claims Administrator in considering the claim; and that demonstrates the Claims Administrator's processes for ensuring proper, consistent decisions.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of preservice claims, the first-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim.
- For appeals of post-service claims, the first-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

Oxford Health Plans level-two appeal

If you are not satisfied with the first-level appeal decision of the Claims Administrator, you have the right to request a second-level appeal from the Claims Administrator. Your second-level appeal request must be submitted to the Claims Administrator within 60 days from receipt of first-level appeal decision.

For appeals of preservice claims, the second-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first-level appeal decision.

For appeals of post-service claims, the second-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first-level appeal decision.

For preservice and post-service claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claims Administrator's decisions are conclusive and binding. **Note:** The Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Oxford Health Plans urgent claim appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claims Administrator's decisions are conclusive and binding.

Notwithstanding the foregoing, the Health Care Reform Law enacted in 2010 requires the Plan to comply with additional internal claim and appeal procedure standards and offer claimants a new external review option beginning in 2011. Citi is working in good faith to implement each of the new standards in a timely manner and will provide additional communications to participants regarding the new standards after final guidance has been issued. A new external appeal option may be available for adverse benefit determinations that do not relate to failure to meet the eligibility requirements under the Plan. The rules governing how the external review process will work are not yet fully established. If your claim for benefits has been denied and you received an adverse benefit determination in response to your subsequent appeal, please contact the Citi Benefits Center at **1-800-881-3938** for information on how to request an external review.

Prescription drugs

Express Scripts manages the Citigroup Prescription Drug Program for participants in ChoicePlan 500, the High Deductible Health Plans - Basic and Premier, and the Hawaii Health Plan.

Prescription drug benefits for the Oxford Health Plans PPO are provided through Medco. For information on the Oxford PPO prescription drug benefits, see "Prescription drugs in the Oxford PPO" on page 129.

Prescription drug benefits for HMOs are provided through the HMOs, and are not included here. Contact your HMO for its prescription drug benefits.

Express Scripts covers FDA (Food and Drug Administration)-approved (federal legend) medications that require a prescription from your doctor. The Plan does *not* cover over-the-counter (OTC) products such as aspirin, vitamins, supplements, or other products that do not require a prescription.

Medications for which there are OTC products of the same chemical equivalents are not covered under this program. These decisions are made at the discretion of Express Scripts. The majority of these OTC products are for seasonal allergies or for coughs and cold. None of the drugs are maintenance medications intended for long-term use. If you have any questions about whether a medication is covered, call Express Scripts at **1-800-227-8338**.

Express Scripts offers two ways to purchase prescription drugs:

1. Through a network of retail pharmacies nation wide where you can obtain prescription drugs for your immediate short-term needs, such as an antibiotic to treat an infection
2. Through the Express Scripts Home Delivery program where you may save money by having your maintenance and preventive drugs delivered by mail.

You will pay a deductible, as shown in the following table, for drugs purchased at a retail pharmacy, before the Plan will pay benefits. *You will never pay more than the cost of the drug.*

Contents

Express Scripts Prescription drug benefits at a glance

PRESCRIPTION DRUG PROGRAM AT A GLANCE			
	ChoicePlan 500	High Deductible Health Plan – Basic and Premier*	Hawaii Health Plan
Deductible Applies to drugs purchased at a retail pharmacy	$100 per person/$200 family maximum (prescription drug deductible)	**Basic:** Individual: $2,100 network/$3,100 out of network; Family: $4,200 network/$6,200 out of network **Premier:** Individual: $1,200 network/$2,400 out of network; Family: $2,400 network/$4,800 out of network	$50 per person/$100 family maximum
Copayment for up to a 34-day supply at a network pharmacy after you meet your deductible			
• Generic drug**	$5		$10
• Preferred brand name or formulary drug***	$30		$20
• Non-preferred brand name or non-formulary drug • You may have the same prescription filled up to three times at a retail pharmacy. On the fourth fill, you will pay 100% of the cost of the medication****	50% of the cost of the drug with a minimum payment of $50 to a maximum of $150 after you meet the deductible		50% of the cost of the drug with a minimum payment of $40 to a maximum of $100 after a $50/$100 deductible
Copayment for a 90-day supply through the Express Scripts Home Delivery program (no deductible to meet)			
• Generic drug**	$12.50		$25
• Preferred brand name or formulary drug***	$75		$50
• Non-preferred brand name or non-formulary drug	50% of the cost of the drug with a minimum payment of $125 to a maximum of $375		50% of the cost of the drug with a minimum payment of $100 to a maximum of $250
Copayment for a 30-day supply of specialty medication through the CuraScript Specialty Pharmacy or at a retail network pharmacy			
• Generic drug**	$5 (no deductible to meet if purchased through CuraScript)	$5 copay per prescription after deductible	$10
• Preferred brand name or formulary drug***	$60 (no deductible to meet if purchased through CuraScript)	$60 copay per prescription after deductible	$20
• Non-preferred brand name or non-formulary drug	50% of the cost of the drug with a minimum payment of $50 to a maximum of $150 (no deductible to meet if purchased through CuraScript)	50% of the cost of the drug with a minimum payment of $50 to a maximum of $150 after deductible	50% of the cost of the drug with a minimum payment of $40 to a maximum of $100 after a $50/$100 deductible
Benefits at an out-of-network pharmacy	50% of your cost after you meet the deductible; you must file a claim for reimbursement		

* In the High Deductible Health Plan, you must meet your combined medical/prescription drug deductible before the Plan will pay benefits except for certain preventive drugs. For a list of these preventive drugs, call Express Scripts at **1-800-227-8338** or visit **www.express-scripts.com**. Your cost for these preventive drugs is the applicable copayment or coinsurance, which will count toward your out-of-pocket maximum.

** The use of generic equivalents whenever possible (through both the retail and Express Scripts Home Delivery programs) is more cost-effective. Ask your medical professional about this distinction. If you request a brand name drug and a generic alternative is available, you will pay the difference between the cost of the brand-name drug and the generic drug in addition to the copayment for the generic drug.

***Citi does not determine formulary drugs. Rather, Express Scripts brings together an independent group of practicing doctors and pharmacists who meet quarterly to review the formulary list and make determinations based on current clinical information. Call Express Scripts at **1-800-227-8338** for a copy of its Preferred Formulary or visit **www.express-scripts.com**.

**** Retail pharmacy purchases are not reimbursable under the Plan after three refills of the same drug.

NOTE: Pharmacy and/or home delivery copayments do not count toward your medical plan's annual deductible or out-of-pocket maximum. At out-of-network pharmacies:

- For non-emergencies: You will be reimbursed for 50% of the covered drug cost after the applicable deductible when a claim is filed.
- For emergencies: Reimbursement for all but the network copayment may be available. Please call Express Scripts at **1-800-227-8338**.

Retail network pharmacies with Express Scripts

When you need a prescription filled the same day, for example, an antibiotic to treat an infection, you can go to one of the thousands of pharmacies nationwide that participate in the Express Scripts network and obtain up to a 34-day supply for your copayment (once you meet your deductible).

For some drugs to be covered, you may have to provide a letter from your physician. Prescriptions may be screened for specific requirements and must be related to the diagnosis for which they are prescribed.

If you expect to have the prescription filled more than three times, use the Express Scripts Home Delivery program.

To find out whether a pharmacy participates in the Express Scripts network:

- Ask your pharmacist;
- Visit **www.express-scripts.com** and use the online pharmacy locator; or
- Call Express Scripts at **1-800-227-8338** and follow the prompts for the retail pharmacy locator.

A network pharmacy will accept your prescription and prescription drug ID card, and, once you have met your deductible, charge the appropriate copayment/ coinsurance for a covered drug. Your copayment/ coinsurance will be based on whether your prescription is for a generic drug, a preferred brand-name drug on the Express Scripts Preferred Formulary, or a non-preferred brand-name drug.

'Dispense as written'

If your physician writes "Dispense as written" on the prescription or if your physician prescribes a drug for which there is no generic equivalent, your copayment is that of either a preferred brand-name drug or a non-preferred brand-name drug. If the pharmacy's price is less than the copayment, you will pay the pharmacy's price. Benefits do not start until the annual deductible has been met.

Send all completed claim forms to:

Express Scripts Pharmacy
P.O. Box 66566
St. Louis, MO 63166

Using your prescription drug ID card

You must use your prescription drug ID card when purchasing drugs at a retail pharmacy.

You will have a 45-day grace period from the effective date of your enrollment in which you will be covered even though you do not present your prescription drug ID card when purchasing drugs at a retail pharmacy. If you do not present your prescription drug ID card at the time of service during this initial 45-day period, you will still be reimbursed for 100% of the cost of any covered drugs, less the network copayment, after meeting the annual deductible.

If you do not use your card at network pharmacies *after* your first 45 days of participation, you will be reimbursed for only 50% of the cost of the prescription drug after you have met the annual deductible.

In either case, you must pay the entire cost of the prescription drug and then submit a claim form to be reimbursed.

Meeting your deductible

When you buy a prescription drug at a retail pharmacy, you must meet the applicable deductible (individual or family) before the Plan will pay benefits.

For answers to your questions about the applicable deductibles, call Express Scripts at **1-800-227-8338**.

Express Scripts Home Delivery

For prescriptions for maintenance medications that you have filled more than three times, you must use the Express Scripts Home Delivery program to avoid paying 100% of the cost of the drug.

Through Express Scripts Home Delivery you can buy up to a 90-day supply at one time. You will make one copayment for each prescription drug or refill, and your cost will be less than what you would pay to purchase the same amount at a retail network pharmacy.

Prescription drugs

When you use Express Scripts Home Delivery:

- Your medications are dispensed by one of Express Scripts Home Delivery pharmacies and delivered to your home.
- Medications are shipped by standard delivery at no cost to you. You will pay for express shipping.
- You can order and track your refills online at **www.express-scripts.com**, or you can call Express Scripts at **1-800-227-8338** to order your refill by telephone.
- Registered pharmacists are available 24/7 for consultations.

Obtaining a refill of a maintenance medication with Express Scripts

The first three times you purchase a maintenance medication at a retail network pharmacy or out-of-network pharmacy after you meet the applicable deductible, you will pay the applicable copayment or coinsurance. You will receive a notice from Express Scripts advising you of the benefits of the Express Scripts Home Delivery program.

If, after the prescription is filled three times, you still want to purchase this maintenance medication at a retail pharmacy instead of through Express Scripts Home Delivery, you will pay 100% of the cost of the current prescription or a new prescription for the same medication and strength. Maintenance drugs, generally, are drugs taken on a regular basis for conditions such as asthma, heartburn, blood pressure, and high cholesterol. If you need to know if your prescription drug is considered a maintenance medication, call Express Scripts at **1-800-227-8338**.

Specialty medication with Express Scripts

CuraScript — Express Scripts' specialty pharmacy — dispenses oral and injectable specialty medications for the treatment of complex chronic diseases, such as, but not limited to, multiple sclerosis, hemophilia, cancer, and rheumatoid arthritis. Prescriptions sent to Express Scripts Home Delivery that should be filled by CuraScript will be forwarded. Specialty medications purchased at a retail pharmacy or through CuraScript are limited to a 30-day supply.

CuraScript offers the following:

- Once you are using the CuraScript program, CuraScript will call your doctor to obtain a prescription and then call you to schedule delivery.
- Prescription drugs can be delivered via overnight delivery to your home, work, or doctor's office within 48 hours of ordering.
- You are not charged for needles, syringes, bandages, sharps containers, or any supplies needed for your injection program.
- A CuraScript team of representatives is available to take your calls, and you can consult 24/7 with a pharmacist or nurse experienced in injectable medications.
- CuraScript will send monthly refill reminders to you.

To learn more about CuraScript's services, including the cost of your prescription drugs, call CuraScript at **1-866-413-4135**.

Controlled substances with Express Scripts

Upon request, Express Scripts will fill prescriptions for controlled substances for up to a 90-day supply, subject to state limits.

Because special requirements for shipping controlled substances may apply, Express Scripts uses only certain Home Delivery pharmacies to dispense these medications. If you submit a prescription for a controlled substance along with other prescriptions, it may need to be filled through a different pharmacy from your other prescriptions. As a result, you may receive your order in more than one package.

For more information about controlled substances and for the laws in your state, call Express Scripts at **1-800-227-8338**.

Note: Kentucky and Hawaii state laws require you to provide your Social Security number or government ID to the pharmacy or to Express Scripts before it can dispense your medication(s).

Generics Preferred with Express Scripts

The Generics Preferred program was designed to encourage the use of generic drugs instead of brand-name drugs. Typically, brand-name medications are 50% to 75% more expensive than generics.

If you choose the brand-name drug, where a generic exists, you must pay the difference between the brand and generic in addition to your copayment. *Express Scripts will always dispense an available generic medication unless otherwise indicated by the prescriber or the member.*

Prior authorization with Express Scripts

To purchase certain medications or to receive more than an allowable quantity of some medications, your pharmacist must receive "prior authorization" from Express Scripts before these drugs will be covered under the Citigroup Prescription Drug Program.

- Examples of medications requiring "prior authorization" are Retin-A cream, growth hormones, anti-obesity medications, rheumatoid arthritis medications, and Botox.
- Examples of medications whose quantity will be limited are smoking cessation products, migraine medications, and erectile dysfunction medications.

Other medications, such as certain non-steroidal anti-inflammatories, will be covered only in situations where a lower-cost alternative medication is not appropriate.

To determine if your medication requires a prior authorization or is subject to a quantity limit, call Express Scripts at **1-800-227-8338** or visit the Express Scripts website at **www.express-scripts.com**. Your pharmacist can also determine if a prior authorization is required or a quantity limit will be exceeded at the time your prescription is dispensed.

If a review is required, you or your pharmacist can ask your doctor to initiate a review by calling **1-800-224-5498**. After your doctor provides the required information, Express Scripts will review your case, which typically takes one to two business days. Once the review is completed, Express Scripts will notify you and your doctor of its decision.

If your medication or the requested quantity is not approved for coverage under the Citigroup Prescription Drug Program, you can purchase the drug at full cost.

Note: If you are covered under the Oxford Plan, you can obtain the appropriate telephone number from Oxford by calling the telephone number on the back of your ID card.

Medical necessity review (for non-formulary drugs) with Express Scripts

Under certain circumstances, you and your doctor may request that Express Scripts perform a medical review of your medications. For additional information and instructions on how your doctor can request a review, call Express Scripts at **1-800-227-8338**.

High Deductible Health Plan information

The High Deductible Health Plan covers the cost of certain preventive drugs without having to meet a deductible. You will pay the applicable copayment or coinsurance, which will count toward your out-of-pocket maximum.

For a list of these preventive medications, call Express Scripts at **1-800-227-8338**. You can also visit **www.express-scripts.com**. From the Benefit Overview menu, select "Coverage & Copayments."

If, for 2011, you are enrolled in an HMO or are not enrolled in Citi coverage *and* you are considering enrolling in the High Deductible Health Plan for 2012, visit **https://member.express-scripts.com/preview/citigroup2012** to view the 2012 list of preventive medications. On the home page scroll to "High Deductible Health Plan Preventive Drug List" for a link to the list.

For all other covered drugs, you must meet your combined medical/prescription drug deductible before the Plan will pay benefits.

Covered drugs

The following drugs and products are covered under the Citigroup Prescription Drug Program:

- Federal legend drugs;

Prescription drugs

- State-restricted drugs;
- Compounded medications of which at least one ingredient is a legend drug;
- Insulin;
- Needles and syringes;
- Over-the-counter (OTC) diabetic supplies (except blood glucose testing monitors);
- Oral and injectable contraceptives (up to a 90-day supply);
- Fertility agents;
- Legend vitamins;
- Amphetamines, through age 18;
- Drugs to treat impotency, for males age 18 and older (quantity limits apply);
- Retin-A/Avita (cream only), through age 34;
- Retin-A (gel), with no age restrictions; and
- Botulinum Tox Type A or B (Botox/Myobloc).

Some drugs require prior authorization. They include:

- Legend anti-obesity preparations;
- Amphetamines, age 19 and over;
- Retin-A/Avita (cream only), age 35 and over;
- Botulinum Tox Type A or B (Botox/Myobloc); and
- Zelnorm.

Step Therapy

Some brand-name medications, such as, but not limited to, certain non-steroidal anti-inflammatories and COX2 may require Step Therapy and will be covered only in situations where a lower-cost alternative medication is not appropriate after a trial with that lower-cost alternative. To determine if your prescription requires Step Therapy, or is subject to limitations, call Express Scripts at **1-800-227-8338**. If you have a discontinuance or lapse in therapy of more than 120 days while using the brand-name medication and need to restart therapy, you will be subject to another review under the Step Therapy program to determine if the cost of the brand-name medication will be covered under the Plan.

Other limits

Coverage limits apply to some categories of drugs. These categories include:

- Erectile dysfunction;
- Anti-influenza (retail only);
- Smoking deterrents;
- Migraine medications;
- H2-receptor antagonists; and
- Proton pump inhibitors

Drugs not covered

The following drugs and products are not covered under the Citigroup Prescription Drug Program. This list is not exhaustive and there may be other drugs that are not covered:

- Non-federal legend drugs;
- For the ESI coverage, but not for Oxford, prescription drugs for which there are OTC equivalents available, including, but not limited to, Benzoyl Peroxide, Hydrocortisone, Meclizine, Ranitidine, and Zantac;
- Contraceptive jellies, creams, foams, devices, or implants;
- Drugs to treat impotency for all females and males through age 17;
- Irrigants;
- Relenza (this exclusion applies only to Express Scripts Home Delivery; prescriptions for Relenza are covered if filled at a retail pharmacy);
- Tamiflu;
- Gardisil and Zostavax (vaccinations are covered under the medical plan; therefore, the provider must bill under medical plan)
- Topical fluoride products;
- Blood glucose testing monitors;
- Therapeutic devices and appliances;
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine®, Propecia®) or is for cosmetic purposes only (e.g., Renova®);
- Allergy sera;

- Biologicals, blood or blood plasma products;
- Drugs labeled "caution — limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual;
- Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law or any state or governmental agency or medication furnished by any other drug or medical service for which no charge is made to the member;
- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended-care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution that operates, or allows to be operated, a facility for dispensing pharmacetuicals on its premises;
- Any prescription refilled in excess of the number of refills specified by the physician or any refill dispensed after one year from the physician's original order; and
- Charges for the administration or injection of any drug.

Claims and appeals for Express Scripts

The amount of time Express Scripts will take to make a decision on a claim will depend on the type of claim.

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension due to matters beyond the control of the Claims Administrator (notice of the need for an extension must be given before the end of the 30-day period) • Notice that more information is needed must be given within 30 days • You have 45 days to submit any additional information needed to process the claim*
Preservice claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) • Notice that more information is needed must be given within five days • You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours • Notice that more information is needed must be given within 24 hours • You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information

* Time period allowed to make a decision is suspended pending receipt of additional information.

Claim forms may be obtained at **www.express-scripts.com**. These forms tell you how and when to file a claim.

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

- The specific reasons for the denial;
- The specific references in the Plan documentation on which the denial is based;
- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review;
- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under Section 502(a) of ERISA after exhaustion of the Plan's appeals procedure.

Express Scripts level-one appeal

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

During the 180-day period, you may review any pertinent documents and information relevant to your claim, if you make a request in writing. This material includes all information that was relied on in making the benefit determination; that was submitted to, considered, or generated by the Claims Administrator in considering the claim; and that demonstrates the Claims Administrator's processes for ensuring proper, consistent decisions.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation

of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of preservice claims, the first-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for the appeal of a denied claim. The second-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims, the first-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for the appeal of a denied claim. The second-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Express Scripts level-two appeal

If you are not satisfied with the first-level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator as the Plan Administrator. Your second-level appeal request must be submitted to the Claims Administrator within 60 days from receipt of first-level appeal decision.

For preservice and post-service claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding. Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Express Scripts urgent claim appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations the appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

Notwithstanding the foregoing, the Health Care Reform Law enacted in 2010 requires the Plan to comply with additional internal claim and appeal procedure standards and offer claimants a new external review option. Citi is working in good faith to implement each of the new standards in a timely manner and will provide additional communications to participants regarding the new standards after final guidance has been issued. A new external appeal option may be available for adverse benefit determinations that do not relate to failure to meet the eligibility requirements under the Plan. The rules governing how the external review process will work are not yet fully established. If your claim for benefits has been denied and you received an adverse benefit determination in response to your subsequent appeal, call the Citi Benefits Center through ConnectOne at **1-800-881-3938** for information on how to request an external review. From the ConnectOne main menu, choose the "health and welfare" option.

Prescription drugs in the Oxford PPO

Feature	Retail	Mail order
When to use	When you need a prescription drug on a short-term basis, for example, an antibiotic to treat an infection	For prescription drugs you use on a regular basis, for example, maintenance drugs to treat asthma or diabetes
Quantity available for each prescription or refill	Up to a 34-day supply	Up to a 90-day supply with refills for up to one year
Your copayment for each prescription or refill	At network pharmacies:	
	• $10 for a generic drug	• $20 for a generic drug
	• $20 for a preferred brand-name drug	• $40 for a preferred brand-name drug
	• $40 for a non-preferred brand-name drug	• $80 for a non-preferred brand-name drug
	At out-of-network pharmacies:	
	For non-emergencies: You will be reimbursed for 50% of the covered drug cost after the applicable deductible when a claim is filed.	
	For emergencies: Reimbursement for all but the network copayment may be available. Call the Plan for details.	

Retail network pharmacies with Oxford

When you need a prescription filled the same day, for example, an antibiotic to treat an infection, you can go to one of the pharmacies that participate in the Oxford network and obtain up to a 34-day supply for your copayment.

If your prescription is for medication that you expect to use on an ongoing basis (like a maintenance medication used to treat a chronic condition such as high cholesterol), use the Medco By Mail mail-order pharmacy benefit.

To find out whether a pharmacy participates in the Oxford network:

- Ask your pharmacist;
- Visit **www.oxhp.com**; or
- Call Oxford at **1-800-396-1909**

A network pharmacy will accept your prescription and prescription drug ID card charge the appropriate copayment/ coinsurance for a covered drug.

Medco by mail

Oxford's mail-order pharmacy benefits are administered through Medco Health Solutions. Medco By Mail, Medco's Health Home Delivery Pharmacy Service, offers you the ability to obtain up to a 90-day supply of certain medications.

Filling a prescription for the first time

You can submit a prescription to Medco By Mail in one of three ways:

- **By mail**: Send the prescription, along with the appropriate copayment and the Medco Health Home Delivery Service Order Form, to Medco Health at:

  Medco by Mail Medco Health Solutions of Fairfield
  P.O. Box 747000
  Cincinnati, OH 45274-7000

- **By Fax**: Your doctor can fax the prescription directly to Medco.
- **Online**: Visit **www.medcohealth.com.** Click on "Order Center", then "Request a new prescription from your doctor" and follow the on-screen instructions.

Prescription drugs

Refilling a prescription

You can easily refill a prescription online, by phone, or by mail.

- **By mail**: Use the refill order form that comes with your prescription to order a refill. Send the form, along with your copayment, using the return envelope provided.
- **By phone**: Call Medco's automated refill system at **1-800-905-0201**.
- **Online**: Log on to **www.medcohealth.com** and go to "Order Center". Choose from your available prescription refills and follow the on-screen instructions to check out.

To be sure you don't run out of medication, you should order your refill 14 days before your medication runs out.

Covered drugs

For a list of drugs that are covered under the Oxford PPO prescription drug benefit, as well as information about drugs that are excluded from coverage, visit **www.oxhp.com**.

Claims and appeals for Oxford

The amount of time Oxford Health Plans will take to make a decision on a claim will depend on the type of claim.

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Preservice claims (for services requiring notification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that the claim was improperly filed and how to correct the filing must be given within five days Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring notification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision for all other claims made within 15 days for preservice claims and 30 days for post-service claims

* The time period allowed to make a decision is suspended pending receipt of additional information.

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

- The specific reasons for the denial;
- The specific references in the Plan documentation on which the denial is based;
- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review;
- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the Plan's appeals procedure.

If you have a question or concern about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the telephone, you may submit your question in writing. However, if you are not met with a benefit determination, you may appeal it as described here, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the address of the Claims Administrator.

The Customer Service telephone number is on your ID card. Customer Service representatives are available during regular business hours Monday through Friday. If you are appealing an urgent care claim denial, contact Customer Service immediately.

Oxford Health Plans level-one appeal

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the ID number from the ID card;
- The date(s) of medical service(s);
- The provider's name;
- The reason you believe the claim should be paid; and
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

During the 180-day period, you may review any pertinent documents and information relevant to your claim, if you make a request in writing. This material includes all information that was relied on in making the benefit determination; that was submitted to, considered, or generated by the Claims Administrator in consideration of the claim; and that demonstrates the Claims Administrator's processes for ensuring proper, consistent decisions.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of preservice claims, the first-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim.
- For appeals of post-service claims, the first-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

Oxford Health Plans level-two appeal

If you are not met with the first-level appeal decision of the Claims Administrator, you have the right to request a second-level appeal from the Claims Administrator. Your second-level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first-level appeal decision.

For appeals of preservice claims, the second-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first-level appeal decision.

For appeals of post-service claims, the second-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first-level appeal decision.

For preservice and post-service claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claims Administrator's decisions are conclusive and binding. **Note:** The Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Oxford Health Plans urgent claim appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claims Administrator's decisions are conclusive and binding.

Notwithstanding the foregoing, the Health Care Reform Law enacted in 2010 requires the Plan to comply with additional internal claim and appeal procedure standards and offer claimants a new external review option. Citi is working in good faith to implement each of the new standards in a timely manner and will provide additional communications to participants regarding the new standards after final guidance has been issued. A new external appeal option may be available for adverse benefit determinations that do not relate to failure to meet the eligibility requirements under the Plan. The rules governing how the external review process will work are not yet fully established. If your claim for benefits has been denied and you received an adverse benefit determination in response to your subsequent appeal, please contact the Citi Benefits Center at **1-800-881-3938** for information on how to request an external review.

Dental

Citi offers two dental options to provide dental care for you and your eligible dependents (including your spouse/civil union partner/domestic partner). They are the:

- MetLife Preferred Dentist Program (MetLife PDP); and
- Cigna Dental HMO (dental health maintenance organization).

You can enroll in Citi dental coverage even if you do not enroll in Citi medical coverage. You can enroll in any of the same four coverage categories available for medical coverage: Employee Only, Employee Plus Spouse/Civil Union Partner/Domestic Partner, Employee Plus Children, or Employee Plus Family. See "Coverage categories" in the *Eligibility and Participation* section.

The MetLife PDP allows you to visit any dentist. However, when you visit a dentist in the Plan's network, you will pay a discounted fee. See Your Personal Enrollment Worksheet on Your Benefits Resources™ for the cost of the options available to you.

Quick tips

Dental plan differences

The Cigna Dental HMO costs less than the MetLife PDP, but you must use a Cigna Dental HMO provider to receive a benefit, except in very limited circumstances. See "Cigna Dental HMO" beginning on page 138.

Spending accounts

The Health Care Spending Account (HCSA) and the Limited Purpose Health Care Spending Account (LPSA) can save you money on your out-of-pocket dental expenses. Since you forfeit any money remaining in the account that you do not use by year-end, estimate conservatively.

For details, see the HCSA or the LPSA section in the *Spending Account* section.

If you choose medical coverage under the Basic or Premier High Deductible Health Plans and establish a Healthcare Savings Account (HSA), you may pay for eligible dental expenses with funds from your HSA.

For details, see the HSA section in the *Spending Account* section.

Contents

Dental options at a glance

	MetLife Preferred Dentist Program (PDP)*	Cigna Dental HMO**
Annual deductible		
• Individual	$50	None
• Family maximum	$150	None
Preventive and diagnostic services	100% paid, no deductible to meet	100% paid when you use your network dentist
Basic services such as fillings, amalgams ("silver") and composite ("white"), root canals, periodontal services, extractions, oral surgery	80% after deductible	You pay a copayment when you use your network dentist
Major restorative services such as crowns, inlays/onlays, bridges, dentures	50% after deductible	You pay a copayment when you use your network dentist
Orthodontia	50% after deductible***	You pay a copayment when you use your network dentist
Lifetime orthodontia limit for children and adults	$3,000 per person	Coverage limited to 24 months of treatment
TMJ (temporomandibular joint) treatment excluding surgery	50% after deductible if not the result of an accident (covered under orthodontia)	Not covered
Implants	Subject to "dental necessity"	Not covered
Annual maximum	$3,000 per person	None

* MetLife PDP providers charge negotiated fees for services. For services other than those for preventive care, you must meet the annual deductible before the Plan will pay a percentage of eligible costs. Benefit amounts for out-of-network dentists are based on maximum allowed amount for your geographic area.

** You can obtain a schedule of charges and a list of providers by calling Cigna Dental HMO at **1-800-244-6224**. Once enrolled, you can obtain a schedule of charges at **www.mycigna.com**.

***Any reimbursements from Delta Dental for orthodontia treatment from 2004-2009 will be applied to the lifetime maximum of $3,000 under the MetLife PDP.

MetLife Preferred Dentist Program (PDP)

The MetLife Preferred Dentist Program (MetLife PDP) is a preferred provider organization (PPO) consisting of a nationwide network of 126,000 dentists, including 30,000 specialists, who charge negotiated fees that are typically lower than the provider's normal fee; this reduces your out-of-pocket cost.

The MetLife PDP offers:

- Total freedom of choice; you can visit any dentist at any time;
- Stringent credentialing requirements for providers; and
- Personalized provider directories that you can view online or order by telephone and have faxed or mailed to you.

You can take advantage of the PDP feature, which consists of a network of dentists who accept fees that are typically 10% to 30% less than community average charges. When visiting a PDP dentist, you are responsible only for the difference between the Plan's benefit payment amount and the PDP dentist's fee.

To find out if your dentist is in the PDP network:

- Visit the MetLife website at **www.metlife.com/mybenefits;** or
- Call **1-888-832-2576** for a provider directory.

When calling to make an appointment, let the dentist know that you participate in the MetLife PDP.

How the Plan works

The MetLife PDP allows you to receive care from any dentist. At the time you need dental care, you decide whether to visit a PDP dentist or go to a dentist outside the PDP network. The Plan provisions (deductibles, coinsurance, and annual and lifetime maximums) will be the same whether your dentist is a PDP provider or not. However, using preferred dentists can reduce your out-of-pocket costs.

Annual deductible and maximum

Before benefits can be paid in a calendar year, you and/or your covered dependent(s) must meet the $50 individual or $150 maximum family deductible. The deductible does not apply to preventive and diagnostic services. However, the deductible does apply to basic, major, and orthodontia services.

You can meet the family deductible as follows:

- Up to three people in a family: Each member must meet the individual deductible; or
- Four or more people in a family: Expenses can be combined to meet the family deductible. However, no one person can apply more than the $50 individual deductible toward the $150 family deductible.

You and/or your covered dependent(s) have an annual maximum benefit of $3,000 per person (excluding orthodontia). A separate lifetime maximum of $3,000 per person applies to orthodontia treatment.

Covered charges

After you have met the deductible, the MetLife PDP reimburses covered charges for out-of-network dentists at a percentage of maximum allowed amount (MAA) charges. The MetLife PDP determines MAA based on the amounts charged for a specific service by most dentists in the same geographic area. For network charges, the reimbursement is based on a percentage of the fees negotiated with the network dentists.

A dental charge is incurred on the date the service is performed or the supply is furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the "preparation date" is considered the date the charge is incurred. The claim will be paid in a lump sum (excluding orthodontia). For example, the preparation date is considered for:

- Root canal therapy as the date the pulp chamber was opened;
- Crowns as the date the tooth was prepared for the crown;
- Partial and complete dentures as the date the impressions were taken; and
- Fixed bridgework as the date the abutment teeth were prepared for the bridge.

Orthodontic payments are paid differently.

Coverage for new orthodontic work

If the orthodontic expense submitted is $5,000, for example, the Plan will pay the 50% benefit, as follows:

Coverage for orthodontic appliance: MetLife will pay an initial appliance component (sometimes referred to as the "banding" fee), based on 20% of the submitted expense, at the 50% coinsurance level:

- $5,000 × 20% = $1,000 × 50% benefit = $500
- First payment will be $500

Coverage for monthly payments:

- $5,000 - $1,000 = $4,000
- $4,000 ÷ 24 months = $167 × 50% benefit = $84
- Monthly payment will be $84

A monthly payment of $84 will be made over the course of treatment, paid each treatment quarter. The first payment will be based on 20% of the expense to cover the appliance fee. The remaining expense will be spread over the expected length of treatment, in this example, 24 months or eight quarterly payments. Orthodontic benefits are subject to the calendar-year deductible and the $3,000 lifetime orthodontia maximum. In this example, assuming the annual deductible has been met, the total amount paid will be $2,516.

Coverage for orthodontic work in progress

The MetLife PDP pays 50% coinsurance, after the annual deductible is met, up to a $3,000 lifetime orthodontia maximum. Orthodontia benefits paid since January 1, 2004, under the MetLife and Delta Dental Citi-sponsored Plan (as of January 1, 2010, the Delta Plan was no longer available) will count toward the lifetime orthodontia maximum across both Plans.

Before you receive care

Before you receive certain dental services, you are advised to discuss the treatment plan with your dentist to determine what is covered.

Dental

Covered services

Preventive and diagnostic services

- Routine oral exams, maximum of two exams per calendar year (additional medically necessary oral exams will be reviewed by MetLife Dental Consultants);
- Routine cleanings, maximum of two cleanings per calendar year;
- Fluoride treatments through age 18, maximum of one application per calendar year;
- Space maintainers through age 18;
- Full mouth series and panoramic X-rays, once every 36 months;
- Bitewing X-rays, up to two bitewing X-rays per calendar year (up to eight films per visit);
- Sealants, permanent molars only through age 16, one application every 36 months; and
- Palliative treatments: Emergency treatment only; not paid as a separate benefit from other services on the same day.

Basic services

- Fillings (except gold fillings): Includes amalgam ("silver") and composite ("white") fillings to restore injured or decayed teeth;
- Extractions;
- Endodontic treatment;
- Oral surgery, unless covered under your medical plan or your HMO;
- Repair prosthetics: No limit;
- Recementing (crowns, inlays, onlays, bridgework, or dentures): No limit;
- Addition of teeth to existing partial or full denture;
- Denture relining and rebasing: Once every 36 months;
- Periodontal maintenance treatments, up to four per calendar year; this covers up to two regular cleanings per year paid at 100% and up to four periodontal maintenance visits per year paid at 80%. These services are combined and do not exceed four per year in total;
- Periodontal scaling and root planing: No limit (subject to consultant review);
- Bruxism appliance; and
- General anesthesia, when medically necessary, as determined by the Claims Administrator and administered in connection with a covered service.

Major services

- Inlays, onlays, and crowns (including precision attachments for dentures; must be at least five years old and unserviceable); limited to one per tooth every five years;
- Removable dentures, initial installation, and any adjustments made within the first six months;
- Removable dentures (replacement of an existing removable denture or fixed bridgework with new denture; dentures must be at least five years old and unserviceable); limited to once every five years;
- Fixed bridgework, including inlays, onlays, and crowns used to secure a bridge (initial installation);
- Fixed bridgework, including inlays, onlays, and crowns used to secure a bridge (replacement of an existing removable denture or fixed bridgework with new fixed bridgework or addition of teeth to existing fixed bridgework; bridgework must be at least five years old and unserviceable); limited to once every five years; and
- Dental implants (subject to medical necessity and consultant review); medical necessity, as determined by the Claims Administrator, is based on the number and distribution of all missing, unreplaced teeth in the arch, as well as the overall periodontal condition of the remaining normal teeth.

Oral cancer services

Dental coverage may be available for those participants diagnosed with oral cancer.

Orthodontia services

- Orthodontic X-rays;
- Evaluation;
- Treatment plan and record;

- Services or supplies to prevent, diagnose, or correct a misalignment of teeth, bite, jaws, or jaw joint relationship;
- Removable and/or fixed appliance(s) insertion for interreceptive treatment;
- Temporomandibular joint (TMJ) disorder appliances (for TMJ dysfunction that does not result from an accident); and
- Harmful habit appliances; includes fixed or removable appliances.

Procedures and services that are not covered

Benefits are not provided for services and supplies not medically necessary for the diagnosis or treatment of dental illness or injury. For example, cosmetic services such as tooth whitening are elective in nature and, therefore, not covered by the Plan. Medical necessity is the treatment of dental diseases, such as dental decay and periodontal (gum) diseases. Dental services must be performed by a dentist licensed to practice in the state or by a legally qualified physician. A dentist is a doctor of dental surgery or a doctor of medical dentistry.

The Plan Administrator, acting through the Claims Administrator, reserves the right to determine whether, in its judgment, a service or supply is medically necessary or payable under this Plan. The fact that a dentist has prescribed, ordered, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Exclusions that apply to the MetLife PDP include, but are not limited to, the following, which are *not* covered by the Plan:

- Dental care received from a dental department maintained by an employer, mutual benefit association, or similar group;
- Treatment performed for cosmetic purposes;
- Use of nitrous oxide;
- Treatment by anyone other than a licensed dentist, except for dental prophylaxis performed by a licensed dental hygienist under the supervision of a licensed dentist;
- Services in connection with dentures, bridgework, crowns, and prosthetics if for:
  - Prosthetics started before the patient became covered;
  - Replacement within five years of a prior placement covered under this Plan;
  - Extensions of bridges or prosthetics paid for under this Plan, unless into new areas;
  - Replacement due to loss or theft;
  - Teeth that are restorable by other means or for the purpose of periodontal splinting; and
  - Connecting (splinting) teeth, changing or altering the way the teeth meet, restoring the bite (occlusion), or making cosmetic changes.
- Any work done or appliance used to increase the distance between nose and chin (vertical dimension);
- Facings or veneers on molar crowns or molar false teeth;
- Training or supplies used to educate people on the care of teeth;
- Charges for crowns and fillings not covered under basic services;
- Any charges incurred for services or supplies not recommended by a licensed dentist;
- Any charges incurred due to sickness or injury that is covered by a Workers' Compensation Act or other similar legislation or arising out of or in the course of any employment or occupation whatsoever for wage or profit;
- Any charges incurred while confined in a hospital owned or operated by the U.S. government or an agency thereof for treatment of a service-connected disability;
- Any charges that, in the absence of this coverage, you would not be legally required to pay;
- Any charges incurred that result directly or indirectly from war (whether declared or undeclared);
- Any charges due to injuries sustained while committing a felony or assault or during a riot or insurrection;
- Any charges for services and supplies furnished for you or your eligible dependent(s) prior to the effective date of coverage or subsequent to the termination date of coverage;

Dental

- Any charges for services or supplies that are not generally accepted in the United Students as being necessary and appropriate for the treatment of dental conditions including experimental care;
- Any charges for nutritional supplements and vitamins;
- Services covered by motor vehicle liability insurance;
- Services that would be provided free of charge but for coverage;
- Broken appointments;
- Charges for filing claims or charges for copies of X-rays;
- Any charges for services rendered to sound and natural teeth injured in an accident;
- Care and treatment that is in excess of the reasonable and customary charge; and
- Services that, to any extent, are payable under any medical benefits, including HMOs.

Alternate benefit provision

Before deciding how much the Plan will pay for covered procedures, MetLife will consider any less-costly alternatives that will produce a satisfactory result based on generally accepted dental standards of care. You and your dentist may choose the more costly procedure, but you will be responsible for the difference in cost between the benefit amount and the dentist's charge.

Predetermination of benefits

MetLife recommends that you obtain a predetermination of benefits before undergoing any procedure that will cost more than $300. By requesting a predetermination of benefits, you will know in advance how much you will be responsible for paying. Then, you can choose whether to continue with the more expensive treatment or the alternative procedure.

If you do not request a predetermination of benefits, you may find that the Plan will pay less than you anticipated or nothing at all, depending on the procedure and treatment provided.

Medical necessity

Medical necessity is the treatment of dental diseases, such as dental decay and periodontal (gum) diseases. Dental services must be performed by a dentist licensed to practice in the state or by a legally qualified physician. A dentist is a doctor of dental surgery or a doctor of medical dentistry.

The Plan Administrator, acting through the Claims Administrator, reserves the right to determine whether, in its judgment, a service or supply is medically necessary or payable under this Plan. The fact that a dentist has prescribed, ordered, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Filing a claim

When you visit the dentist, you will pay the dentist directly and then submit a claim for benefits. See "Claims and appeals for the MetLife PDP" on page 144.

Cigna Dental HMO

Cigna Dental HMO operates like a health maintenance organization: Once enrolled, you must receive all services from the Cigna Dental HMO provider you selected. Except for emergency treatment for pain, you will not be covered for any dental services you receive outside the Cigna Dental HMO network.

As a Cigna Dental Plan member, you may be eligible for various discounts, benefits, and other considerations to promote your general health and well being. Visit the Cigna website at **www.mycigna.com**.

Enrollment in the Cigna Dental HMO allows the release of your and your covered dependents' dental records to Cigna Dental for administrative purposes.

The Cigna Dental HMO has no annual individual or family deductibles and no lifetime dollar maximums. Most preventive services are 100% paid when you use a network general dentist. You pay a patient charge when you use a network general dentist for other services. See "Patient Charge Schedule" on page 140 for more information. You can obtain a schedule of charges when you enroll in the Cigna Dental HMO or by calling Cigna Dental at **1-800-Cigna24** or visit **www.mycigna.com/dental**.

Is your dentist in the Cigna Dental HMO network?

Cigna Dental contracts with network dentists in most areas of the country. Network dentists provide covered services to Cigna Dental HMO members at independently owned network dental offices. You can request a list of network dental offices in your area by calling Cigna Dental at **1-800-Cigna24**. You can also find a provider on the Cigna website at **http://cigna.benefitnation.net/cigna/(ksmtg545tvtqiyezhahstk45)/docdir.aspx.**

If you want to enroll in the Cigna Dental HMO but have a dentist whom you want to continue using, you should verify that he or she is in the Cigna Dental HMO. Since this Plan has no out-of-network benefits, other than for emergency treatment for pain, you won't be reimbursed for any dental services if you continue to visit your current dentist and he or she is not in the Cigna Dental HMO network.

If you do not choose a primary dentist when you enroll, Cigna Dental HMO will assign a dentist to you based on your home zip code.

Cigna Dental HMO confirms that each dentist in its network is properly licensed, certified, and insured and complies with government health standards.

Cigna Dental HMO features

- A nationwide network of approximately 34,000 dentists (you must use one of these providers);
- No deductibles to meet;
- No annual or lifetime dollar maximums;
- No charge for exams, X-rays, or routine cleanings;
- Reduced prices on covered procedures when there is a charge;
- Specialist care with an approved referral at the same fees you would pay a general dentist;
- Automated Dental Office Locator for 24-hour information by telephone or fax to help you find the right dentist;
- Automatic participation in the Cigna Healthy Rewards® program, which offers discounts on various health-related services and products; for more information, visit **www.cigna.com**;
- Orthodontia for children and adults limited to 24 months of treatment; additional treatment is available at a prorated cost of the initial treatment;
- Coverage for general anesthesia and IV sedation *when medically necessary and performed by a network oral surgeon or periodontist for covered procedures;* general anesthesia does not include nitrous oxide; and
- Two routine cleanings for normal healthy teeth and gums every calendar year at no charge and two additional per calendar year with a copayment; charges are listed on your Patient Charge Schedule.

Referrals for children

You are not required to obtain a referral from a network general dentist for a Cigna Dental HMO member under age 7 to be treated by a network pediatric dentist. Exceptions for coverage at the network pediatric dentist for children ages 7 and older are considered for clinical and/or medical reasons.

How the Plan works

When you enroll in the Cigna Dental HMO, you must select a network dental office. If your first or second choice is not available, the network dental office nearest your home will be selected for you.

You can choose a different dentist in the network for yourself and each of your covered dependents. When you visit a network office, you will show your Cigna Dental HMO ID card and pay the amount shown on your Patient Charge Schedule for covered services. If you undergo a procedure that is not on your Patient Charge Schedule, you will pay the dentist's usual charges. If you visit an office other than your network dental office, you will pay the dentist's usual charges, except for emergencies or as authorized by Cigna Dental.

Specialized care

If your network general dentist determines that you need specialized dental care, he or she will begin the specialty referral process. Follow your network general dentist's instructions regarding access to specialty care. Care from a network specialist is covered when Cigna Dental authorizes payment. Treatment by a network specialist must begin within 90 days from the date of Cigna Dental's

authorization. If you are unable to obtain treatment within the 90-day period, call Member Services to request an extension. Your coverage must be in effect when each procedure begins. A referral is not necessary when visiting an orthodontist or pediatric dentist who participates in the Cigna Dental HMO network. **Note:** Services performed by a pediatric dentist are covered until the child reaches age 7. Services performed by a pediatric dentist after the child reaches age 7 are not covered.

You should verify with the network specialist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins. If you receive specialty care, and payment is not authorized by Cigna Dental, you may be responsible for the network specialist's usual charges.

Changing your dentist/dental office

If you decide to change your network dental office, Cigna Dental can arrange a transfer. You and your enrolled dependents may each transfer to a different network general dentist. You should complete any dental procedure in progress before transferring to another dental office.

To arrange a transfer, call Member Services at **1-800-Cigna24**. Your transfer request will take about five days to process. Transfers generally will be effective the first day of the month after your request is processed. Unless you have an emergency, you will be unable to schedule an appointment at the new dental office until your transfer becomes effective.

There is no charge to you for the transfer. However, all patient charges that you owe to your current dental office must be paid before the transfer can be processed.

Appointments

To make an appointment with your network general dentist, call the dental office that you have selected or to which you have been assigned. When you call, your dental office will ask for your ID number (which can be found on your Cigna Dental HMO ID card) and will check your eligibility.

Broken appointments

The time your network general dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your dental office to maintain a schedule that is convenient for you and efficient for the staff. The delay in treatment resulting from a broken appointment can turn a minor problem into a complex one resulting in higher cost to you, your dentist, and Cigna Dental.

If you or your enrolled dependent(s) breaks an appointment with fewer than 24 hours' notice to the dental office, you may be charged a broken appointment fee for each 15-minute block of time that was reserved for your care. Consult your Patient Charge Schedule for maximum charges for broken appointments (not applicable in **Texas**).

Patient Charge Schedule

Your Patient Charge Schedule lists the benefits of the Cigna Dental HMO including covered procedures and patient charges. Patients pay the patient charges listed only when the procedures are performed by a network dentist. Procedures performed by an out-of-network dentist are not covered, and patients will be charged the dentist's usual fee for those procedures. Procedures not listed on your Patient Charge Schedule are not covered and are the patient's responsibility at the dentist's usual fees. You may request your Patient Charge Schedule when you enroll in the Cigna Dental HMO or by calling Cigna Dental at **1-800-Cigna24** or visit **www.mycigna.com** (if you are already a member).

Emergencies

An emergency is a dental condition of recent onset and severity that would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your network general dentist if you have an emergency.

Examples of a dental emergency include:

- The loss of a large filling in a tooth or crown or a cracked tooth that resulted in significant acute pain and discomfort; and
- Swelling of the mouth that is a result of an infection, normally associated with an abscess.

Examples of non-dental emergencies include:

- A slight injury that did not result in significant bleeding, severe pain, or acute infection;
- A sore spot under dentures that has created a small ulcer;
- A wisdom tooth that is erupting or painful, but there is no swelling; and
- A chipped tooth that produced a sensitive spot that irritates the tongue.

Routine restorative or definitive treatment (root canal therapy) is not considered emergency care and should be performed or referred by the network general dentist or network pediatric dentist.

Away from home

If you have an emergency while you are out of your service area or unable to contact your network general dentist, you may receive emergency covered services from any general dentist. Routine restorative procedures or definitive treatment (e.g., root canal) are not considered emergency care. You should return to your network general dentist for these procedures. For emergency covered services, you will be responsible for the patient charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you for the difference, if any, between the dentist's usual fee for emergency covered services and your patient charge, up to a total of $50 per incident.

- For **Arizona** residents: An emergency is a dental problem that requires immediate treatment (includes control of bleeding, acute infection, or relief of pain including local anesthesia). Reimbursement for emergencies will be made by Cigna Dental in accordance with your plan benefits regardless of the location of the facility providing the services.
- For **Pennsylvania** residents: If any emergency arises and you are out of your service area or are unable to contact your network general dentist, Cigna Dental covers the cost of emergency dental services so that you are not responsible for greater out-of-pocket expenses than if you were attended by your network general dentist.
- For **Texas** residents: Emergency dental services are limited to procedures administered in a dental office, dental clinic, or other comparable facility to evaluate and stabilize emergency dental conditions of recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would cause a prudent layperson with average knowledge of dentistry to believe that immediate care is needed.

To receive reimbursement, send appropriate reports and X-rays to the following Cigna Dental address:

Cigna Dental
P.O. Box 188045
Chattanooga, TN 37422-8045

After hours

There is a patient charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable patient charges.

Member Services

If you have any questions or concerns about the Cigna Dental HMO, call a Member Services representative who can explain your benefits or help with matters regarding your dental office or the Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, covered services, plan benefits, ID cards, location of dental offices, conversion coverage or other matters, call Member Services at **1-800-Cigna24**. If you are hearing impaired, call the state TTY toll-free relay service in your local telephone directory.

Limitations on covered services

- **Frequency:** See your Patient Charge Schedule for limitations on frequency of covered services, such as cleaning.
- **Specialty care:** Except for pediatric dentistry and endodontics, payment authorization from the Cigna Dental HMO is required for coverage of services performed by a network specialty dentist.
- **Pediatric dentistry:** Coverage from a pediatric dentist ends on a covered child's seventh birthday. Cigna Dental HMO may consider exceptions for medical reasons on an individual basis. The network general dentist will provide care after the child's seventh birthday.
- **Oral surgery:** The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is for orthodontic reasons only. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Orthodontics in progress.** If orthodontic treatment is in progress for you or your dependent at the time you enroll, call Member Services at **1-800-Cigna24** to find out if you are entitled to any benefit under the Plan.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

You will pay full cost of procedures and services that are not covered. Visit the Cigna website at **www.cigna.com**, or call **1-800-244-6224** for more information.

Conversion to an individual policy

You may have the right to convert your Cigna Dental HMO coverage into an individual policy after you terminate employment with Citi. For more information, contact the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Procedures and services that are not covered

Listed below are the services or expenses that are *not* covered under the Cigna Dental HMO (this list is not exhaustive, and other exclusions may apply). These services are your responsibility and are billed by the dentist at his/her usual fee:

- Services not listed on your Patient Charge Schedule;
- Services provided by an out-of-network dentist without Cigna Dental's prior approval (except emergencies, as explained under "Emergencies" on page 140);
- Services related to an injury or illness covered under Workers' Compensation, occupational disease or similar laws; (for **Florida** residents, this exclusion relates to such services paid under Workers' Compensation, occupational disease, or similar laws);
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision, or a public program other than Medicaid;
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war, or acts of war;
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule;
- General anesthesia, sedation, and nitrous oxide unless specifically listed on your Patient Charge Schedule; when listed on your Patient Charge Schedule general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with covered services performed by an oral surgeon or periodontist; (for **Maryland** residents, general anesthesia is covered when medically necessary and authorized by your physician);
- Prescription drugs;
- Procedures, appliances, or restorations if the main purpose is to change vertical dimension (degree of separation of the jaw when teeth are in contact); to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ) unless TMJ therapy is specifically listed on your Patient Charge Schedule; or to restore teeth damaged by attrition, erosion or abrasion, and/or abfraction; (for **California** residents, the word "attrition" is modified as follows: except for medically necessary treatment where functionality of teeth has been impaired);

- The completion of crown and bridge, dentures, or root canal treatment already in progress on the date you become covered by the Plan; (for **Texas** residents, pre-existing conditions, including the completion of crown and bridge, dentures, or root canal treatment already in progress on the effective date of your coverage, are not excluded if otherwise covered under your Patient Charge Schedule);
- Replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen, or damaged due to patient abuse, misuse, or neglect;
- Services associated with the placement or prosthodontic restoration of a dental implant;
- Services considered unnecessary or experimental in nature; (for **Pennsylvania** residents, this exclusion applies only to services considered experimental in nature; for **California** and **Maryland** residents, this exclusion applies only to services considered unnecessary);
- Procedures or appliances for minor tooth guidance or to control harmful habits;
- Hospitalization, including any associated incremental charges for dental services performed in a hospital; benefits are available for network dentist charges for covered services performed at a hospital; other associated charges are not covered and should be submitted to your medical carrier for benefit determination);
- Services to the extent you are compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy; (for **Arizona** and **Pennsylvania** residents, this exclusion does **not** apply; for **Kentucky** and **North Carolina** residents, this exclusion does **not** apply to services compensated under no-fault auto or insured motorist policies; for **Maryland** residents, this exclusion does **not** apply to services compensated under group medical plans.);
- Crowns and bridges used solely for splinting; and
- Resin bonded retainers and associated pontics.

Except for the limitations listed above, pre-existing conditions are not excluded.

Filing claims

You do not need to file any claims for benefits. However, if benefit payment is denied, you may file an appeal. See "Claims and appeals for the Cigna Dental HMO" on page 144.

Extension of benefits

Coverage for a dental procedure, other than for orthodontics, which was started before you dropped coverage, will be extended for 90 days after the date coverage ends unless coverage loss was due to non-payment of premiums.

Coverage for orthodontia treatment started before you dropped coverage will be extended to the end of the quarter or for 60 days after the date coverage ends, whichever is later, unless coverage loss was due to non-payment of premiums.

Disclosure statement

Cigna Dental refers to the following operating subsidiaries of Cigna Corporation: Connecticut General Life Insurance Company and Cigna Dental Health, Inc. and its operating subsidiaries. The Cigna Dental Care Plan is provided by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., a prepaid limited health services organization licensed under Chapter 636, Florida Statutes, Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska), Cigna Dental Health of Kentucky, Inc., Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., Cigna Dental Health of Virginia, Inc. In other states, the Cigna Dental Care plan is underwritten by Connecticut General Life Insurance Company or Cigna HealthCare of Connecticut, Inc. and administered by Cigna Dental Health, Inc.

Claims and appeals

This section describes the claims and appeals process for the MetLife PDP and the Cigna Dental HMO.

Claims and appeals for the MetLife PDP

The amount of time MetLife will take to make a decision on a claim will depend on the type of claim.

Type of claim	Timeline after a claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Preservice claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where a delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

* The time period allowed to make a decision is suspended pending receipt of additional information.

You have the right to request a reconsideration of the denied claim by calling or writing to MetLife. Any additional information that you feel would support the claim should be provided to MetLife.

If, after the review, it is determined that the initial denial can be reversed and claim paid, normal processing steps are followed. If, after the review, it is determined that the original denial stands, a denial letter is written to you.

Responses to an appeal are conducted by an individual of higher authority than the person who originally denied the claim. The response includes:

- An explanation in plain language of why the charges are denied in plain language and
- A reference to the wording from this Plan Document that justifies the denial.

The appeal request must be submitted in writing to MetLife within 180 days of receipt of the denial letter. As part of this review, you or your legal representative has the right to review all pertinent documents and submit issues and comments in writing to a committee selected by MetLife. The committee consists of senior representatives of MetLife Dental Claim Management and a Dental Consultant.

For preservice and post-service claim appeals, Citi has delegated to MetLife as Claims Administrator the exclusive right to interpret and administer the provisions of the Dental Benefit Plan. The Claims Administrator's decisions are conclusive and binding. The Claims Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Claims and appeals for the Cigna Dental HMO

If you have a concern about your dental office or the Cigna Dental HMO, call **1-800-Cigna24** and explain your concern to a Member Services representative. You can also express that concern to Cigna Dental in writing. Most matters can be resolved with the initial telephone call. If more time is needed to review or investigate your concern, Cigna Dental will respond to you as soon as possible, usually by the end of the next business day but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to the Cigna Dental HMO within one year from the date of the initial Cigna Dental decision. You should state the reason why you believe your request should be approved and include any information supporting your request. If you are unable or choose not to write, you can ask Member Services to register your appeal by calling **1-800-Cigna24**.

Cigna Dental HMO level-one appeal

Your level-one appeal will be considered and the resolution made by someone not involved in the initial decision or occurrence. Issues involving dental necessity or clinical appropriateness will be considered by a dental professional.

If your appeal concerns a denied precertification, Cigna Dental will respond with a decision within 15 calendar days after your appeal is received. For appeals concerning all other coverage issues, Cigna Dental will respond with a decision within 30 calendar days after your request is received. If Cigna Dental needs more information to make your level-one appeal decision, it will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

- For **New Jersey** residents, Cigna Dental will respond in writing within 15 working days;
- For **Colorado** residents, Cigna Dental will respond within 20 working days; and
- For **Nebraska** residents, Cigna Dental will respond within 15 working days if your complaint involves an adverse determination.

If you are not satisfied with the decision, you may request a level-two appeal.

Cigna Dental HMO level-two appeal

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review. The level-two appeals process does not apply to resolutions made solely on the basis that the Plan does not provide benefits for the service performed or requested.

The review will be completed within 30 calendar days. If Cigna Dental needs more information to complete the appeal, it will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

Cigna Dental HMO expedited appeal

You may request that the complaint or appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the Plan will respond orally with a decision within 72 hours, followed up in writing.

- For **Maryland** residents, Cigna Dental will respond within 24 hours and
- For **Texas** residents, Cigna Dental will respond within one business day.

Cigna Dental independent review

The independent review procedure is a voluntary program arranged by the Plan and is not available in all areas. Call Cigna Dental at **1-800-Cigna24** for details.

Appeals to the state

You have the right to contact your state's Department of Insurance or Department of Health for assistance at any time.

Cigna Dental will not cancel or refuse to renew coverage because you or your dependent has filed a complaint or appealed a decision made by Cigna Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

Vision

The Aetna Vision Plan, offers a variety of routine vision care services and supplies.

You may enroll in the Plan as a new hire or during annual enrollment. You can change your election if you have a qualified status change, as described in the *Eligibility and Participation* section.

When you enroll in the Plan, you will receive two ID cards in the mail.

The Aetna Vision Plan offers both network and out-of-network benefits. For example, you can obtain an annual eye exam from a network provider while purchasing frames and lenses out of network. However, before taking a prescription from one vendor to be filled at another vendor, you should confirm that the prescription will be honored.

The Aetna Vision Plan is underwritten by Aetna Life Insurance Company. Certain claims administration services are provided by First American Administrators, Inc., and certain network administration services are provided through EyeMed Vision Care, LLC.

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Benefits at a glance

The following table summarizes the vision benefits available to you and your eligible dependents:

Network benefit	Coverage
Routine eye exam	• Covered at 100% including dilation, one exam per calendar year
Frames and lenses	• One pair of frames and lenses per calendar year • Frames covered at 100% up to the frame allowance below • Lenses covered at 100% • $150 frame allowance; member pays 80% of balance over the $150 plan allowance • 40% discount on additional pairs of glasses
Contact lenses (in lieu of glasses)	• Covered at 100% up to the contact lense allowance below; one allowance per calendar year in lieu of eyeglasses • $130 allowance for conventional or disposable contact lenses; member pays 85% of balance over $130 allowance for conventional contact lenses and 100% over $130 allowance for disposable contact lenses • 15% discount on additional conventional contact lens purchases • Medically necessary contact lenses covered in full
Laser vision correction (Lasik)	• 15% off retail price or 5% off promotional price; must use the U.S. Laser Network to receive discount
Maximum benefit	• The most the Plan will pay for the service or benefit; excludes copayments and allowances
Out-of-network benefit	**Coverage**
Routine eye exam	• Up to $50
Frames/lenses	• Frame; up to $100 • Single vision lenses up to $50, bifocal up to $60, trifocal up to $90, and lenticular up to $125
Contact lenses	• Contact lenses; up to $130 • Medically necessary contact lenses; up to $225

Network services

To receive the greatest value for your dollar, you should receive vision care services from an Aetna Vision network provider. However, you can use out-of-network providers and receive a benefit.

Network providers are licensed doctors in your area who have contracted to provide vision care services at a discount. You and your covered family members can select a different Aetna Vision network provider each time you receive vision care services.

Your doctor may apply to join the Aetna provider network by calling EyeMed at **1-800-521-3605**. Membership in the network is not guaranteed.

Using network providers

To find a network provider in your area and schedule an appointment, follow these instructions.

- **If you are a member:** Visit Aetna Navigator at **www.aetna.com** or visit **www.aetnavision.com**, and enter the employee's member ID number.
- **If you are not a member:** During your enrollment period visit **www.AetnaVisionOE.com/avp1**.
- You may also call the Aetna Vision Plan at **1-877-787-5354**. An automated voice response unit (available 24/7) or a Member Services representative (available from 7:30 a.m. to 11 p.m. ET on weekdays and Saturdays and 11 a.m. to 8 p.m. on Sundays) will assist you.

Once you have obtained the name of a network provider, call him or her to schedule an appointment and provide the Citi employee's member ID number. If you are calling for services for a covered dependent, you will need to provide your dependent's date of birth.

Note: Claim forms are not required when obtaining network services.

Network benefits

Network benefits include:

- Routine eye exam: One eye exam, including dilation, when professionally indicated, each calendar year covered at 100%;
- Frame and spectacle lenses: One pair of eyeglasses each calendar year; frame allowance of $150 per calendar year; members pay 80% of the balance over this allowance;
- Contact lenses in lieu of eyeglasses: $130 allowance per calendar year and a 15% discount over the allowance for conventional contact lenses; and
- A 40% discount on additional pairs of glasses at most network providers.

The following lenses are covered at 100%: plastic lenses (single, bifocal, or trifocal); all prescription ranges, including post-cataract lenses; tinting of plastic lenses; standard and premium progressive addition multifocals; polycarbonate lenses; oversize lenses; ultraviolet coating; blended segment lenses; PGX (sun-sensitive) glass lenses; scratch-resistant coating; intermediate-vision lenses; anti-reflective coatings; hi-index lenses; polarized lenses; and plastic photosensitive lenses.

Note: Some brand exceptions may apply and may require a copayment.

Mail-order contact lenses

You can purchase replacement or additional pairs of contact lenses by calling the Aetna Vision Plan at **1-877-787-5354** or visiting **www.aetnavision.com**.

Travel and student coverage

If you or a covered dependent(s) requires vision care services while traveling or away at school, call the Aetna Vision Plan at **1-877-787-5354**.

Out-of-network benefits

If you receive services outside the Aetna network, the Plan will provide reimbursements of up to the following amounts:

- Annual exam: $50;
- Lenses: Single vision, $50; bifocal, $60; trifocal, $90; lenticular, $125;
- Frame only: $100; and
- Contact lenses: $130 elective; $225 medically necessary.

When you receive services outside the provider network, you will need to submit your itemized paid receipts with a Vision Claim Submission Form. You can visit **www.aetnavision.com** to obtain the form.

Mail the completed form and your itemized paid receipts to:

Aetna Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Allow at least 14 calendar days for your claims to be processed after receipt. A check and/or explanation of benefits will be mailed within seven calendar days of the date your claim is processed. If you have any questions about your claims, call the Aetna Vision Plan at **1-877-787-5354**.

Laser vision correction

Laser vision correction is not covered under the Plan. However, if you use a provider in the U.S. Laser Network, you are eligible for up to a 15% discount off the retail price or a 5% discount off any promotional price. The U.S. Laser Network comprises more than 550 provider locations, including Lasik*Plus* Vision Centers nationwide, and offers a broad choice of the latest technologies in the industry.

The list of doctors and facilities performing laser vision correction is different from the routine vision provider listing. For more information about laser vision correction, call the Aetna Vision Plan at **1-877-787-5354** or visit **www.eyemedlasik.com**.

What is not covered

Below is a partial list of exclusions and limitations:

- Special vision procedures, such as orthoptics, vision therapy, or vision training;
- Vision services that are covered, in whole or in part, under any other part of this plan or under any other plan of group benefits provided by the policyholder, or under any Workers' Compensation law, or any other law of like purpose;
- An eye exam that is required by an employer as a condition of employment, or that an employer is required to provide under a labor agreement, or that is required by any law of a government;
- The cost of prescription sunglasses in excess of the amount that would be covered for non-tinted lenses;
- Replacement of lost, stolen, or broken prescription lenses or frames; and
- Any exams given during your stay in a hospital or other facility for medical care.

Other exclusions and limitations may apply.

Claims and appeals for the Aetna Vision Plan

The amount of time Aetna will take to make a decision on a claim will depend on the type of claim.

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	• Decision within 30 days; one 15-day extension (notice of the need for an extension must be given within 30 days) • Notice that more information is needed must be given within 30 days • You have 45 days to submit any additional information needed to process the claim.
Preservice claims (for care or treatment requiring approval before the care or treatment is received)	• Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) • Notice that more information is needed must be given within 15 days • You have 45 days to submit any additional information needed to process the claim.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider, you may write to Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter.

Aetna will review the information and provide a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and the information cannot be obtained within this period. The notice of the decision will tell you what to do to seek an additional review.

Appeals of adverse benefit determinations

If Aetna notifies you of an adverse benefit determination — that is, a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service, supply or benefit — you may submit an appeal.

An adverse benefit determination may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is experimental or investigational;
- A determination that the service or supply is not medically necessary; or
- Contractual issues.

The Plan provides two levels of appeal. It will also provide an option to request an external review of the adverse benefit determination.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your level-one appeal. Your appeal may be submitted in writing and should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

You may file your appeal in writing or by telephone:

- In writing: Send your appeal to Customer Service at the address on your Aetna Vision Plan ID card, or
- By telephone: Call the Aetna Vision Plan at **1-877-787-5354**.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna.

Level-one appeal

A level-one appeal of an adverse benefit determination shall be made by Aetna personnel who were not involved in making the adverse benefit determination.

For preservice claims (may include concurrent care claim reduction or termination), Aetna shall issue a decision within 15 calendar days of receipt of the request for an appeal.

For post-service claims, Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Level-two appeal

If Aetna upholds an adverse benefit determination at the first level of appeal, you or your authorized representative has the right to file a level-two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a level-one appeal.

A level-two appeal of an adverse benefit determination of an urgent care claim, a pre-service claim, or a post-service claim shall be made by Aetna personnel who were not involved in making the adverse benefit determination.

For preservice claims (may include concurrent care claim reduction or termination), Aetna shall issue a decision within 15 calendar days of receipt of the request for a level-two appeal.

For post-service claims, Aetna shall issue a decision within 30 calendar days of receipt of the request for a level-two appeal.

Exhaustion of process

You must exhaust the applicable level-one and level-two processes of the Aetna appeal procedure before you do any of the following regarding an alleged breach of the policy terms by Aetna Life Insurance Company or any matter within the scope of the appeals procedure:

- Contact your state's Department of Insurance to request an investigation of a complaint or appeal; or
- File a complaint or appeal with your state's Department of Insurance; or
- Establish any litigation, arbitration, or administrative hearing.

External review

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is experimental or investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with Aetna's decision. An external review is a review by an independent physician, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

- You have received notice of Aetna's denial of a claim; and
- Your claim was denied because Aetna determined that the care was not necessary or was experimental or investigational; and
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the applicable internal appeal processes.

Aetna's claim denial letter will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim-denial letter. You must also include a copy of the final claim-denial letter and all other pertinent information that supports your request.

Aetna will contact the Independent Review Organization that will conduct the review of your claim. The Independent Review Organization will select a physician reviewer with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits.

You will be notified of the decision of the Independent Review Organization usually within 30 calendar days of Aetna's receipt of your request form and all necessary information. A quicker review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the requested service or supply would endanger your health. Expedited reviews are decided within three to five calendar days after Aetna receives the request.

Aetna will abide by the decision of the independent reviewer, except where Aetna can show conflict of interest, bias, or fraud.

You are responsible for the cost of compiling and sending to Aetna the information that you wish to be reviewed by the Independent Review Organization. Aetna is responsible for the cost of sending this information to the Independent Review Organization and for the cost of the external review.

For more information about Aetna's External Review program, call the Aetna Vision Plan at **1-877-787-5354**.

Wellness benefits

Your Citi benefits include programs intended to help you improve your health and reduce health care costs. These programs include:

- The Citi Live Well Program;
- Citi on-site medical clinics; and
- Citi on-site health and fitness centers.

Contents

The Citi Live Well Program

The Citi Live Well Program is designed to help you improve your health. Live Well gives you and your family the tools and resources to both manage your health care and achieve your health goals. Here are the components of the Live Well Program.

At a glance

Live Well tools and resources	Description	Who participates	How to access
Health Advocate	A free, personal support service to help you manage your health care needs, from working through difficult health claims to choosing a doctor to making choices regarding a serious illness.	Active employees (full time and part time), their spouses/partners, dependents, parents, and parents-in-law. You do not need to be enrolled in a medical plan offered by Citi to use Health Advocate.	**1-866-449-9933** from 8 a.m. to 9 p.m. ET on weekdays; after hours and on weekends, leave a message and a representative will return your call the next business day.
Health Assessment on the Citi Live Well Portal	A secure, online health questionnaire that is a part of your Personal Health Record. By completing it, you can learn more about your health.	Active, benefits-eligible employees can participate and do not need to be enrolled in a medical plan offered by Citi. However, spouses/partners must be enrolled in a medical plan offered by Citi to participate.	You can access the Citi Live Well Portal without an additional login via Total Comp @ Citi at **www.totalcomponline.com**; your spouse/partner can go to **www.myactivehealth.com/citi**. They will have to create a username and password for the Portal the first time they log in.
Personal Health Record on the Citi Live Well Portal	A secure, online health record to keep track of important health information in one place.	Active, benefits-eligible employees can participate and do not need to be enrolled in a medical plan offered by Citi. However, spouses/partners must be enrolled in a medical plan offered by Citi to participate.	Citi Live Well Portal via Total Comp @ Citi at **www.totalcomponline.com**; your spouse/partner and dependents 18 and over can go to **www.myactivehealth.com/citi**. They will have to create a username and password for the Portal the first time they log in.
Live Well Health Management Program	A program to help you improve and manage your health. Once enrolled, you will be paired with a nurse, who will work with you to ensure you are taking the right steps to treat your chronic medical condition.	Active employees, their spouses/partners, and dependents who are enrolled in one of the following medical plans offered by Citi and are invited by ActiveHealth to participate: Aetna, Empire BlueCross BlueShield, and Oxford Health Plans.	**1-800-490-3054** More information on the program may be found on the Citi Live Well Portal via Total Comp @ Citi at **www.totalcomponline.com**; your spouse/civil union partner/domestic partner and dependents 18 and over can go to **www.myactivehealth.com/citi**. They will have to create a username and password for the Portal the first time they log in.
24-Hour Nurseline	Access to nurses who can respond around the clock to immediate health issues.	Active, benefits-eligible employees, their spouses/partners, and dependents. You do not need to be enrolled in a medical plan offered by Citi to call the 24-Hour Nurseline.	**1-866-494-7879**; available 24/7
Live Well Tobacco Cessation Program	A program to help you become tobacco-free. Once enrolled you will work with a certified tobacco cessation specialist.	Active employees, their spouses/partners, and dependents who are enrolled in one of the following medical plans offered by Citi: Aetna, Empire BlueCross BlueShield, and Oxford Health Plans.	**1-800-490-3054** More information on the program may be found on the Citi Live Well Portal via Total Comp @ Citi at **www.totalcomponline.com**; your spouse/civil union partner/domestic partner and dependents 18 and over can go to **www.myactivehealth.com/citi**.
Lifestyle Management Tools	Tools and trackers that can support lifestyle changes, such as exercising, healthy eating, and quitting tobacco.	Active, benefits-eligible employees can participate and do not need to be enrolled in a medical Plan offered by Citi. However, spouses/partners and dependents must be enrolled in a medical plan offered by Citi to participate.	Citi Live Well Portal via Total Comp @ Citi at **www.totalcomponline.com**; your spouse/civil union partner/domestic partner and dependents 18 and over can go to **www.myactivehealth.com/citi**. From the Personal Health Record website, click on "Active Lifestyle Coaching."

Health Advocate

Health Advocate is a free program available to you *and* your family — your spouse/civil union partner/domestic partner, children, parents, and parents-in-law — regardless of your health coverage. You and your family members do not need to be enrolled or eligible to participate in a medical Plan offered by Citi to use Health Advocate.

Health Advocate helps you take control of your health care issues. You and your family can call Health Advocate to speak with a staff of medical professionals and health-related specialists to help you:

- Resolve insurance claims and billing issues;
- Identify and make appointments with a hard-to-reach specialist;
- Obtain additional information about a medical condition;
- Address medical issues and health care needs of your family members; and
- Understand issues related to prescription drugs, such as comparisons between generic and brand-name medications.

Health Assessment

The Health Assessment is a brief, online questionnaire that provides a snapshot of your current health status and may recommend ways to make healthy changes. It can help you build your Personal Health Record.

The Health Assessment is available to active, benefits-eligible employees. You do not need to be enrolled in a medical plan offered by Citi to participate. Same or opposite sex spouses/civil union partners/domestic partners may also complete the Health Assessment but only if they are enrolled in a medical plan offered by Citi.

The Health Assessment is a simple, secure, online questionnaire that takes about 15 minutes to complete. It immediately generates a personalized report summarizing your health. You can use the report to discuss concerns with your doctor, as a checklist of questions to ask, or to update your doctor on your health status, for example, if any signs or symptoms are worsening. If you have previously taken the Health Assessment, you are able to update your prior responses and answer new questions at any time. It is linked automatically to your Personal Health Record.

An alert will be sent to you and your doctor if your Health Assessment report indicates an opportunity to improve your care. You may also receive an outreach call from a nurse, if applicable.

Note: If you are not enrolled in any Citi medical plans, any credits you receive as part of the Live Well Rewards program will be placed in a Health Care Spending Account. This may inhibit your ability to establish a Health Savings Account if, as a result of a qualified change in status, you decide to enroll in a High Deductible Health Plan.

Personal Health Record

The Personal Health Record gives you a place to store all of your medical information. Depending on the medical plan in which you are enrolled, it can provide:

- A health summary of your conditions, allergies, prescribed medications, and recent testing, based on the claims submitted by your providers in your medical plan;
- Ways to help you track your hospital visits and insurance claims information;
- Personalized alerts that notify you of health risks, such as for high blood pressure, or health reminders to get an annual screening; and
- Online health information resources, including a medical dictionary, to put information at your fingertips whenever you need it.

Even if you are not enrolled in an Aetna, Empire BlueCross BlueShield, or Oxford Health Plans, the Personal Health Record can still help you track and manage your health. You can keep your Personal Health Record up to date by entering recent doctor's visits, immunizations, medications, and other information.

If you, your spouse/civil union partner/domestic partner, and dependents are enrolled in one of the Plans listed above, your Personal Health Record and that of your family will be populated automatically with the pertinent claims data from your health care provider.

To opt out of the Personal Health Record, you must call the Citi Live Well Program at 1-800-490-3054 to terminate your access to the database.

Note: The Personal Health Record may not contain all of the information about your health unless you supply such information. Alerts or Care Considerations may be mailed to your home if opportunities to improve your health are indicated.

Live Well Health Management Program

The Live Well Health Management Program offers support, tools, resources, and information about your health to help you and your doctor better manage your care.

Depending on your health history, claims data, and information entered into your Health Assessment and Personal Health Record, you may be invited to participate in the Live Well Health Management Program.

You may benefit from the Live Well Health Management Program in two ways:

1. Receipt of Care Considerations; and
2. Nurse coaching support for covered conditions (by invitation only).

Care Considerations

A Care Consideration is an alert, based on your medical claims and other medical information, sent to you and your doctor from ActiveHealth, a third party hired by Citi. Care Considerations identify opportunities to improve your health care. These Care Considerations provide information that could affect your health, may require action by you and/or your doctor, and are designed to promote care according to medical best practices and to identify potential medical issues.

Nurse coaching support for a covered condition

Covered conditions include, but are not limited to, asthma; arthritis; cancer; chronic low back pain; cystic fibrosis; gastrointestinal conditions, such as Crohn's disease; migraines; renal disease; sickle cell disease; vascular conditions, including diabetes, coronary artery disease, high blood pressure, and high cholesterol; and weight management (obesity).

As part of the Live Well Health Management Program, you will receive support including educational materials, information about warning signs, and suggestions for questions and issues to discuss with your doctor. The program does not replace your doctor; rather, it is designed to enhance your care and help you and your doctor make more informed decisions about your health.

This program is voluntary. If you are invited to participate but decide that you do not want to participate, call the Citi Live Well Program at **1-800-490-3054** and notify a nurse that you want to be removed from the program. You can rejoin the program at any time by calling the same number.

24-Hour Nurseline

The 24-Hour Nurseline is available 24/7 to active, benefits-eligible employees and their spouses/civil union partners/domestic partners and dependents. You can call the 24-Hour Nurseline at any time to speak with a registered nurse who can answer questions about an immediate health issue or any other health topic.

The 24-Hour Nurseline can help when you or your family members experience medical symptoms or have a health question, such as:

- "My child is running a fever;"
- "I think I have poison ivy;" or
- "I have a pain in my arm."

You also have 24-hour access to an audio health library equipped with information in both English and Spanish on more than 2,000 health topics and accessible on demand through any touch-tone telephone. For a list of topics, visit Total Comp @ Citi at www.totalcomponline.com and click on "Live Well" and then on "24-Hour Nurseline."

Call **1-866-494-7879** to access the 24-Hour Nurseline and audio health library.

Live Well Tobacco Cessation Program

The Live Well Tobacco Cessation Program is available to active employees and their spouses/civil union partners/domestic partners enrolled in the following medical plans offered by Citi: Aetna, Empire BlueCross BlueShield, and Oxford. You can call the Tobacco Cessation Program and speak with a certified tobacco cessation specialist, who will work with you to help you quit smoking. You can reach the program Monday through Friday, 8:30 a.m. to 11 p.m. ET, and Saturday, 9 a.m. to 2 p.m. ET by calling **1-800-490-3054**.

Your health coach will work with you to identify the challenges you face when quitting and set goals to overcome them. You and your spouse/civil union partner/domestic partner may be eligible for free Nicotine Replacement Therapy (NRT) for up to eight weeks. If so, your health coach can help you choose the type of NRT that best meets your needs. If you have stopped using tobacco products recently, a health coach can help you keep your commitment to be tobacco-free.

Program representatives will reach out to employees who have indicated on their Health Assessment that they use tobacco products or have stopped using tobacco products within the past 12 months, but you don't need to wait to be invited if you're enrolled in one of the Citi medical plans above.

Lifestyle Management Tools

Available via the Citi Live Well Portal, these tools and trackers can support lifestyle changes such as exercising, healthy eating, and quitting tobacco.

There is no cost to you to use these or any of the Live Well resources. The tools can help you take charge of your health and change the behaviors you want to change. Because the tools are online, you can take advantage of them on your own schedule and at your own pace. To make "Active Lifestyle Coaching" work even better for you, if you have not done so already, be sure to complete the Health Assessment on the (Personal Health Record) PHR website. To access the online tools, log in to the PHR website and click on the "Active Lifestyle Coaching" link.

Employees can visit the PHR via Total Comp @ Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet. Spouses and domestic partners can go to **www.myactivehealth.com/citi**. Then, click "Personal Health Record" and follow the links.

Since the tools are available through the PHR website, the access for the tools is the same as that noted above for the PHR.

Live Well Rewards

For the 2012 plan year, Citi is offering three different Live Well Rewards.

Health Assessment

If you complete the Health Assessment within the time frame referenced in your annual enrollment materials, you will receive a $200 credit toward the cost of your annual medical, dental, or vision coverage.

Any excess credits will be put into a Health Care Spending Account or Limited Purpose Health Care Spending Account, as applicable. Benefits-eligible employees, as well as spouses/civil union partners/domestic partners who are covered under a medical Plan offered by Citi are eligible to earn Live Well Rewards.

Tobacco Free Attestation

In addition, if, during enrollment, you complete the Tobacco Free Reward Attestation on Your Benefits Resources™ indicating that you do not use tobacco products in any form, you will receive an additional $200 credit toward the cost of your annual medical, dental, or vision coverage.

Any excess credits will be put into a Health Care Spending Account (HCSA) or Limited Purpose Health Care Spending Account (LPSA), as applicable. Benefits eligible employees, as well as spouses/civil union partners/domestic partners who are covered under a medical Plan offered by Citi are eligible to earn the Live Well Rewards.

Live Well Health Management Program

If you are invited to participate in the Live Well Health Management Program and you complete four telephone coaching sessions with a nurse or health coach during 2012, you and your eligible spouse (same or opposite sex)/civil union partner/domestic partner will each receive a $300 credit toward the cost of your annual medical, dental, or vision coverage.

Each quarter, ActiveHealth will notify the benefits administrator that you have completed your fourth telephone session with a nurse and the annual credit will be applied for the remaining pay periods of 2012. Employees as well as spouses/partners who are enrolled in one of the following medical plans offered by Citi: Aetna, Empire BlueCross BlueShield, and Oxford Health Plans, and are invited by ActiveHealth, may participate.

Note: If an HCSA is set up on your behalf to obtain Live Well Rewards because you are not enrolled in a Citi health benefit, you may be ineligible to establish an HSA later in the year. If you experience a qualified change in status during the plan year that permits you to elect health plan coverage mid-year (see "Changing your coverage" in the Eligibility and Participation section) and you elect to enroll in a HDHP, you will not be eligible to establish an HSA. You will remain ineligible to establish an HSA until the beginning of the next plan year even if you exhaust all of the funds in the HCSA prior to the end of the year.

Important information

The Citi Live Well Program was designed to provide for your privacy and to comply with all federal and state privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Personal health information is maintained by a third-party vendor (ActiveHealth, a subsidiary of Aetna) and is not maintained on Citi data systems.

All information provided through the Citi Live Well Program is available for review by you, your doctors, and other health care professionals. Safeguards have been implemented to prevent your personal information from being seen by or shared by other persons. No Citi employee should see your health information on the Personal Health Record website. Citi will receive aggregate reports to review the performance of the program.

By enrolling in the Citigroup Health Benefit Plan, you consent to the terms and conditions of the Citi Live Well Program, as they may be amended from time to time. If you are enrolled in an Aetna, Empire BlueCross BlueShield, or Oxford Plan, your claims information, including prescription drug information, will be transmitted to ActiveHealth as part of your participation in the Citigroup Health Benefit Plan.

Citi on-site medical clinics

Citi operates medical clinics at the following locations: Jacksonville and Tampa, FL; Warren, NJ; 399 Park Ave., 111 Wall St., and 388 Greenwich St., New York, NY; Long Island City, NY; and San Antonio, TX.

The clinics offer the following services:

- Assessment, treatment, recommendations, and/or referral for illness and injury;
- Laboratory blood tests, and EKGs on the order of the employee's physician;
- Ergonomic workstation evaluations;
- Lactation rooms including pumps, refrigerator for milk storage, and attachment kits for purchase;
- Immunizations and consultations for international business travel;
- Periodic medical exams for expatriate staff and spouses;
- Referrals to appropriate medical specialists and other on-ground resources worldwide for expatriate staff and international business travelers; and
- Monitoring of international medical care and emergency medical evacuations coordinated through **Travel Health Services** and Citi Travel Health Assistance.

Citi on-site Health and Fitness Centers

All Citi Health and Fitness Centers (CHFCs) are staffed by degreed fitness professionals who work closely with employees to create customized exercise programs and work together to plan and achieve individual fitness goals. Employees in locations with on-site CHFCs who desire membership must complete a health and entry screening process that includes two short appointments during which medical history, program policy, safety, goals, and equipment operations are reviewed.

Members are then provided with information and recommendations about frequency, duration, mode, and intensity of an individualized exercise program. Fitness center staff members are available and ready to assist with program updates and changes throughout your visits to the Citi facilities.

All Citi fitness facilities feature strength and cardiovascular equipment, and most offer a variety of group exercise classes at no additional charge.

CHFCs frequently offer motivational or incentive programs; screenings, such as cholesterol, blood pressure, and skin cancer; and site-wide events to educate and motivate employees toward healthy lifestyle changes and maintenance.

Most of the CHFCs offer towel service at no additional charge, and some offer other services, such as massage therapy, nutrition programming, and/or personal training for a fee.

The CHFCs have a fee structure that is very competitive with the surrounding geographic area and that typically is well below market rates for similar operations and facilities. Visit your CHFC for membership fee rates.

Citi operates CHFCs at the following locations:

Getzville (Amherst), Long Island City, and New York, NY; Bayamon, PR; Blue Ash, OH; Meridian (Boise), ID; Elk Grove Village, IL; Florence, KY; Mcleansville (Greensboro), NC; Hagerstown, MD; Irving and San Antonio, TX; Jacksonville and Tampa, FL; Kansas City, MO; Las Vegas, NV; Mississauga, Ontario, Canada; Sioux Falls, SD; and Warren, NJ. More information is available on Citi For You (intranet only).

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP), provided through Harris Rothenberg International (HRI), Inc., is a confidential counseling service designed to help you and your family resolve issues that affect your personal life or interfere with your job performance. You may call the EAP 24/7 for help with issues such as sleeping difficulties, anxiety or depression, substance or alcohol abuse, emotional and physical abuse, family and relationship issues, workplace conflict, adopting healthy behaviors, financial concerns, and others.

When you or an immediate family member calls the EAP, you will speak with a licensed counselor who will talk with you about your concerns and, if warranted, refer you to an appropriate counselor near your work or home. You can attend up to three in-person counseling sessions at no cost to you. If you require additional counseling, you will be responsible for any fees. Expenses for subsequent counseling may be covered by other Citi benefits.

All EAP services are confidential according to law. That is, no information will be shared without the written consent of the individual seeking assistance, unless the counselor is legally bound to take action.

The EAP is a core benefit available to all benefits-eligible employees. You do not have to enroll or make any contributions to use this benefit.

Employees and their family members can also access HRI's website, which includes dozens of locator tools that allow targeted searches for health and wellness services, child care providers, adoption professionals, schools and colleges, daily living services, older adult care providers, and much more. The site also includes dozens of calculators that can help your figure out everything from mortgage interest to how much to save for your children's college education.

Contact the EAP as follows:

Telephone: **1-800-952-1245**
TTY: **1-800-256-1604**

Website: **www.hriworld.com**
Username: resources
Password: for_you

Geriatric Assistance Program

When an older relative's physical or mental health changes or her or his ability to handle routine activities is impaired, the stress on you and your family can be significant, and few people have the expertise to determine which concerns require immediate care. The situation can be even more difficult for those who live at a distance from older relatives.

The Geriatric Assistance Program can provide the following:

- Professional consultation with a highly experienced counselor who can answer common care giving questions
- Assistance with care planning, including a full assessment of the adult's health and living situation
- A review of the quality of care in different facilities
- Implementation and coordination of care-giving services to meet the needs of the older adult and family members.

Call the Geriatric Assistance Program through Citi's EAP or Work/Life Program:

EAP
1-800-952-1245
TTY: **1-800-256-1604**

Work/Life Program
1-866-449-9933, option 2 for the Work/Life program

Work/Life Program

Citi's Work/Life Program is designed to save you time by providing valuable advice on a number of common everyday challenges facing Citi employees. Whether you are researching options for child care, need to speak with a financial counselor, or are dealing with the concerns of your elderly parent, Citi's Work/Life Program can help. All Work/Life services are completely confidential.

Call Citi's Work/Life Program for information and practical solutions, customized referrals, and resources and research information on a wide variety of topics ranging from parenting/child care to adoption, identity theft, legal and wills, and advice and resources about caring for older adults. You can also obtain assistance with common challenges, such as what size home or mortgage you can afford or the cost of living in another city.

The Work/Life Program is a core benefit available to all benefits-eligible employees. You do not have to enroll or make any contributions to use this benefit. Citi provides the Work/Life Program through a contract with Health Advocate Inc.

Contact Citi's Work/Life Program from 8 a.m. to 9 p.m. ET on weekdays, excluding holidays.

- Telephone: **1-866-449-9933**, select option #2 for Work/Life program
- Website: **www.HealthAdvocate.com/citiworklife**

Spending accounts

Spending accounts allow you to pay for certain health care, dependent day care, and transportation expenses with before-tax contributions from your pay.

- **Health Care Spending Account (HCSA)**: Use the HCSA to pay for certain health care expenses for yourself and your qualified dependents that are not paid by any medical, dental, or vision plan. You are eligible to enroll in the HCSA if you are not enrolled in a High Deductible Health Plan. *If you enroll in a High Deductible Health Plan, you cannot enroll in the HCSA.*

Your Spending Account™ website

The Your Spending Account™ (YSA™) website makes it easy for you to manage your spending accounts. You can file claims, confirm which expenses are eligible, check your account balance, and more. See the YSA™ Guide for more information.

- **Limited Purpose Health Care Spending Account (LPSA):** Use the LPSA if you are enrolled in a High Deductible Health Plan-Basic or Premier to pay for dental, vision, and/or preventive care medical expenses for yourself and your qualified dependents that are not paid by any medical, dental, or vision plan or your Health Savings Account (HSA).
- **Dependent Day Care Spending Account (DCSA):** Use the DCSA to pay for certain dependent day care expenses so that you (and your spouse, if you are married) can work or look for work. **Note:** This account cannot be used to pay health care expenses for your dependents.
- **Transportation Reimbursement Incentive Program (TRIP)**: Use the TRIP to pay for the cost of public transportation and parking so you can commute to work. **Note:** TRIP is not part of annual enrollment. You can enroll at any time.

Contents

How the spending accounts work

Enrolling in the spending accounts

To have continued coverage in the Health Care Spending Account, Limited Purpose Health Care Spending Account, and/or Dependent Day Care Spending Account, you *must* enroll each year. *Your election does not roll over from year to year.*

For TRIP, you can enroll at any time. Before-tax, and if needed, after-tax, payroll contributions will be taken as soon as administratively possible to pay for your transit and/or parking pass, which must be purchased online.

Once enrolled, you can obtain information about your account on Your Benefits Resources™:

- Visit Total Comp @ Citi at **www.totalcomponline.com**; click Spending Accounts under Health & Welfare Benefits.
- Go directly to Your Benefits Resources™ at **http://resources.hewitt.com/citigroup**.

Contributions to the spending accounts from your pay will be available as follows:

If you enroll during the annual enrollment period:

- **HCSA and LPSA:** The entire amount of the 2012 contributions you elect will be posted to your account January 1. You can be reimbursed up to the entire amount of your contribution at any time during the plan year.
- **DCSA:** Contributions will be posted to your account each pay period. You can be reimbursed up to the amount available in your account. The balance of any claim will be paid as additional contributions are deposited into your account.
- **TRIP:** Contributions will be deducted each pay period to purchase transit and/or parking passes you have selected online.

If you enroll as a new hire:

- **HCSA and LPSA:** The entire amount of the 2012 contributions you elect will be posted to your account within 31 days after you enroll. You can be reimbursed up to the entire amount of your contribution at any time during the plan year.
- **DCSA:** Contributions will be posted to your account each pay period. You can be reimbursed up to the amount available in your account. The balance of any claim will be paid as additional contributions are deposited into your account.
- **TRIP:** Contributions will be deducted each pay period to purchase transit and/or parking passes you have selected online.

Changing your contribution amounts

You may change your contributions for the HCSA, LPSA, and DCSA only during annual enrollment or as a result of a qualified change in status.

Review the Instructions for Change in Status Worksheet (Form 308A) and the Change in Status Worksheet (Form 308B), which lists status events and the corresponding changes you can make to your benefits coverage for each event, on **Citi For You** (intranet only).

Legal requirement: Save your receipts

Each time you "swipe" the Your Spending Account™ (YSA™) Card (described in "*Health Care Spending Account (HCSA)"* on page 168), be sure to save your receipt in case you are required at a later date to substantiate that your expense was eligible for reimbursement under the Plan. *Per IRS rules, unsubstantiated expenses will be considered taxable income.*

You have until June 30, 2013, to resolve any 2012 transactions that require receipts. If you fail to resolve these transactions with the Citi Benefits Center by the deadline, the amount of the transaction in dispute, considered an "overpayment," will be added to the amount of your 2013 earnings. Applicable taxes will be withheld and reported on a Form W-2 (if you are an active employee) or a Form 1099-MISC (if you are no longer a Citi employee) at the time year-end tax forms are distributed.

Reimbursements

Reimbursements for eligible HCSA/LPSA and DCSA expenses will be deposited directly to your bank account, or sent via check to your home address, if no direct deposit account is on file. To add direct deposit account information, visit Your Benefits Resources™ through Total Comp @ Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet and click on "Spending accounts." You can also go directly to **http://resources.hewitt.com/citigroup**.

If your HCSA or LPSA claim is denied, see "Claims and appeals for the HCSA/LPSA" on page 179.

Overpayments

In the event an expense reimbursed by any of the spending accounts is not eligible for reimbursement, you agree to reimburse Citi for any amount owed. In the event that amounts are owed under the HCSA, your privileges under the YSA™ Card may be subject to suspension or termination.

Tax exemptions

Spending accounts are exempt from all federal income and employment taxes and most state and local taxes. If you live in a state that does not exempt spending contributions from state or local tax, you will be taxed on the benefit. The amount reported as "state wages" on your Form W-2 Wage and Tax Statement for the year of the contribution will be higher than the amount reported for federal wages.

Spending accounts at a glance

	Health Care Spending Account (HCSA)	Limited Purpose Health Care Spending Account (LPSA)	Dependent Day Care Spending Account (DCSA)	Transportation Reimbursement Incentive Program (TRIP)[1]
Why enroll?	To reduce your taxes by paying for eligible expenses with before-tax dollars			
What is reimbursed	Health care expenses for you and your family that are not paid by any medical, dental, or vision plan.	Vision, dental, and preventive care medical expenses for you and your family that are not paid by any medical, dental, or vision plan or your HSA.	Dependent day care expenses for your qualified dependents so that you (and your spouse, if you are married) can work or look for work.	Eligible transit and parking expenses. **Note:** Your contributions are used to purchase transit/parking passes online. There is no claim-filing process.
Contribution limits	From $120 to $15,000 per year per family; money is deducted in equal amounts each pay period.	From $120 to $5,000 per year per family; money is deducted in equal amounts each pay period.	From $120 to $5,000 per year per family; money is deducted in equal amounts each pay period.	**Transit:** Up to $125 per month before-tax and up to $770 in after-tax dollars. **Parking:** Up to $240 per month before-tax and up to $770 in after-tax dollars.
Forfeiture provisions	You will forfeit any money you contribute but do not use each calendar year.	You will forfeit any money you contribute but do not use each calendar year.	You will forfeit any money you contribute but do not use each calendar year.	If your account remains inactive for 12 consecutive months, you will forfeit any remaining contributions.
Changing your election	You can change your election as the result of a qualified status change; you cannot enroll in December for the current year.	You can change your election as the result of a qualified status change; you cannot enroll in December for the current year.	You can change your election as the result of a qualified status change; you cannot enroll in December for the current year.	You can change your online purchase at any time; the change will be effective as soon as administratively possible.
Filing a claim	You must file claims for 2012 expenses so they are postmarked no later than June 30, 2013.	You must file claims for 2012 expenses so they are postmarked no later than June 30, 2013.	You must file claims for 2012 expenses so they are postmarked no later than June 30, 2013.	Not applicable **Note:** With the exception of the Parking Cash Reimbursement Option (CRO). CRO claims must be filed within 12 months from the date of service.

1. TRIP is not part of annual enrollment. You can enroll in TRIP at any time.

Health Care Spending Account (HCSA)

You can contribute between $120 and $15,000 a year on a before-tax basis to reimburse yourself for eligible out-of-pocket health care expenses. Contributions are taken each pay period before federal and, in most locations, state and local taxes are withheld.

You must actively elect to participate in the HCSA during each annual enrollment or within 31 days of a qualified change in status. You may enroll in the HCSA if you are *not* enrolled in a High Deductible Health Plan.

You can be reimbursed for expenses incurred only during the time you are enrolled. You can enroll as a new employee, during the annual enrollment period, or within 31 days of a qualified change in status at which time you may change or stop your contributions. However, you cannot enroll in December for the current calendar year.

HCSA claims must be filed by June 30 of the calendar year following the calendar year in which the expense was incurred. You may change or stop your contributions as a result of a qualified change in status.

The amount of your payroll contributions will appear on your Form W-2 Wage and Tax Statement for the year in which you were enrolled.

In accordance with Internal Revenue Service (IRS) guidelines, the Plan Administrator may reduce the rate of contribution by certain participants to ensure that the HCSA is not deemed to discriminate in favor of highly compensated employees.

Under the Heroes Earnings Assistance Relief Tax Act of 2008, if you are a reservist called to active military duty for more than 179 days on or after January 1, 2010, you are entitled to receive a taxable distribution of your HCSA balance (contributions less the amount reimbursed) if you request a distribution by the last day of the calendar year in which you made the contributions.

Rules and features

General rules about expenses

Most health care expenses that the IRS considers as deductible on your federal income tax return are eligible for reimbursement from the HCSA, provided the expenses are not reimbursed from any other source.

You can be reimbursed for your expenses or those incurred by anyone you can claim as a dependent on your federal tax return, regardless of whether you or your dependent is covered under any Citi medical, dental, or vision plan.

Estimate expenses conservatively. You cannot receive a refund for contributions intended to reimburse yourself for a surgery or procedure that is later canceled.

Examples of eligible health care expenses

- Your share of expenses that are not paid by your medical, dental, and/or vision plan, such as deductibles, coinsurance, and copayments;
- Other charges that exceed what your medical, dental, and/or vision plan will pay, such as charges above maximum allowed amounts or other plan limits;
- Vision care expenses, such as exams, prescription eyeglasses and sunglasses, contact lenses, and laser surgery, that are not covered by your medical or vision plan;
- Hearing care expenses, such as exams, hearing aids, and hearing aid batteries, that are not covered by your medical plan;
- Certain equipment and training for disabled individuals;
- Childbirth classes, such as Lamaze, for up to two people;
- Chiropractic care that is not covered by your medical plan;
- Physical therapy, psychiatric therapy, and counseling that are not covered by your medical plan;
- Cholesterol tests, vaccines, and immunizations that are not covered by your medical plan;
- Prescription contraceptives and infertility treatments that are not covered by your medical plan;
- Smoking cessation programs;
- Certain over-the-counter (OTC) drugs, medicines, and biologicals, for which you have a receipt as well as a prescription (see the lists of eligibility requirements below);
- Medicines prescribed by a doctor that your medical plan or prescription drug program does not cover; and
- Transportation necessary to obtain certain health care services.

OTC drugs, medicines, and biologicals

You may only be reimbursed for over-the-counter medicines and biologicals through your HCSA in instances when a doctor has prescribed the medicine or biologicals or if the medicine is insulin.

Note: You cannot use the Your Spending Account™ (YSA™) Card to pay for these items. You will need to pay out of pocket and then submit a paper claim along with your receipt and prescription.

Examples of ineligible health care expenses

- Expenses for which you have been reimbursed from another source, such as Citi's or another employer's medical, dental, and/or vision plan, Medicare, or Medicaid;
- Elective cosmetic surgery or cosmetic dental work;
- Vitamins or minerals taken for general health purposes, including those recommended by your doctor;
- Maternity clothes or diaper services;
- Nursing services to care for a healthy newborn;
- Household help or custodial care at home or in an institution, even if recommended by your doctor;
- Health club fees, exercise classes, or weight-loss programs for general health purposes, even if recommended by your doctor;
- Cosmetics, toiletries, or toothpaste;

- Amounts you pay for medical and dental insurance premiums;
- Over-the-counter items and biologicals for which you do not have a doctor's prescription; and
- Long-term-care services including insurance premiums for long-term care insurance.

For more information

For more information about eligible expenses, see *IRS Publication 502: Medical and Dental Expenses* at **www.irs.gov** or contact your tax adviser. You can also call the IRS at **1-800-829-1040**.

Note: The IRS publication is a guideline for use in preparing tax returns; it is not a description of the Citi Plan.

Your Spending Account™ Card

When you enroll in the HCSA, you may elect to receive a Your Spending Account™ (YSA™) Card to use at any provider that accepts MasterCard as a form of payment. **Note:** The YSA™ Card is not available for use with any of the other spending accounts. Once you elect to receive a card, the automatic claims submission feature, described below, will be turned off automatically.

You cannot use the YSA™ Card to purchase over-the-counter drugs or medicines or biologicals even if you have a prescription for them.

A YSA™ Card transaction(s) of $100 or more requires substantiation. If you do not provide substantiation within 45 days of the transaction, your card will be "shut off" until the substantiation is provided. For details, see the YSA™ guide available on Citi For You.

Automatic claims submission

The following Plans will submit your claims to the HCSA administrator so you can be reimbursed automatically for many eligible expenses without having to file a claim:

- Aetna and Empire BlueCross BlueShield ChoicePlan 500;
- Oxford Health Plans PPO;
- Aetna Vision℠ Plan
- Citigroup Prescription Drug Program; and
- MetLife Preferred Dentist Program (PDP).

However, if you elect to receive a YSA™ Card, the automatic claims submission feature will be turned off and used only to validate purchases made with the YSA™ card. You will then need to file a claim for any eligible expenses for which you do not use your YSA™ card.

If you do not want to be reimbursed for your claims automatically, you may cancel automatic reimbursement or you may elect to receive a YSA™ card, which will turn off the automatic claims submission feature. You may change your election one time during the plan year on the YSA™ website during the plan year.

You may access the YSA™ website through Your Benefits Resources™. Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Spending accounts." Select the "Health and Insurance" tab and select any spending account you wish to access. To access the YSA™ website, click on either "Manage Your Account" or "Your Spending Account™."

Paying for your expenses out of pocket

You can choose to pay out of pocket for eligible expenses and submit a claim online on the YSA™ website or you can submit a paper claim to YSA™ using the HCSA/LPSA Claim Form (Form 316). The claim filing instructions are on the YSA™ website and the HCSA/LPSA Claim Form.

Reimbursements

At any time, up until June 30 of the following plan year, you may be reimbursed for eligible expenses up to the total amount you elected to contribute for the year. If you increase your contributions during the year because of a qualified change in status, you may be reimbursed from the increased amount only for expenses incurred *after* the date of the qualified change in status.

Using HCSA during an unpaid leave or after your termination of employment

You can continue your HCSA coverage under COBRA through the end of the calendar year in which you take an unpaid leave of absence or your employment is terminated. If you do not continue coverage under COBRA, you cannot use the account for expenses incurred beyond the start date of your leave or your termination date, respectively. However, you will have until the following June 30 to submit your claims for services incurred before the start date of your leave/your termination date.

Effect on other benefits

Even though you reduce your taxable income by using the spending account(s), you are not reducing your pay for determining any Citi pay-related benefits, such as disability or life insurance. Benefits under these Plans are based on your total compensation *before* Your Spending Account™ contributions are deducted.

Effect on taxes

You receive a tax advantage by paying for eligible health care expenses through the HCSA *or* by claiming a federal income tax deduction for eligible expenses that exceed 7.5% of your adjusted gross income. However, you cannot claim a deduction for an expense on your federal tax return if you have been reimbursed for the same expense through the HCSA.

Social Security

Your Spending Account™ contributions will reduce the amount of your Social Security taxes. If your taxable pay is below the Social Security taxable wage base, your future Social Security benefits may also be reduced.

Filing a claim

See "How to file a claim" in the *Eligibility and Participation* section.

Generally, you will have until June 30 following the year in which you incur the eligible expense to file a claim for reimbursement. If mailing your 2012 claims, your envelope must be postmarked no later than June 30, 2013.

For more information

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

You also can visit the Social Security Administration website at **www.socialsecurity.gov** for information about the taxable wage base for a given year and Social Security plans and provisions.

Limited Purpose Health Care Spending Account (LPSA)

You must be enrolled in the Citi High Deductible Health Plan - Basic or Premier to enroll in the LPSA. You can enroll as a new employee, during the annual enrollment period, or within 31 days of a qualified change in status. However, you cannot enroll in the LPSA in December for the current calendar year. You may change or stop your contributions as a result of a qualified change in status.

Rules and features

You can contribute between $120 and $5,000 a year on a before-tax basis to reimburse yourself for eligible out-of-pocket dental, vision, and preventive care medical expenses. Contributions are taken each pay period before federal and, in most locations, state and local taxes are withheld.

General rules about expenses

Since the LPSA is intended to be used in conjunction with a Health Savings Account, eligible expenses are limited to those for dental, vision, and preventive care medical expenses that are not already covered. Other medical care expenses should be paid from your HSA.

OTC drugs, medicines and biologicals

You may only be reimbursed for over-the-counter medicines and biologicals through your LPSA in instances when a doctor has prescribed the medicine or biologicals or if the medicine is insulin.

Examples of eligible health care expenses

- Your share of expenses that are not paid by your dental and/or vision plan, such as deductibles, coinsurance, and copayments and charges that exceed maximum allowed amounts or other plan limits;
- Vision care expenses, such as exams, prescription eyeglasses and sunglasses, contact lenses, and laser surgery, which are not covered by your medical or vision plan;
- Preventive care medical expenses not already covered by the Plan;
- Tobacco-cessation programs;
- Certain over-the-counter drugs and medicines for which you have a receipt as well as a prescription (see the lists of eligibility requirements below);
- Expenses for insulin;
- Obesity weight-loss programs; and
- Screening services including routine cancer, heart disease, and infectious disease screening.

Since network preventive care is covered at 100% in the High Deductible Health Plan, you will not need this account to reimburse yourself for network preventive medical care expenses. However, if you obtain preventive care from an out-of-network doctor, the High Deductible Health Plan will cover 100% of maximum allowed amount only. As a result, not all preventive care charges may be covered.

Examples of ineligible health care expenses

- Expenses for which you have been reimbursed from another source, such as Citi's or another employer's medical, dental, and/or vision plan, Medicare or Medicaid, or your HSA;
- Non-preventive-care medical expenses;
- Elective cosmetic surgery or cosmetic dental work;
- Vitamins or minerals taken for general health purposes, including those recommended by your doctor;
- Maternity clothes or diaper services;
- Nursing services to care for a healthy newborn;
- Household help or custodial care at home or in an institution, even if recommended by your doctor;
- Health club fees, exercise classes, or weight-loss programs for general health purposes, even if recommended by your doctor;
- Cosmetics, toiletries, or toothpaste;
- Amounts you pay for medical and dental insurance premiums; and
- Long-term-care services including insurance premiums for long-term care insurance.

For more information

For more information about eligible expenses, see *IRS Publication 502: Medical and Dental Expenses* at **www.irs.gov** or contact your tax adviser. You also can call the IRS at **1-800-829-1040**.

Note: The IRS publication is a guideline for use in preparing tax returns; it is not a description of the Citi Plan.

Is the Limited Purpose Health Care Spending Account for you?

The Limited Purpose Health Care Spending Account (LPSA) is for employees who enroll in the High Deductible Health Plan - Basic or Premier.

Generally, employees who enroll in the High Deductible Health Plan and establish a HSA also enroll in an LPSA to pay for eligible health care expenses with before-tax dollars. ("Establish" an account means you apply for an account and are approved because you meet certain credit and "know your customer" requirements. If your account is not established, you cannot receive the employer contribution.) However, you may enroll in an LPSA if you are not enrolled in an HSA (as long as you are enrolled in the High Deductible Health Plan).

Note: Employees who enroll in a High Deductible Health Plan or who establish an HSA are *not* eligible to enroll in a HCSA.

Plan your LPSA contributions accordingly

Since network preventive care is covered at 100% in the High Deductible Health Plan, you will not need this account to reimburse yourself for network preventive medical care expenses. However, if you obtain preventive care from an out-of-network doctor, the High Deductible Health Plan will cover 100% of maximum allowed amount only. As a result, not all preventive care charges may be covered.

To participate in the LPSA each year you must actively enroll. Your enrollment does not carry over from year to year.

You can be reimbursed for expenses incurred only during the time you are enrolled. The amount of your payroll contributions will appear on your Form W-2 Wage and Tax Statement for the year in which you were enrolled.

In accordance with IRS guidelines, the Plan Administrator, in its discretion, may reduce the rate of contribution by certain participants to ensure that the LPSA is not deemed to discriminate in favor of highly compensated employees.

Paying for your expenses out of pocket

You can submit claims for certain expenses under the following plans:

- High Deductible Health Plan-Basic and Premier;
- Dental; and
- Vision.

However, you must pay for eligible expenses out of pocket and submit qualified expenses for reimbursement using the HCSA/LPSA Claim Form (Form 316). You can submit a claim online on the YSA™ website or you can submit a paper claim to YSA™ using the HCSA/LPSA Claim Form (Form 316). The claim filing instructions are on the YSA™ website and the HCSA/LPSA Claim Form.

Reimbursements

At any time, up until June 30 of the following plan year, you may be reimbursed for eligible expenses up to the total amount you elected to contribute for the Plan year. If you increase your contributions during the year because of a qualified change in status, you may be reimbursed from the increased amount only for expenses incurred *after* the date of the qualified change in status.

Using LPSA after your termination of employment

You can continue your LPSA coverage under COBRA through the end of the calendar year in which you take an unpaid leave of absence or your employment is terminated. If you do not continue coverage under COBRA, you cannot use the account for expenses incurred beyond the start date of your leave or your termination date, respectively. However, you will have until the following June 30 to submit your claims for services incurred before the start date of your leave/your termination date.

Effect on other benefits

Even though you reduce your taxable income by using the spending account(s), you are not reducing your pay for determining any Citi pay-related benefits, such as disability or life insurance. Benefits under these Plans are based on your total compensation *before* Your Spending Account™ contributions are deducted.

Effect on taxes

You receive a tax advantage by paying for eligible health care expenses through your LPSA *or* by claiming a federal income tax deduction for eligible expenses that exceed 7.5% of your adjusted gross income. However, you cannot claim a deduction for an expense on your federal tax return if you have been reimbursed for the same expense through the LPSA.

Social Security

Your Spending Account™ contributions will reduce the amount of your Social Security taxes. If your taxable pay is below the Social Security taxable wage base, your future Social Security benefits may also be reduced.

Filing a claim

See "How to file a claim" in the *Eligibility and Participation* section.

Generally, you will have until June 30 following the year in which you incur the eligible expense to file a claim for reimbursement. If mailing your 2012 claims, your envelope must be postmarked no later than June 30, 2013.

You may access the Your Spending Account™ (YSA™) website through a link on the Your Benefits Resources™ (YBR™) website. To access YBR™, visit Total Comp @ Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet; or go directly to **http://resources.hewitt.com/citigroup** using your YBR™ user ID and password. If you haven't set up a user ID and password, click on "Register as a New User" to create your user ID and password.

Follow these steps to submit an online claim from the YSA™ home page:

1. Select the appropriate account page—HCSA/LPSA or DCSA;
2. Select "Submit Claims";
3. Enter your claim detail information;
4. Select "Review Claims" at the bottom of the page;
5. Create Fax Cover Sheet; and
6. Fax the claim form and receipt(s) to Your Spending Account™ at **1-888-211-9900**.

For more information

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

You can also visit the Social Security Administration website at **www.socialsecurity.gov** for information about the taxable wage base for a given year and Social Security plans and provisions.

Dependent Day Care Spending Account (DCSA)

You can contribute between $120 and $5,000 a year on a before-tax basis to reimburse yourself for day care expenses for qualified dependents so that you (and your spouse, if you are married) can work or look for work. See "Qualifying individuals" on page 175.

You can be reimbursed for expenses incurred only during the time you are enrolled. You can enroll as a new employee, during the annual enrollment period, or within 31 days of a qualified change in status. However, you cannot enroll in December for the current calendar year.

The amount of your payroll contributions will appear on your Form W-2 Wage and Tax Statement for the year in which you were enrolled.

In accordance with IRS guidelines:

- The Plan Administrator, in its discretion, may reduce the rate of contribution by certain participants during the year to ensure that the DCSA is not deemed to discriminate in favor of highly compensated employees.
- Eligible expenses submitted via paper claim with future dates of service will not be reimbursed prior to the last day of the billing period.

Quick tip: You cannot use the DCSA to reimburse yourself for your dependents' health care expenses; use the HCSA or LPSA for that purpose.

Rules and features

Examples of eligible dependent day care expenses

- Care at a licensed nursery school, day camp (including specialty camps), or day care center; the facility must comply with state and local regulations, serve more than six individuals, and receive fees for services;
- Services from individuals who provide dependent day care in or outside your home, unless the provider is your spouse, your own child under age 19, or any other dependent (these individuals must provide their Social Security numbers to you);
- After-school care for children under age 13;
- Household services related to the care of an elderly or disabled adult who lives with you;
- Expenses for a care provider for the transportation between your house and the place that provides day care services;
- Your portion of FICA and other taxes that you pay for a care provider; and
- Any other services that qualify as dependent day care under IRS rules.

Examples of ineligible dependent day care expenses

- Expenses for food, clothing, or education;
- Expenses for transportation between your house and the place that provides day care services;
- Expenses for dependent day care when either you or your spouse is not working;
- Charges for convalescent or nursing home care for a parent or disabled spouse;
- Overnight camp expenses;
- Expenses for dependent day care that enables you or your spouse to do volunteer work;
- Payments made to your spouse, your own child under age 19, or any other dependent; and
- Expenses for which you take the federal child care tax credit.

For more information

For more information about eligible dependents and expenses, see *IRS Publication 503: Child and Dependent Care Expenses* at **www.irs.gov** or contact your tax adviser. You also can call the IRS at **1-800-829-1040**.

Note: The IRS publication is a guideline for use in preparing tax returns; it is not a description of the Citi Plan.

Qualifying individuals

According to IRS rules, you may be reimbursed only for expenses incurred in caring for a qualifying individual. Generally, a qualifying individual includes:

- Each of your children under age 13 who must share your residence for more than half the year and who must not provide more than half of his or her own support;
- Your spouse who is physically or mentally unable to care for himself or herself and resides with you for more than half the year; and
- Dependents who are mentally or physically unable to care for themselves, reside with you for more than half the year.

Marital status and your DCSA contribution

If you file a joint tax return: You and your spouse together may contribute up to $5,000 a year before-taxes to DCSAs. For example, if your spouse contributes $2,000 to his or her employer's DCSA, you can contribute up to $3,000 to yours. If either you or your spouse earns less than $5,000 annually, the combined amount you and your spouse contribute cannot exceed the lower salary.

If you file separate tax returns: You and your spouse each may contribute up to $2,500 a year before-taxes to your respective DCSA.

If your spouse does not work: In general, you cannot use the DCSA if your spouse does not work, unless he or she is a full-time student for at least five months during the calendar year, is looking for work, or is disabled.

To determine the maximum contribution in these cases, your spouse is considered to earn $250 a month if you have one qualified dependent or $500 a month if you have two or more qualified dependents. For Plan purposes, count only the months that your spouse is either in school or disabled.

These limits are subject to change.

Paying for your expenses out of pocket

You can submit a claim for eligible expenses online on the YSA™ website or you can submit a paper claim to YSA™ using the DCSA Claim Form (Form 317). The claim filing instructions are on the YSA™ website and the DCSA Claim Form.

Reimbursements

You cannot be reimbursed for expenses that exceed the amount of your contributions.

If your claim exceeds your current account balance, you will be reimbursed up to your account balance. Any outstanding amount of your claim will be paid to you automatically after the next pay period when new contributions are added to your account until the total amount is paid or the money in your account is depleted.

The maximum you can receive tax-free from your DCSA is reduced by the value of any employer-provided day care you use, whether provided through Citi or your spouse's employer.

For example, if you receive a DCSA subsidy of $1,000, then you can receive up to $4,000 tax-free from your DCSA. If you contribute more than $4,000, any amount reimbursed above $4,000 will be included as taxable income on your Form W-2 Wage and Tax Statement for that year.

Effect on other Citi benefits

Even though you reduce your taxable income by using the spending account(s), you are not reducing your pay for determining any Citi pay-related benefits, such as disability or life insurance. Benefits under these Plans are based on your compensation before Your Spending Account™ contributions are deducted.

Effect of DCSA participation on Social Security

Your Spending Account™ contributions will reduce the amount of your Social Security taxes. If your taxable pay is below the Social Security taxable wage base, your future Social Security benefits may also be reduced.

Using DCSA after your termination of employment

You may submit claims for eligible expenses incurred after your termination date but within 2012. You must submit any eligible 2012 claims no later than June 30, 2013.

DCSA subsidy

If you are eligible *and* you elect the DCSA subsidy during enrollment (either as a new hire or during annual enrollment) Citi will pay up to 30% of your DCSA contribution. The percentage will depend on the amount of your total compensation and whether you work part-time or full-time.

Alert: To obtain the DCSA subsidy you must elect it; it is not automatic.

You are eligible for a subsidy if you enroll in the DCSA and on your enrollment date:

- **If you are a sole financial provider:** Your total compensation *and* your total annual household income together do not exceed $90,000; or
- **If you are in a dual-income household:** Your total compensation does not exceed $45,000 *and* your total annual household income does not exceed $90,000.

You must enroll for the subsidy during your enrollment period. You cannot receive the subsidy through any other process. You must elect the full amount that you want to use to reimburse yourself for eligible expenses. The deductions from your pay will be the amount of the election minus the amount of the subsidy.

The amount of your subsidy will not change during the year even if you change your DCSA contribution amount as a result of a qualified change in status. Your subsidy will be credited to you during the first quarter if you enroll during annual enrollment or within 31 days after you enroll as a new hire or newly eligible for benefits.

You cannot become eligible for the DCSA subsidy midyear as a result of a qualified change in status, such as a divorce or death of your spouse.

If your total compensation is*:	Your DCSA subsidy will be:	
	For full-time employees	For part-time employees
Up to $25,000	30% of your DCSA contribution; maximum subsidy is $1,500	22-1/2% of your DCSA contribution; maximum subsidy is $1,125
$25,001-$35,000	20% of your DCSA contribution	15% of your DCSA contribution
$35,001-$45,000	15% of your DCSA contribution	11-1/4% of your DCSA contribution
$45,001-$90,000 if you are the sole financial provider of your dependents	15% of your DCSA contribution	11-1/4% of your DCSA contribution

* Your total household income cannot exceed $90,000 at the time you enroll.

If you are rehired

If you terminate employment with Citi and are rehired in the same year, you must re-enroll to have DCSA coverage. If you re-enroll in the DCSA, you are not eligible for the subsidy since your subsidy was credited during your employment earlier in the same year. (Subsidies are credited during the first quarter if you enroll during annual enrollment or within 31 days after you enroll as a new hire or newly eligible for benefits.)

Filing a claim

See "How to file a claim" in the Eligibility and Participation section.

Generally, you will have until June 30 following the year in which you incur an eligible expense to file a claim for reimbursement. For example, you will have until June 30, 2013, to file claims for reimbursement of expenses incurred in 2012. (Your envelope must be postmarked no later than June 30, 2013.)

Note: You cannot submit claims for if the services have not been rendered. Claims submitted in advance will be denied as ineligible and you will need to resubmit them to be reimbursed.

For more information

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

Transportation Reimbursement Incentive Program (TRIP)

TRIP allows you to purchase transit and parking passes online so you can commute to and from work; they are not for business travel, for example, to use public transportation to attend a business meeting.

The first $125 of the cost of your transit and/or $240 of your parking pass will be deducted from your pay before taxes are withheld. Any amount of your transit pass that exceeds $125 or parking pass that exceeds $240, as applicable, will be deducted from your pay after taxes are withheld.

By enrolling in TRIP, you lower your taxable income and, as a result, pay less in federal and FICA taxes, and, in most locations, state and local taxes.

You can set up or change your online purchase at any time. Your enrollment or change will be effective as soon as administratively possible.

Are you eligible to enroll in TRIP?

You are eligible to enroll in TRIP if:

- You commute to work by public transportation (bus, subway, train, ferry, or van pool) or you commute to work by car and have out-of-pocket parking expenses.
- You do *not* participate in a Company-sponsored parking or mass transit program.

If you enroll in TRIP and later begin participating in a Company-sponsored parking or mass transportation program, you must cancel the purchase of your online transit or parking pass.

Quick tip

You do not need to wait until Annual Enrollment to enroll in TRIP. The deadline to enroll or change your TRIP participation is the 10th of every month for participation the first of the following month. If you miss the deadline, your enrollment/change will be effective the following month.

Note for rail commuters using the Long Island Rail Road and Metro North Railroad: The deadline to enroll or change your TRIP participation is the 4th of the month.

How the program works

TRIP is made up of two accounts:

- **A Transit Account** to pay for eligible transit expenses. The Code defines transit expenses as those for bus, subway, train, metro passes, ferry, and van pooling. A van must be a "licensed commuter highway vehicle" with seating capacity of six or more adults, excluding the driver.
- **A Parking Account** to pay for parking on or near Citi's business premises or near a location from which you commute to work by mass transit, van pool, or car pool.

You can enroll to purchase both a transit and/or a parking pass or 2 types of transit media (pass, token or ticket) or 2 types of parking media (parking permit or parking garage) online, depending on what is required for your commute to and from work. When enrolling, you can set up a recurring purchase or you can arrange to purchase your pass each month. The pass will be mailed to your home in time for use beginning the first of the following month.

The deadline to enroll or change your TRIP participation is the 10th of every month for participation the first of the following month. If you miss the deadline, your enrollment/change will be effective the following month.

Once enrolled, you can cancel or suspend your online purchase at any time. If you cancel or suspend your purchase by the 10th of any month (the monthly purchase deadline), a pass will not be purchased for you for the following month.

Note for rail commuters using the Long Island Rail Road (LIRR) and Metro North Railroad (MNR): An earlier deadline applies to you. Your orders and cancellations must be placed by the fourth of the month.

If you:	Order:	Receive:
Enroll to purchase a transit and/or parking pass on the Your Spending Account™ (YSA™) website, available as a link from Your Benefits Resources™	No later than the 10th of any month; for LIRR and MNR commuters, no later than the fourth of any month	Your pass will be purchased and mailed to your home address on Citi records so you have it before the first of the following month

Cash reimbursement option

The cash reimbursement option for parking expenses is a solution intended to cover situations when you are unable to participate in the TRIP Parking Account using the parking voucher, parking debit card, or the pay-provider-the-directly option. This may work for you if you pay for your parking on a quarterly basis or a year in advance. To be reimbursed in cash, you must submit a claim for eligible expenses online on the YSA™ website or you can submit a paper claim to YSA™ .Be sure to include your itemized receipts with the claim.

To be reimbursed in cash, you must submit a paper claim to Your Spending Account™ with your itemized receipts. For more information about the cash reimbursement option, see the Cash Reimbursement Option document in the spending account section of the Citi intranet at **www.citigroup.net/human_resources/pdf/trip_parking_cro.pdf** or you can visit the Your Spending Account™ website through Total Comp @ Citi at **www.totalcomponline.com,** available from the Citi intranet and the Internet.

Examples of eligible expenses	
Parking Account	Transit Account
• Parking at or near your work location; and • Parking at or near a location from which you commute to work by mass transportation, car pool, or other means	• Transportation passes; • Any pass, token, fare card, ticket, or similar item that entitles you to ride public transportation to and from work; • Transportation between work and your residence in a "commuter highway vehicle" that: – Seats six or more adults excluding the driver; – Is used 80% or more (based on mileage) for transporting employees between work and home; and – Includes at least three commuters, excluding the driver, on each trip.

Examples of ineligible expenses	
Parking Account	Transit Account
• Non-work-related parking expenses; • Parking at or near your residence; • Parking for which you receive a before-tax benefit; • Parking paid for by your employer; • Parking expenses incurred by family members; and • Expenses eligible to be reimbursed from the Transit Account.	• Car pooling and/or van pooling in a vehicle seating fewer than six passengers, excluding the driver; • Taxi fares; • Highway, bridge, or tunnel tolls; • Expenses incurred for business travel (such as traveling from the office to a business or client meeting); • Gas or mileage expenses; • Transit expenses incurred by family members; and • Expenses eligible to be reimbursed from the Parking Account.

Changing your TRIP pass election

Once enrolled, you can change your online purchase at any time; the change will be effective as soon as administratively possible. For example, you are enrolled to purchase a parking pass and a train pass, but you relocate so you require a bus pass only. If, by May 10 (for example), you cancel the train and parking pass purchase and enroll for a bus pass, your new bus pass will be mailed to your home address on Citi records for use as of June 1.

To enroll in TRIP or to change your election once enrolled, visit the Your Spending Account™ (YSA™) website through the Your Benefits Resources™. Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Spending accounts". From the "Manage Your Spending Account™" section, click on the link for "Your Spending Account™."

If your employment is terminated

If your employment is terminated, your payroll deductions will stop and your account will be closed as of your termination or transfer date. You will forfeit any balance in your account.

For more information

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

Claims and appeals for the HCSA/LPSA

If you are denied a benefit under the HCSA/LPSA, you should proceed in accordance with the following procedures.

Step 1: A Denial Notice is mailed from the Citi Benefits Center. If your claim is denied, you will receive written notice from the Citi Benefits Center that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of the Citi Benefits Center, it may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Citi Benefits Center must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: Once you have received your notice from the Citi Benefits Center, review it carefully. The notice will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit to submit the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures;
- A right to request all documentation relevant to your claim; and
- A statement explaining your rights to bring civil action under Section 502(a) of ERISA after an adverse benefit determination upon review.

Step 3: If you disagree with the processing of your claim, contact the Citi Benefits Center for assistance. If you are still unable to resolve your issue and have your claim approved, you may file a level-one appeal. You may obtain a level-one appeal form from the Citi Benefit Center spending account team. Complete and return the form along with any additional documentation supporting why you believe your claim should be approved.

You should file your appeal no later than 180 days after receipt of the notice described in Step 1. Mail your appeal to the Citi Benefits Center at the address below (the address is also on the first page of the appeal form). Be sure to submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Your Spending Account™
Claims and Appeals Management
P.O. Box 1444
Lincolnshire, IL 60069-1444

Step 4: Notice of Denial is received from the claims reviewer. If the claim is again denied, you will be notified in writing. The notice will be mailed no later than 30 days after receipt of the appeal by the Citi Benefits Center.

Step 5: Review your notice carefully. You should take the same action described in Step 2. The notice will contain the same type of information that is provided in the first notice of denial provided by the third-party administrator.

Step 6: If you still do not agree with the Citi Benefits Center's decision, you may file a written level 2 appeal with Citi at the address listed below within 60 days after receiving the latest denial notice from the Citi Benefits Center. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If Citi denies your appeal, you will receive notice within 30 days after Citi receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Citigroup Inc.
Plans Administration Committee of Citigroup Inc.
1 Court Square, 46th Floor
Long Island City, NY 11120

Disability Coverage

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

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

Managed Disability Brochure

For more information about the disability benefits offered by Citi, including how to report a disability and what happens to your benefits coverage while you are on a leave of absence, see the Managed Disability brochure, available at **www.benefitsbookonline.com/managed-disability-brochure.pdf.**

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

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

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

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

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Short-Term Disability (STD)

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

STD pays 100% or 60% of base salary (not total compensation) during an approved disability of up to 13 weeks based on your years of service. For employees hired on or after January 1, 2011, there is a three-month waiting period before disability benefits are payable (as shown in the following schedules of benefits). For employees hired on or before December 31, 2010, there is a one-month waiting period before disability benefits are payable.

STD Schedule of benefits for benefits-eligible salaried employees			
Years of service*	Weeks at 100% of base salary	Weeks at 60% of base salary	Total weeks of base salary
Less than 3 months	0	0	0
3 months to less than 1 year	1	12	13

STD Schedule of benefits for benefits-eligible salaried employees			
1 year to less than 2 years	4	9	13
2 years to less than 3 years	6	7	13
3 years to less than 4 years	8	5	13
4 years to less than 5 years	10	3	13
5 or more years	13	0	13

* If you were hired on or before December 31, 2010, you will satisfy one month of service to be eligible for STD benefits.

STD schedule of benefits for Account Executives in the Institutional Clients Group			
Years of service*	Minimum benefit (% of total compensation)	Plus additional benefit	Maximum benefit (% of total compensation)
Less than 3 months	0	0	0
3 months to less than 3 years	60%	Commissions	100%
3 years to less than 7 years	70%	Commissions	100%
7 or more years	80%	Commissions	100%

* If you were hired on or before December 31, 2010, you will satisfy one month of service to be eligible for STD benefits.

Pregnancy leave for benefits-eligible salaried employees			
Years of service*	Weeks at 100% of base salary	Weeks at 60% of base salary	Total weeks of benefit
Less than 3 month	0	0	0
3 months to less than 1 year	1	12	13
1 or more years	13	0	13

* If you were hired on or before December 31, 2010, you will satisfy one month of service to be eligible for pregnancy leave benefits.

Pregnancy leave for benefits-eligible commission-paid Account Executives			
Years of service*	Minimum benefit (% of total compensation)	Plus additional benefit	Maximum benefit (% of total compensation)
Less than 3 months	0	0	0
3 months to less than 1 year	70%	Commissions	100%
1 or more years	80%	Commissions	100%

* If you were hired on or before December 31, 2010, you will satisfy one month of service to be eligible for pregnancy leave benefits.

For employees paid on commission working in Consumer Banking and North America Cards: You will receive STD benefits based on a phantom salary (and not based on total compensation). If any commissions are generated while you are on an STD leave, they will be paid in addition to the STD benefit based on your years of service.

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

When STD benefits are payable

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

You are not considered to have a disability if your illness, injury, or pregnancy prevents you from commuting to and from work only. To qualify for STD benefits, you must be receiving appropriate care and treatment on a continuing basis from a licensed health care provider. You cannot qualify for STD benefits if you return to work on a part-time basis unless you work in California.

If you qualify for STD benefits, return to work, and then within a 30-day period you are unable to work as a result of the same or a related total disability, your absence will be processed as a recurrent claim and you will be eligible to receive the balance of your STD benefits (for a reduced period to reflect the STD benefits paid during the prior absence). STD benefits are taxable as ordinary income. Citigroup will withhold taxes, as well as deductions for other employee benefits, from STD benefits.

Exclusions

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

- A disability when your care is not supervised by a qualified physician;
- Injuries caused by war, international armed conflict, riot, or civil disobedience;
- Intentional self-inflicted injury;

- A disability that begins during an unapproved leave of absence;
- A disability that results from an attempted or committed felony, assault, battery, other public offense, or during incarceration; or
- A disability resulting from cosmetic surgery, which is a surgical procedure that is not necessary to correct a sickness or injury (except for statutory benefits required under applicable state law).

For employees who work in California

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

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

Long-Term Disability (LTD)

You may be eligible to receive LTD benefits after 13 weeks of an approved STD leave. LTD coverage is offered to replace 60% of your total compensation (predisability earnings) as of the day before your approved disability when your disability continues for more than 13 weeks.

For purposes of calculating your LTD benefit, total compensation is limited to a maximum of $500,000.

Participation

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

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

If your total compensation increases to $50,001 or above for benefits purposes in the 2011 plan year or thereafter, you will be automatically enrolled in LTD coverage so your coverage continues uninterrupted. The cost of LTD coverage will be deducted from your pay beginning January 1 of the next plan year (following annual enrollment) unless you decline coverage. Refer to the Your Benefits Resources™ website during annual enrollment for the cost.

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

If your total compensation is:	
$50,000.99 or less*	Citi provides LTD coverage at no cost to you.
From $50,001 to $500,000	You will pay for coverage with after-tax dollars.

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

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

LTD BENEFITS	
Age when total disability begins	Date monthly LTD benefits will stop
Under 60	Upon attaining age 65
60	The date the 60th monthly benefit is payable
61	The date the 48th monthly benefit is payable
62	The date the 42nd monthly benefit is payable
63	The date the 36th monthly benefit is payable
64	The date the 30th monthly benefit is payable

LTD BENEFITS	
Age when total disability begins	Date monthly LTD benefits will stop
65	The date the 24th monthly benefit is payable
66	The date the 21st monthly benefit is payable
67	The date the 18th monthly benefit is payable
68	The date the 15th monthly benefit is payable
69 or over	The date the 12th monthly benefit is payable

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

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

You do not have to enroll in LTD coverage despite automatic enrollment, as described. However, if you decide to enroll in LTD coverage at any time other than when first eligible (within 31 days of when you become eligible for Citi benefits or as the result of a qualified change in status), you must take a physical exam and/or provide evidence of good health before coverage will be approved.

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

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

Converting your coverage

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

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

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

When LTD benefits are payable

For purposes of initially qualifying for LTD benefits, a disability means that due to sickness, pregnancy, or accidental injury, you are receiving appropriate care and treatment from an attending physician on a continuing basis and are unable to perform your own occupation for any employer in your local economy. After a period up to 60 months, and depending on your predisability earnings, you may continue to qualify for benefits if you are unable to earn more than 60% of your predisability earnings at any occupation for which you are reasonably qualified.

LTD benefits become payable after you are approved for and receive 13 weeks of continuous STD benefits. To qualify for LTD benefits, you must be under the continuous care of an attending physician during the STD period.

Claims and appeals

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

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

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

- Name, address, telephone number, and Social Security number;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Insurance Benefits

Citi provides the opportunity for you to purchase insurance at group rates for your safety and security and that of your dependents:

- Group Universal Life (GUL)/Accidental Death and Dismemberment (AD&D) insurance for you and your spouse/civil union partner/domestic partner;
- Term life insurance for your children; and
- Long-Term Care insurance.

In addition, certain employees are eligible to receive Basic Life/AD&D insurance at no cost to them.

All regular full-time and part-time employees are also covered under the Business Travel Accident/Medical Plan, which pays benefits in the event of death, dismemberment, paralysis, and loss of speech and/or hearing while traveling on an approved trip made on behalf of the Company. In addition, the Business Travel Medical program provides non-routine and emergency medical coverage while traveling on business for Citi.

Insurance benefits are fully-insured. Benefits are provided under the contracts entered into between the Plan Sponsor and the insurers. The insurers, not the Committee or the Plan Sponsor, administer benefit claims and appeals procedures and are responsible for paying claims.

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Basic Life/AD&D insurance

Citi provides Basic Life insurance (through MetLife) and Accidental Death and Dismemberment (AD&D) insurance (through Cigna) at no cost to you if your total compensation is less than $200,000. AD&D pays a benefit if you are dismembered or die as a result of an accidental injury. If your annual total compensation is equal to or above $200,000, you are *not* eligible for company-paid Basic Life/AD&D insurance.

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

Since Citi pays the full cost of Basic Life insurance, you must pay taxes on the value of the coverage above $50,000 as required by the IRS. This amount, called "imputed income," is shown on your pay statement and Form W-2 Wage and Tax Statement for the year in which coverage was effective. Imputed income is not a deduction but an amount added to your taxable pay based on the amount of Basic Life insurance coverage above $50,000.

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

If your total compensation is increased to $200,000 or above

Once your total compensation is equal to or exceeds $200,000, you may have the opportunity to enroll in Group Universal Life (GUL) coverage equal to one times your total compensation up to $500,000 *without providing evidence of good health,* subject to the Plan's maximum coverage limits.

If you are enrolled in GUL up to the maximum coverage amount — the lesser of 10 times your total compensation or $5 million — then you are not eligible to increase GUL coverage.

Basic Life accelerated benefits option

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

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

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

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

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

Naming a beneficiary

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

You may designate or charge your beneficiary for Basic Life insurance at any time by visiting Your Benefits Resources™ through Total Comp @ Citi at **www.totalcomponline.com** (under Health and Welfare, select "Health and welfare benefits." You can also go directly to **http://resources.hewitt.com/citigroup**. From the home page, click on the "Health and Insurance" tab. Then click on "Overview" and "Beneficiaries."

Your beneficiary for Basic Life insurance is also your beneficiary for AD&D coverage. If there is no beneficiary designated or no surviving beneficiary at your death, the Claims Administrator will determine the beneficiary in the following order:

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

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

Converting to an individual policy

You can convert your Basic Life/AD&D to an individual policy by calling the Citi Benefits Center within 31 days after your termination of employment from Citi. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

If you become ineligible for Basic Life/AD&D coverage because your total compensation for the plan year equals or exceeds $200,000, you can convert your current Basic Life/AD&D coverage to an individual policy — without providing evidence of good health — by contacting the Citi Benefits Center within 31 days after you are notified that your Basic Life/AD&D coverage will end.

GUL/Supplemental AD&D insurance

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

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

If you are enrolling in GUL insurance outside your initial eligibility period (31 days from your date of hire/date you are eligible to enroll in Citi benefits), outside of a qualified change in status, or for an amount greater than three times your total compensation or $1.5 million, you must provide evidence of good health and be actively at work before coverage will be effective (this does not apply to AD&D insurance). "Actively at work" means that you are regularly scheduled to work in the office or at home and you are not away from work due to a disability. You must be able to perform all the activities of your job.

Enrolling in GUL coverage

You do not enroll in GUL coverage through Citi. Instead, you enroll in GUL coverage by contacting MetLife. Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Dental/Disability/Group Universal Life (GUL)", or submit an enrollment form, which you can obtain by calling MetLife at **1-800-523-2894**. Your spouse/civil union partner/domestic partner must complete an enrollment form.

If your total compensation is reduced, your GUL amount will continue to be based on the higher total compensation unless you call MetLife at **1-800-523-2894** to request that the GUL amount be reduced. Once you reduce coverage, you can increase it only by purchasing additional multiples of your total compensation. You may be asked to provide satisfactory evidence of good health before the increased coverage will become effective. GUL coverage for an employee ends at age 95.

Once enrolled in GUL, you automatically will receive Supplemental AD&D coverage in the same amount as your GUL coverage. Supplemental AD&D coverage is provided by Cigna.

If you leave Citi, you can continue coverage under an individual policy. MetLife will bill you directly at a higher rate than the Citi group rate. The rate will become effective the month following your termination of employment. Your Supplemental AD&D coverage ends on the last day of the month in which your employment was terminated. To convert your Supplemental AD&D coverage to an individual policy, 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 speak to a Citi Benefits Center representative.

GUL accelerated benefits option

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

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

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

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

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

Accelerated benefits are not payable if:

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

Cash Accumulation Fund

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

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

If your contributions for GUL, including the CAF, exceed the actual limits of the coverage for which you are enrolled, MetLife will notify you about a refund. For the actual amount that applies to you under the applicable tax laws, call MetLife at **1-800-523-2894**.

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

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

For more information about the CAF, call MetLife at **1-800-523-2894**.

Taking a loan from your CAF

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

Loan interest is charged at a rate set by MetLife. This rate will never be more than the maximum permitted by law and will not change more often than once a year on the plan anniversary date. Call MetLife at **1-800-523-2894** for the current interest rate.

You may repay all or part of a loan (but not less than $100) at any time while you are alive and enrolled in GUL coverage. If any payment is intended as a loan repayment, rather than a contribution to your CAF, you must notify MetLife when you make the payment. Loans are not payable through payroll deductions.

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

For more information about CAF loans, call MetLife at **1-800-523-2894.**

Assignment

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

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

MetLife is not responsible for the validity of an assignment.

Naming a beneficiary

Your beneficiary is the person or persons you choose to receive any benefit payable upon your death. You may designate or charge your beneficiary for GUL insurance at any time by calling MetLife at **1-800-523-2894**.

Your beneficiary for GUL also is your beneficiary for Supplemental AD&D coverage.

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

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

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

Coverage for your spouse/civil union partner/domestic partner

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

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

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

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

Once enrolled in GUL, your spouse/civil union partner/domestic partner automatically will receive Supplemental AD&D coverage in the same amount as his/her GUL coverage. AD&D is provided by Cigna.

If you leave Citi or terminate your marriage, civil union, or domestic partnership, your spouse/civil union partner/domestic partner can continue coverage under an individual policy. MetLife will bill him or her directly at a higher rate than the Citi group rate. The rate will become effective the month following your termination of employment, divorce, or termination of your civil union or domestic partnership. Supplemental AD&D coverage terminates on the last day of the month in which the events noted above occur.

Your spouse/civil union partner/domestic partner can convert his/her Supplemental AD&D coverage to an individual policy. 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 speak to a Citi Benefits Center representative.

Life/AD&D insurance for your children

If you have enrolled in GUL/Supplemental AD&D coverage for yourself or your spouse/civil union partner/domestic partner, you can enroll for life/AD&D insurance from $5,000 to $20,000, in $5,000 increments, for your eligible dependent children. *A child must be at least 14 days old to be covered.* Life insurance coverage is provided by MetLife. To enroll in child life coverage, call MetLife at **1-800-523-2894**. When you enroll in child life coverage, all your eligible children are covered.

Once enrolled for child life, your child automatically receives Supplemental AD&D coverage in the same amount as the child life coverage. AD&D coverage is provided by Cigna.

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

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

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

You may designate or change your beneficiary for life insurance for your child at any time by calling MetLife at **1-800-523-2894**.

Details about AD&D insurance

Schedule of covered losses

- Loss of life: 100% of the principal sum;
- Loss of two or more hands/feet: 100% of the principal sum;
- Loss of sight of both eyes: 100% of the principal sum;
- Loss of one hand or one foot and sight in one eye: 100% of the principal sum;
- Loss of speech and hearing (in both ears): 100% of the principal sum;
- Quadriplegia: 100% of the principal sum;
- Paraplegia: 75% of the principal sum;
- Hemiplegia: 50% of the principal sum;
- Loss of one hand or foot: 50% of the principal sum;
- Loss of sight in one eye: 50% of the principal sum;
- Loss of speech: 50% of the principal sum;
- Loss of hearing (in both ears): 50% of the principal sum;
- Loss of all four fingers of the same hand: 25% of the principal sum;
- Loss of thumb and index finger of the same hand: 25% of the principal sum; and
- Loss of all the toes of the same foot: 20% of the principal sum.

Age reduction schedule

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

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

Coverage for a child is not continued for 12 months if the child reaches maximum age (age 26).

Coverage for a spouse ends at age 70.

Additional Basic AD&D benefits

Ambulance benefits

- $500 per emergency ambulance service.

Basic AD&D coverage for injury resulting from felonious assault

- AD&D benefit: 10% multiplied by the percentage of the principal sum applicable to the covered loss, as shown in the schedule of covered losses, subject to a maximum of $100,000; and
- Hospital stay benefit: $100 per day; maximum benefit period of 365 days per hospital stay per covered accident.

Seatbelt and airbag benefit

- Seatbelt benefit: 10% of the principal sum subject to a maximum benefit of $25,000;
- Airbag benefit: 5% of the principal sum subject to a maximum benefit of $15,000;
- Default benefit: $1,000.

Additional Supplemental AD&D benefits

Child care center benefit

5% of the employee's principal sum subject to a maximum of $10,000 per year. The maximum benefit period is to age 13 for each surviving dependent child.

Increased dependent child dismemberment benefit

100% multiplied by the percentage of the child's principal sum applicable to the covered loss, as shown in the "Schedule of covered losses."

Special education benefit

Cigna will pay 5% of the principal sum to a maximum benefit of $10,000 for each qualifying dependent child who is insured under the covered employee's benefits coverage on the date the employee dies. The covered employee's death must result directly and independently of all other causes from a covered accident for which an accidental death benefit is payable under this policy. This benefit is subject to the conditions and exclusions described below.

A qualifying dependent child must:

- Be enrolled as a full-time student in an accredited school of higher learning beyond the 12th-grade level on the date of the covered employee's covered accident or be at the 12th-grade level on the date of the covered employee's covered accident and then enroll as a full-time student at an accredited school of higher learning within 365 days from the date of the covered accident and continue his or her education as a full-time student.
- Continue his or her education as a full-time student in such accredited school of higher learning; and
- Incur expenses for tuition, fees, books, room and board, transportation and any other costs payable directly to, or approved and certified by, such school.

Up to four annual payments will be made at the end of each year to each qualifying dependent child or to the child's legal guardian, if the child is a minor. Cigna must receive satisfactory proof of the dependent child's enrollment and attendance within 31 days of the end of each year.

If no dependent child qualifies for a Special Education Benefit within 365 days of the covered employee's death, Cigna will pay a default benefit of $1,000 to the covered employee' beneficiary.

Spouse or domestic partner retraining benefit

Cigna will pay expenses incurred, as described below, up to the maximum benefit of $10,000 to enable the covered employee's spouse to obtain occupational or educational training needed for employment if the covered employee dies directly and independently of all other causes from a covered accident.

A covered spouse must have been insured under this policy on the date of the covered employee's death to be eligible. This benefit will be payable if the covered employee dies within one year of a covered accident and is survived by his or her spouse who:

- Enrolls, within three years after the covered employee's death in any accredited school for the purpose of retraining or refreshing skills needed for employment; and
- Incurs expenses payable directly to, or approved and certified by, such school.

Exclusions

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

- Intentionally self-inflicted injury, suicide, or any such attempt while sane or insane;
- Commission of or attempt to commit a felony or an assault;
- Commission of or active participation in an insurrection; terrorist act or riot (participation in a riot means taking part, joining, or sharing with others in a violent disturbance of the public peace of persons assembled for a common purpose);
- Bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
- Declared or undeclared war or act of war;
- Flight in, boarding, or alighting either from an aircraft or any craft designed to fly above the earth's surface:
  - Except as a passenger on a regularly scheduled commercial airline;
  - Being flown by the covered person or in which the covered person is a member of the crew;
  - Being used for:
    - Crop dusting, spraying or seeding, giving and receiving flying instruction, firefighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
    - Any operation that requires a special permit from the Federal Aviation Administration, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
    - Designed for flight above or beyond the earth's atmosphere;
    - An ultra-light or glider;
    - Being used for the purpose of parachuting or skydiving; or
    - Being used by any military authority, except an aircraft used by the Air Mobility Command or its foreign equivalent.
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
- Travel in any aircraft owned, leased or controlled by the policyholder, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by the policyholder if the aircraft may be used as the policyholder wishes for more than 10 straight days or more than 15 days in any year;
- A covered accident that occurs while engaged in the activities of active-duty service in the military, navy, or air force of any country or international organization. Covered accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic, or other intoxicant including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the covered accident occurred;
- Voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by his/her physician; (accidental ingestion of a poisonous substance or controlled drug is not excluded); and
- Benefits will not be paid for services or treatment rendered by a physician, nurse, or any other person who is:
  - Employed or retained by the policyholder;
  - Providing homeopathic, aromatherapeutic, or herbal therapeutic services;
  - Living in the covered person's household; or
  - A parent, sibling, spouse, or child of the covered person.

Business Travel Accident/Medical insurance

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

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

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

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

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

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

Converting to an individual policy

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

Filing a claim for Basic Life, GUL, and BTA/Medical insurance

You must provide written or authorized electronic/telephone notice of your claim within 31 days after a covered loss occurs or begins or as soon as reasonably possible.

- For Basic Life and GUL, your beneficiary may call the Citi Benefits Center. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "pension, retiree health and welfare and survivor support" option.

If written or authorized electronic/telephone notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephone notice was given as soon as was reasonably possible.

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

Survivor Support will send claim forms for filing proof of loss when it receives notice of a claim. The claimant must provide written or authorized electronic proof of loss, satisfactory to MetLife, within 90 days of the loss for which the claim is made. If Survivor Support does not send claim forms within 15 days after it receives notice of a potential claim, you or your beneficiary can submit — within 90 days — written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

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

Long-Term Care (LTC) insurance

Effective January 1, 2012, no new participants will be permitted to enroll into the LTC plan. Participants who enrolled on or before December 31, 2011 will continue to be participants under the Plan.

You can purchase LTC coverage for you and eligible members of your family can purchase LTC coverage for themselves at any time. Coverage is provided by the John Hancock Life Insurance Company (U.S.A).

To be eligible, you and your family members must reside in the United States (50 states, the District of Columbia, and Puerto Rico). Eligible family members may apply for the benefit even if you do not. Eligible family members are:

- Your spouse, civil union partner/domestic partner;
  - **Note**: Coverage is not available to domestic partners residing in Louisiana.
- Your parents and your parents-in-law;
- Your adult children or the adult children of your spouse, civil union partner, or domestic partner; and
- Spouses of your adult children.

Family members must be 18 or older.

- If you are a new hire and enroll during your initial benefits enrollment period: You will not have to provide evidence of good health acceptable to John Hancock.
- If you enroll at any other time: You must provide evidence of good health acceptable to John Hancock.

In either case, coverage will be effective the first of the month after your application is approved, as long as you are actively at work on that date. If you are not at work on the date your coverage would otherwise have become effective, your coverage will become effective the first of the month following your return to work as an active employee.

Premiums for you and your spouse/civil union partner/domestic partner will be deducted from your pay. You will pay for coverage with after-tax dollars; the cost is based on your age when you become insured.

Your family members can complete an application form and must provide evidence of good health acceptable to John Hancock before coverage will be approved. Coverage will be effective the first of the month after their application is approved, provided they are not disabled on that date.

If they are disabled on that date, coverage will take effect the first of the month after their disability ends, provided they are still eligible.

For information on the cost of LTC coverage for yourself or other eligible family members, you can request an enrollment kit or obtain a personal rate quote by visiting the John Hancock website at **http://groupltc.jhancock.com**. The user name is "groupltc," and the password is "mybenefit." You also can call John Hancock at **1-800-222-6814**.

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

Family members, other than spouses/civil union partners/domestic partners, will be billed directly.

Enrolling in LTC coverage

To enroll in LTC coverage, submit the appropriate application to John Hancock or click on a link from Your Benefits Resources™. Eligible family members must complete an application.

When LTC benefits are payable

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

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

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

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

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

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

Benefits and services covered

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

Choosing a level of coverage

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

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Nursing home DMB	$115	$175	$230	$290	$345	$405
Alternate care facility DMB	$115	$175	$230	$290	$345	$405
*Community-based professional care DMB***	$86.25	$131.25	$172.50	$217.50	$258.75	$303.75
Informal care DMB	$28.75	$43.75	$57.50	$72.50	$86.25	$101.25
Informal care calendar-year maximum	$862.50	$1,312.50	$1,725	$2,175	$2,587.50	$3,037.50
Lifetime maximum benefit (excluding stay-at-home benefit)	$209,875	$319,375	$419,750	$529,250	$629,625	$739,125
Stay-at-home lifetime maximum	$3,450	$5,250	$6,900	$8,700	$10,350	$12,150

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

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

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

Stay-at-home benefit

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

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

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

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

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

For an additional cost, you can also choose to include a non-forfeiture benefit (reduced lifetime maximum paid-up benefit) in your coverage at enrollment. If you do not elect this option, the contingent non-forfeiture benefit will be included in your coverage at no additional cost.

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

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

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

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

Choosing inflation protection: ABI or future purchase option

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

Under the ABI option, increases to your benefit amounts occur automatically each year. Each January 1, the DMB amount will be increased at an annual rate of 5% compounded. The LMB will be increased in proportion to the increase in the nursing home DMB. If your insurance becomes effective January 1, no increase will apply on your effective date of coverage.

The benefit increase will continue to be made annually regardless of your age or whether you have met the benefit eligibility requirements under the policy. However, no future increases in benefit amount will apply if you stop paying premiums and continue coverage in effect on a reduced paid-up basis under the non-forfeiture benefit.

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

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

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

Visit the John Hancock website at **http://groupltc.jhancock.com** (the user name is "groupltc," and the password is "mybenefit") for an online tool that can help you determine which inflation protection provision may suit your needs.

Additional features

Return of premium at death benefit

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

Age	Percentage of premium returned upon death
65 or younger	100%
66	90%
67	80%
68	70%
69	60%
70	50%
71	40%
72	30%
73	20%
74	10%
75 or older	0%

Waiver of premium

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

Portability

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

Bed reservation benefit

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

Alternate plan of care

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

Restoration of benefits

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

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

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

Coordination of benefits and exclusions

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

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

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

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

Tax implications

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

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

For more information

To obtain details of the coverage available and its cost, contact John Hancock either by:

- Calling the John Hancock Long-Term Care Insurance Department at **1-800-222-6814**; or
- Visiting the John Hancock website at **http://groupltc.jhancock.com**. The user name is "groupltc," and the password is "mybenefit."

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

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 (HIPAA) is a federal law enacted to provide improved portability and continuity of health insurance coverage for dependents.

HIPAA restricts the ability of group health plans to exclude coverage for pre-existing conditions. HIPAA also requires plans to provide a Certificate of Creditable Coverage and provide for special enrollment rights as described under "Your special enrollment rights".

Creditable coverage

Under HIPAA, when you and your dependents no longer have Citi medical coverage, you must receive certification of your coverage from the medical plan in which you were enrolled. You may need this certification in the event you later become covered by a new plan under a different employer, or under an individual policy.

You and/or your dependent(s) will receive a coverage certification when your medical plan coverage terminates, again when COBRA coverage terminates (if you elected COBRA), and upon your request (if the request is made within 24 months following either termination of coverage).

You should keep a copy of the coverage certification(s) you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if you obtain new employment and your new employer's plan has a pre-existing condition limitation (which delays coverage for conditions treated before you were eligible for the new plan), the employer may be required to reduce the duration of the limitation by one day for each day you had prior coverage (subject to certain requirements). If you are purchasing individual coverage, you may need to present the coverage certification to your insurer at that time as well.

Your special enrollment rights

If you decline to enroll in Citi medical coverage for yourself 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 loses 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.

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 Plans 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 "Notice of HIPAA Privacy Practices" on page 203 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.

The Plan Sponsor shall use and disclose individually identifiable health information ("protected health information") 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 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 protected health information to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the plan document has been amended to incorporate the provisions herein. The Plan Sponsor shall ensure that any agents, including subcontractors, to whom it provides protected health information 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 protected health information 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 protected health information that is inconsistent with the uses or disclosures provided for herein of which it becomes aware.

The Plan Sponsor shall make available protected health information to the Plans for purposes of providing access to individuals' protected health information in accordance with 45 C.F.R. sec. 164.524. The Plan Sponsor shall make available protected health information to these plans for purposes of amending the Plans and shall incorporate any amendments to protected health information in accordance with 45 C.F.R. sec. 164.526. The Plan Sponsor shall make available protected health information and any disclosures thereof to these plans 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 protected health information 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 protected health information 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 protected health information to be disclosed, including those employees or persons who receive protected health information 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 protected health information (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 last sentence of 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 Protected Health information 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 protected health information.

This notice also sets out Component Plans' legal obligations concerning your protected health information and describes your rights to access and control your protected health information. 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. Terms that are not defined in this notice have the same meaning as they have in the HIPAA Privacy Rule, as amended by Title XIII, Subtitle D of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) and regulations promulgated thereunder (ARRA).

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. 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 208.

Component Plans' responsibilities

Each Component Plan is required by law to maintain the privacy of your protected health information. The HIPAA Privacy Rule defines "protected health information" to include any individually identifiable health information (1) that is created or received by a health care provider, health plan, 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. Effective February 17, 2010, the Component Plans were required to limit the use, disclosure, or request for protected health information 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 protected health information. Component Plans must abide by the terms of this notice. If the Plan uses or discloses personal health information for underwriting purposes, the Plan will not use or disclose personal health information 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 protected health information. 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 protected health information 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 protected health information to fulfill their responsibilities for coverage and provide benefits as established under their governing documents. For example, Component Plans may disclose your protected health information 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 protected health information 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 protected health information (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 protected health information 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 protected health information with each other to carry out payment and health care activities.

Other covered entities: Component Plans may use or disclose your protected health information 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 protected health information to a health care provider when needed by the provider to render treatment to you. Component Plans may disclose protected health information 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 protected health information 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 protected health information to the extent required by federal, state, or local law.

Public health activities: Each Component Plan may use or disclose your protected health information 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 protected health information, 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 protected health information 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 protected health information 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 protected health information in response to a subpoena, a discovery request, or other lawful process.

Abuse or neglect: Component Plans may disclose your protected health information 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 protected health information to a government entity authorized to receive such information.

Law enforcement: Under certain conditions, Component Plans may also disclose your protected health information 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 protected health information to a coroner or medical examiner when necessary to identify a deceased person or determine a cause of death. Component Plans may also disclose protected health information to funeral directors as necessary to carry out their duties.

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

Research: Component Plans may disclose your protected health information 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 protected health information 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 protected health information 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 protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military: Under certain conditions, Component Plans may disclose your protected health information 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 information to the foreign military authority.

National security and protective services: Component Plans may disclose your protected health information 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 protected health information 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 protected health information 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 protected health information 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 protected health information 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 206. Component Plans may also disclose your information 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 protected health information, 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 protected health information 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 protected health information when you request access to this information. Component Plans will disclose your protected health information 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 protected health information 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 protected health information 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 protected health information, you will receive written notification.

Your rights

The following is a description of your rights regarding your protected health information. 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 208.

Right to request a restriction: You have the right to request a restriction on the protected health information 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 protected health information 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 208.

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 protected health information 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 protected health information 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 protected health information 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 208.

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 protected health information 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 protected health information could endanger you.

Right to request access: You have the right to inspect and copy protected health information 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 protected health information, 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 protected health information if it is maintained in an electronic health record. You may also request that such electronic protected health information 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 protected health information subject to law that prohibits access to protected health information. 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 protected health information held by a Component Plan if you believe that information is incorrect or incomplete. If you request an amendment of your protected health information, your request must be submitted in writing, using the contact information in "Contact information" on page 208, 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 information, 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 protected health information. You may request an accounting using the contact information in "Contact information" on page 208. 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 208.

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 208. Component Plans will not penalize you for filing a complaint.

Administrative information

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 protected health information 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 February 17, 2010.

Contact information

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

Citi Privacy Officer
c/o Corporate Benefits Department
1 Court Square, 46th 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:** Call the Citi Employee Services North America Service Center at 1-469-220-9600. 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.

HIPAA Certificate of Creditable Coverage

You can reduce or eliminate an exclusionary period of coverage for pre-existing conditions (if one exists) under your group health Plan if you have creditable coverage from another plan.

You should receive a Certificate of Creditable Coverage, free of charge, from your group health Plan or health insurance issuer:

- When you lose coverage under the Plan;
- When you become entitled to elect COBRA continuation coverage;
- When your continuation coverage ceases, if you request it before losing coverage; or
- If you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after the date you enroll in coverage.

To request a Certificate of Creditable Coverage, write to the Citi Benefits Center at:

Citi Benefits Center
2300 Discovery Drive
P.O. Box 785004
Orlando, FL, 32878-5004

You may also call the COBRA administrator through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Important notices about your Citi prescription drug coverage and Medicare

Citi has determined that prescription drug coverage provided through the medical options it offers, other the High Deductible Health Plan-Basic and Premier, is "creditable" under Medicare and that the High Deductible Health Plan-Basic or Premier provides "non-creditable" coverage.

This means that if you become eligible for Medicare in the 12 months beginning January 1, 2012, you are enrolled in a High Deductible Health Plan during that period, and you later elect Medicare Part D prescription drug coverage, you may pay more for it. See more information about Medicare and your choices immediately below.

Creditable Coverage Disclosure Notice

For employees and former employees enrolled in Citi medical plans (excluding the High Deductible Health Plan-Basic and Premier)

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.

* Citi is required by law to distribute this notice to both current employees and 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 your 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 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. 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**.

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.

Non-Creditable Coverage Disclosure Notice

For employees and former employees enrolled in the High Deductible Health Plan-Basic and Premier

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 to people with Medicare.

Keep this notice. Please read this notice carefully, and keep it where you can find it. This notice has information about your current prescription drug coverage with Citi and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan.

You may receive this notice at other times, 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 becomes "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.

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

Prescription drug coverage and Medicare

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you enroll in a Medicare Prescription Drug Plan or a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. *All Medicare drug plans provide at least a standard level of coverage set by Medicare.* Some plans may also offer more coverage for a higher monthly premium.

'Non-creditable coverage'

Citi has determined that the prescription drug coverage offered by the High Deductible Health Plan-Basic and Premier is, on average for all plan participants, *not* expected to pay as much as standard Medicare prescription drug coverage pays and, therefore, is considered "non-creditable coverage." This is important because, most likely, you will get more help with your drug costs if you join a Medicare prescription drug plan than if you have prescription drug coverage from a Citi High Deductible Health Plan.

Understanding the basics

You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you enroll in that coverage. Read this notice carefully because it explains your options.

Consider enrolling in a Medicare drug plan

You can keep your coverage from the Citigroup High Deductible Health Plan-Basic or Premier regardless of whether it is as good as a Medicare prescription drug plan. However, because your existing coverage is, on average, not at least as good as standard Medicare prescription drug coverage, you may pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each fall during the Medicare annual enrollment period, from October 15-December 7, for coverage effective the first day of the following year. If you do not enroll in a Medicare drug plan when you are first eligible, you may have to wait to join a Medicare prescription drug plan and may pay a higher premium (a penalty) if you join later.

You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. If you lose your prescription drug coverage under the Citigroup High Deductible Health Plan-Basic or Premier 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 join a Medicare prescription drug plan at that time under the SEP.

However, even though the SEP permits you to enroll in a Medicare drug plan, you still may be required to pay a higher premium (a penalty) under the Medicare drug plan because the Citigroup High Deductible Health Plan prescription drug coverage was not creditable coverage.

You need to make a decision

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you decide to enroll in a Medicare prescription drug plan and you are an active employee or the family member of an active employee, you may continue your Citi coverage. In this case, the Citigroup Prescription Drug Program will continue to be the primary payer as it had before you enrolled in a Medicare prescription drug plan. Medicare will pay for permitted coverage, as applicable, after Citi pays its benefit. If you waive or drop Citi prescription drug coverage, Medicare will be your only payer.

If you decide to join a Medicare prescription drug plan and drop your Citi prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You also should know that since your coverage under the Citigroup High Deductible Health Plan-Basic or Premier is not creditable coverage if you keep your coverage with Citi and do not join a Medicare prescription drug plan within 63 continuous days after you are eligible for Medicare prescription drug coverage, you may pay a higher premium (a penalty) to enroll in a Medicare prescription drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage (creditable coverage), your monthly premium may increase by at least 1% of the base beneficiary premium per month for every month that you did not have creditable coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following 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. 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 prescription drug coverage, in addition to the "Medicare and You" handbook:

- Visit **www.medicare.gov**.
- See the "Medicare & You" handbook, which Medicare mails to Medicare-eligible individuals each year.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for its telephone number) for personalized help.
- Call 1-800-MEDICARE (**1-800-633-4227**); TDD users, call **1-877-486-2048**.

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. You also will receive it 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 through the Citi Benefits Center.

ERISA information

As a participant in Citi Health and Welfare Plans subject to ERISA (which excludes 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). You can review these documents at no cost to you upon request at the location of the Plan Administrator or other specified location.

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

You can reduce or eliminate an exclusionary period of coverage for pre-existing conditions under your group health Plan (if one exists) if you have creditable coverage from another plan.

You should be provided a Certificate of Creditable Coverage, free of charge, from your group health Plan or health insurance issuer:

- When you lose coverage under the Plan;
- When you become entitled to elect COBRA continuation coverage;
- When your continuation coverage ceases, if you request it before losing coverage; or
- If you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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" beginning on page 217.

Under ERISA, you can take steps to enforce the rights described above. For example, if you request materials from the Plan 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 Plans contact the Plan Administrator listed under "Plan administration" on page 223.

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 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 covered person(s) must refund to the Plan the applicable Overpayment and help the Plan 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 Plans, Overpayment recovery will not be more than the amount of the payment. An Overpayment also occurs when payment is made from the Plans that should have been made under another group plan. In that case, the Plans 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 Plans 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 Plans (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 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

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 this Plan or any other disability or health plan maintained by Citi or its participating companies to the extent necessary to reimburse this 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.

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 authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

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 Medical, Dental, or Vision Plan or the Health Care Spending Account who is an alternate recipient under a QMCSO will be considered as having a right to dependent coverage under the Medical, Dental, or Vision Plan, or the Health Care Spending Accounts.

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" options.

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 incurred 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. 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 227.

To file an enrollment-related claim, see "All other benefits claims" on page 221.

Medical	
• For all plans other than HMOs	Use one of the following forms, available on **Citi For You** (intranet only), to file a claim for a covered out-of-network expense: • 301 — Aetna Claim Form (for ChoicePlan 500 and HDHP – Basic and Premier participants) • 303 — UnitedHealthcare Claim Form (for Hawaii Health Plan participants) • 322 — Empire BlueCross BlueShield (for ChoicePlan 500 and HDHP – Basic and Premier participants) • 309 — Oxford Health Plans Claim Form
• HMO participants	• Call your HMO for any claim-filing information.
Prescription Drugs	
• Express Scripts	Use one of the following forms, available on **Citi For You** (intranet only), to file a claim for a covered out-of-network expense or home delivery: • 310 — Express Scripts Retail Pharmacy–prescription drug program related to all non-HMO plans • 311 — Express Scripts Home Delivery–prescription drug program related to all non-HMO plans
• Medco by Mail (for Oxford PPO)	• Form 320 — Medco by Mail order form, available on **Citi For You** (intranet only).
Dental	
• MetLife Preferred Dentist Program (PDP)	• Form 304 — MetLife Dental Claim form, available on **Citi For You** (intranet only).
• Cigna Dental Care DHMO	• There are no claim forms to file under this plan.
Vision	
• Aetna Vision Plan	• Call the Aetna Vision Plan at **1-877-787-5354**.
Employee Assistance Program	
	• Call Harris Rothenberg at **1-800-952-1245** or visit **www.hriworld.com** (benefit service claims only)
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, you can file a claim by using Form 316 — Health Care Spending Account/Limited Purpose Health Care Spending Account Claim Form, available on **Citi For You** (intranet only), 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. To access YBR™, visit: – Through Total Comp @ Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet; or – Directly at **http://resources.hewitt.com/citigroup** using your YBR™ user ID and password.
Dependent Day Care Spending Account (DSCA)	
	• You can file a claim by using Form 317 — DCSA Reimbursement Request Form, available on Citi For You (intranet only)
Transportation Reimbursement Incentive Program (TRIP)	
	• You can file a claim by using Form 306 - Transportation Reimbursement Incentive Program (TRIP) Claim Form. **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.
Basic Life and GUL insurance	
	• For Basic Life and GUL, your beneficiary may call the Citi Benefits Center. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "pension, retiree health and welfare and survivor support" option.

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

- 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 claims must be filed by June 30 of the calendar year following the plan year in which the expense was incurred.
- DCSA claims must be filed by June 30 of the calendar year following the plan year in which the expense was incurred.

To file a claim or appeal, you must use the designated form in accordance with Plan procedures. By participating in the Plans, you and your beneficiaries agree that you cannot commence a legal action against the 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 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 223 and the list of Claims Administrators under "Claims Administrators" on page 227.

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 Plan, you must first go through the 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 Citi medical, dental, vision, HCSA, LPSA, and disability Plans for the redress of claims that are denied are included in this Handbook.

Medical care claims

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

1. **Preservice claim:** A claim is a preservice 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 in this book as being subject to preservice authorization.
2. **Urgent care claim:** A claim involving urgent care is any preservice claim for medical care or treatment to which the application of the time periods that otherwise apply to preservice claims 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 preservice claim, 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 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 preservice 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 90 days 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 12 months 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 preservice 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 preservice 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 preservice, 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 preservice 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 preservice 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 preservice 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 "Medical care claims" on page 218) 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 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 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 "Medical care claims" on page 218) 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 preservice, 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.

All other benefits claims

If your application to enroll in any of the health and welfare Plans subject to ERISA is denied, you may file a claim with the Plans Administration Committee of Citigroup Inc. (the "Committee"). You may also file an appeal if the Committee denies your claim.

To file an enrollment-related claim and for information on the claim review process, follow the instructions included below. Use the Health and Disability 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. Follow the instructions on the form and return the form to the Plans Administration Committee at the address on the form, and also noted below:

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

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 will be administered in accordance with the following timetable.

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).

Appeals

You have a right to appeal a denied claim by filing a written request for review of your claim with the Claims Administrator within 60 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, 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 Plans. Notwithstanding any provision of the Plan 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, 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, without prior notice. Plan amendments shall be adopted and executed by the Senior Human Resources Officer of Citigroup Inc., a Committee of the Board of Directors of Citigroup Inc., or any officer of Citigroup Inc. authorized to adopt plan amendments or sign other documents 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, unless otherwise stated in the applicable Plan document.

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, and the Citigroup Vision Benefit Plan (as well as other plans) 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. 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 and Limited Purpose Health Care Account on a before-tax basis with respect to subsequent expenses that will be incurred and later reimbursed.

Changes in such elections 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.

Plan information

Plan Administrator	Plans Administration Committee of Citigroup Inc. 1 Court Square, 46th Floor Long Island City, NY 11120 **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. From outside the United States, call the Citi Employee Services North America Service Center at **1-469-220-9600**. 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.
Plan sponsor	Citigroup Inc. 750 Washington Blvd., 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.
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	Citigroup Inc. General Counsel HR 1 Court Square, 9th Floor Long Island City, NY 11120
Plan Year (for all Plans)	January 1 — December 31
Plan Names and Numbers	
Medical plans (self-funded ChoicePlans, High Deductible Health Plans-Basic and Premier, Hawaii Health Plan, Oxford Health Plans PPO and HMOs) including prescription drugs; medical clinics	Citigroup Health Benefit Plan Plan number 508
Dental plans	Citigroup Dental Benefit Plan Plan number 505
Vision plan	Citigroup Vision Benefit Plan Plan number 533
Health Care Spending Account/Limited Purpose Health Care Spending Account	Citigroup Flexible Benefits Plan Plan number 512
Employee Assistance Program	Citigroup Employee Assistance Program Plan number 521
Dependent Day Care Spending Account	Not applicable (DCSA is not an ERISA plan)
Basic Life insurance/AD&D and GUL/Supplemental AD&D	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**, and select the "health and welfare benefits" option

Administrative information

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.
• 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/AD&D insurance • GUL/Supplemental AD&D insurance • Business Travel Accident/Medical insurance	Basic Life/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/AD&D and Business Travel Accident coverage is provided through employer contributions; GUL/Supplemental AD&D is provided through employee contributions.
• Disability Plan	STD benefits are paid from the general assets of the Company. STD coverage is provided by Citigroup; no employee contributions are required. LTD benefits are fully insured. 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 benefit Plan, namely, those provisions of the Plan Documents that apply to the participant and are administered by that particular Claims Administrator. Since TRIP and DCSA are not subject to ERISA, neither the Claims Administrator listed below nor the Plans Administration Committee is a fiduciary under ERISA for these arrangements.

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** **Empire BlueCross BlueShield** P.O. Box 5072 Middletown, NY 10940-9072 **1-866-290-9098** (Empire BlueCross BlueShield is a trademark of Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. Empire does not underwrite or assume any financial risk for claims liability.)
High Deductible Health Plan-Basic and Premier	**Aetna** Citigroup Claims Division P.O. Box 981106 El Paso, TX 79998-1106 **1-800-545-5862** **Empire BlueCross BlueShield** P.O. Box 5072 Middletown, NY 10940-9072 **1-866-290-9098**
Health Savings Account (HSA)	ConnectYourCare **1-888-846-6414** **www.connectyourcare.com**
Oxford Health Plans PPO	Oxford Health Plans Attn: Claims Department P.O. Box 7082 Bridgeport, CT 06601-7082 **1-800-396-1909**
Hawaii Health Plan	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 **1-877-311-7845**
For fully insured HMOs	Call the HMO directly at the telephone number on your ID card.
PRESCRIPTION DRUG PROGRAM	
Paper claims address	Express Scripts Pharmacy P.O. Box 66566 St. Louis, MO 63166 **1-800-227-8338**
Home delivery service	Express Scripts Pharmacy P.O. Box 66566 St. Louis, MO 63166 **1-800-227-8338**
For Oxford PPO plans only	Medco by Mail Medco Health Solutions of Fairfield P.O. Box 747000 Cincinnati, OH 45274-7000 **1-800-905-0201**

Administrative information

DENTAL PLAN	
MetLife Preferred Dentist Program (PDP)	Metropolitan Life Insurance Co. MetLife Dental Claims Unit P.O. Box 981282 El Paso TX 79998-1282 **1-888-832-2576** To submit an appeal: Metropolitan Life Insurance Co. P.O. Box 14093 Lexington, KY 40512-4093
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™) P.O. Box 785040 Orlando, FL 32828-5040 Call YSA™ through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the health & welfare benefits option and then the option for spending accounts including transit and parking.
OTHER INSURANCE	
Basic Life	Metropolitan Life Insurance Co. 200 Park Ave. New York, NY 10166 **1-800-638-6420**
Group Universal Life	Metropolitan Life Insurance Co. Group Plan # 96731 P.O. Box 3016 Utica, NY 13504 **1-800-523-2894**
Accidental Death and Dismemberment and Supplemental AD&D	Life Insurance Company of North America (Cigna) 1601 Chestnut St. Philadelphia, PA 19192 **215-761-1000**
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**
Short-Term Disability Long-Term Disability	Metropolitan Life Insurance Co. P.O. Box 14590 Lexington, KY 40511-4590 **1-888-830-7380**
Long-Term Care	John Hancock Life Insurance Co. Group Long-Term Care, B-6 200 Berkeley St. Boston, MA 02117 **1-800-222-6814**

Glossary

Coinsurance: The portion of a covered expense that a participant pays after satisfying the deductible. For example, if a plan pays 90% of certain covered expenses, coinsurance for these expenses is 10%.

Covered expenses: Medical and related costs, incurred by participants, that qualify for reimbursement under the terms of the insurance contract.

Custodial care: Services and supplies furnished to a person mainly to help him or her in the activities of daily life. These services include board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard:

- To whom they are prescribed; or
- To whom they are recommended; or
- Who performs them.

Deductible: The amount of eligible expenses the participant and each covered dependent must pay each calendar year before a plan begins to pay benefits.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A U.S. law mandating that anyone belonging to a group health insurance plan must be allowed to purchase health insurance within an interval of time beginning when the previous coverage is lost.

The law protects employees — especially those with long-term health conditions who may be reluctant to leave jobs because they are afraid that pre-existing condition clauses will limit coverage of any such conditions under a new insurance plan — from losing health insurance due to a change in employment status. See "Notice of HIPAA Privacy Practices" in the Administrative Information section.

Maximum allowed amount (MAA): Any charge that, for services rendered by or on behalf of a non-network physician, does not exceed the amount determined by the Claims Administrator in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Claims Administrator by comparing the actual charge for the service or supply with the prevailing charges made for it. The Claims Administrator determines the prevailing charge by taking into account all pertinent factors including:

- The complexity of the service;
- The range of services provided; and
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

Medically necessary: A service or supply is considered medically necessary if it is a generally accepted health care practice and is required to treat a condition, as determined by the Claims Administrator. No benefit will be paid for services that are not considered medically necessary.

Network provider: A health care provider on a list of providers preselected by the insurer. The insurer will offer discounted coinsurance or co-payments, to a plan member to utilize in-network providers and facilities.

Non-occupational disease: A non-occupational disease is a disease that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from a disease that does.

A disease will be deemed non-occupational regardless of the cause if proof is furnished that the person:

- Is covered under any type of Workers' Compensation law; and
- Is not covered for that disease under such law.

Non-occupational injury: A non-occupational injury is an accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury that does.

Notification: A requirement that a participant calls his or her health plan to coordinate any inpatient surgery, hospitalization, and certain outpatient diagnostic/surgical procedures. Notification helps ensure that the participant obtains the most appropriate care for his or her condition in the most appropriate setting. Call your Plan for more information.

Out-of-pocket maximum: Total payments (deductibles and coinsurance) toward eligible expenses that a covered person pays for himself or herself and/or dependents as defined by the contract.

Once the maximum out-of-pocket amount has been met, the Plan will pay 100% of maximum allowed amount (MAA) charges. If the expenses incurred are higher than the MAA amount, the individual receiving the service is responsible for paying the difference even if the out-of-pocket maximum has been reached.

Precertification: A requirement that a participant calls his or her health Plan before seeking certain treatment. The Plan will:

- Help the participant and his/her health care provider determine the best course of treatment based on the diagnosis and acceptable medical practice; and
- Determine whether certain covered services and supplies are medically necessary.

Obtaining an authorization means that the insurer is obligated to pay for the service, assuming it matches what was authorized.

No benefit will be paid for services that are not considered medically necessary.

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

Preventive care: Routine care exams based on guidelines from the American Medical Association, the United States Preventive Care Task Force, the Advisory Committee on Immunization Practices that has been adopted by Director of the Centers for Disease Control and Prevention, the Comprehensive Guidelines Supported by the Health Resources and Services Administration and doctor recommendations. Covered expenses include routine physical exams (including well-woman and well-child exams), routine cancer screenings, and immunizations. See "Preventive care" in the *Health Care Benefits* section.

Wellness services: Charges for routine care exams based on guidelines from the American Medical Association and doctor recommendations. Covered expenses include, but are not limited to, routine physical exams (including well-woman and well-child exams), cancer screenings, and immunizations.

Additional medical coverage definitions

The following definitions apply to benefits provided under the Plan, unless clearly indicated otherwise.

Accredited school or college: An accredited secondary school, junior college, college, or university or a state or federally accredited trade or vocational school.

Ambulatory surgical center: A specialized facility established, equipped, operated, and staffed primarily to perform surgical procedures and that fully meets one of the following two tests:

- It is licensed as an ambulatory surgical center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all of the following requirements:
  - It is operated under the supervision of a licensed doctor of medicine (MD) or doctor of osteopathy (DO) who devotes full time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area;
  - In all cases, except those requiring only local infiltration anesthetics, it requires that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure;
  - It provides at least one operating room and at least one post-anesthesia recovery room;
  - It is equipped to perform diagnostic X-ray and laboratory exams or has arranged to obtain these services;
  - It has trained personnel and necessary equipment to handle emergency situations;
  - It has immediate access to a blood bank or blood supplies;

  - It provides the full-time services of one or more registered nurses (RN) for patient care in the operating rooms and in the post-anesthesia recovery room; and
  - It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative exam report, medical history and laboratory tests and/or X-rays, an operative report, and a discharge summary.

An ambulatory surgical center that is part of a hospital, as defined herein, will be considered an ambulatory surgical center for the purposes of the Plan.

Birth center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and that fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- It meets all of the following requirements:
  - It is operated and equipped in accordance with any applicable state law;
  - It is equipped to perform routine diagnostic and laboratory exam, such as hematocrit and urinalysis, for glucose, protein, bacteria, and specific gravity;
  - It has available, to handle foreseeable emergencies, trained personnel and necessary equipment, including, but not limited to, oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders;
  - It is operated under the full-time supervision of a licensed doctor of medicine (MD), doctor of osteopathy (DO), or registered nurse (RN);
  - It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications;
  - It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal exam, any laboratory or diagnostic tests, and a postpartum summary; and
  - It is expected to discharge or transfer patients within 24 hours following delivery unless medically necessary.

A birth center that is part of a hospital, as defined herein, will be considered a birth center for the purposes of the Plan.

Brand-name drug: A drug that is under patent by its original innovator or marketer.

Calendar year: January 1 through December 31 of the same year. For new enrollees, the calendar year is the effective date of their enrollment through December 31 of the same year, unless otherwise provided in the annual enrollment materials.

Chiropractic care: Skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a physician to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column. The following are not considered to be chiropractic care: Chiropractic appliances, services related to the diagnosis and treatment of jaw joint problems such as temporomandibular joint (TMJ) syndrome or craniomandibular disorders or services for treatment of strictly non-neuromusculoskeletal disorders.

Claims Administrator: Aetna, Empire BlueCross BlueShield, Oxford PPO Health Plans, UnitedHealthcare, and Express Scripts and any other party designated as a claims fiduciary pursuant to a contractual relationship and as authorized by the Plans Administration Committee of Citigroup Inc. The Claims Administrator does not insure the benefits described in this document.

Comprehensive outpatient rehabilitation facility: A facility that is primarily engaged in providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured or sick persons and that fully meets one of the following two tests:

- It is approved by Medicare as a comprehensive outpatient rehabilitation facility; or
- It meets all of the following tests:
  - It provides at least the following comprehensive outpatient rehabilitation services:
    - Services of physicians who are available at the facility on a full- or part-time basis;
    - Physical therapy; and
    - Social or psychological services;
  - It has policies established by a group of professional personnel (associated with the facility), including one or more physicians to govern the comprehensive outpatient rehabilitation services it furnishes and provides for the carrying out of such policies by a full- or part-time physician;
  - It has a requirement that every patient must be under the care of a physician; and
  - It is established and operates in accordance with the applicable licensing and other laws.

Cosmetic surgery: Medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns, or disfigurements and teeth whitening.

Covered family members or covered person: The employee and the employee's legal spouse (same or opposite sex) and/or dependent children, or qualified domestic partner/civil union partner who are covered under the Plan.

Designated transplant facility: A facility designated by the Claims Administrator to render medically necessary covered services and supplies for qualified procedures under the Plan.

Emergency care: Medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain. The symptoms must be severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's health would be placed in serious jeopardy;
- Bodily function would be seriously impaired; and
- There would be serious dysfunction of a bodily organ or part.

Emergency care includes immediate mental health and chemical dependency treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

ERISA: The Employee Retirement Income Security Act of 1974, as amended.

Experimental, investigational, or unproven services: Medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by any institutional review board for the proposed use;
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in FDA regulations, regardless of whether the trial is actually subject to FDA oversight; and
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Claims Administrator, in its judgment, may deem an experimental, investigational, or unproven service covered under the Plan for treating a life-threatening sickness or condition if it is determined by the Claims Administrator that the experimental, investigational, or unproven service at the time of the determination:

- Is proven to be safe with promising efficacy;
- Is provided in a clinically controlled research setting; and
- Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For purposes of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

Fiduciary: A person who exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan. The "named fiduciary" for the Plan is the Plans Administration Committee of Citigroup Inc., except to the extent fiduciary authority has been delegated by this document or otherwise to Claims Administrators or others.

Generic drug: Equivalent medications that contains the same active ingredient and are subject to the same rigid FDA standards for quality, strength, and purity as their brand-name equivalents. Generic drugs are less expensive than brand-name drugs.

Home health care agency: An agency or organization that provides a program of home health care and meets one of the following three tests:

- It is approved under Medicare;
- It is established and operated in accordance with the applicable licensing and other laws; or
- It meets all of the following tests:
  - Its primary purpose is to provide a home health care delivery system bringing supportive services to the home;
  - It has a full-time administrator;
  - It maintains written records of services provided to the patient;
  - Its staff includes at least one registered nurse (RN) or it has nursing care by a RN available; and
  - Its employees are bonded, and it maintains malpractice insurance.

Hospice: An agency that provides counseling and incidental medical services for a terminally ill individual. Room and board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a hospice;
- It is licensed in accordance with any applicable state laws; or
- It meets the following criteria:
  - It provides 24/7 service;
  - It is under the direct supervision of a duly qualified physician;
  - It has a nurse coordinator who is a RN with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients;
  - The main purpose of the agency is to provide hospice services;
  - It has a full-time administrator;
  - It maintains written records of services given to the patient; and
  - It maintains malpractice insurance coverage.

A hospice that is part of a hospital will be considered a hospice for purposes of the Plan.

Hospital: An institution engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and fully meets one of the following three tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations;
- It is approved by Medicare as a hospital; or
- It meets all of the following tests:
  - It maintains, on the premises, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians;
  - It continuously provides, on the premises, 24/7 nursing service by or under the supervision of registered graduate nurses; and
  - It is operated continuously with organized facilities for operative surgery on the premises.

Injury: An accidental physical injury to the body caused by unexpected external means.

Intensive care unit: A separate, clearly designated service area maintained within a hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has facilities for special nursing care not available in regular rooms and wards of the hospital, special life-saving equipment that is immediately available at all times, at least two beds for the accommodation of the critically ill, and at least one RN in continuous and constant attendance 24/7.

Licensed counselor: A person who specializes in mental health and chemical dependency treatment and is licensed as a Licensed Clinical Social Worker (LCSW) by the appropriate authority.

Lifetime: A word appearing in the Plan in reference to benefit maximums and limitations. Lifetime is understood to mean the period of time in which a participant and his or her eligible dependents are covered under the Plan. Under no circumstances does lifetime mean during the entire lifetime of the covered individual, unless covered by the plan at date of death.

Medically necessary or medical necessity: Health care services and supplies that are determined by the Claims Administrator to be medically appropriate and:

- Necessary to meet the basic health needs of the covered person;
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply;
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Plan;
- Consistent with the diagnosis of the condition;
- Required for reasons other than the convenience of the covered person or his or her physician;
- Must be provided by a physician, hospital, or other covered provider under the Plan;
- With regard to an inpatient, it must mean the patient's illness or injury requires that the service or supply cannot be safely provided to that person on an outpatient basis;
- It must not be primarily scholastic, vocational training, educational or developmental in nature or experimental or investigational;
- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy:
    - For treating a life-threatening sickness or condition;
    - In a clinically controlled research setting; and
    - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, mental illness, or pregnancy does not mean that it is medically necessary as defined above. The definition of medically necessary used in this document relates only to coverage and differs from the way in which a physician engaged in the practice of medicine may define medically necessary. The Plans Administration Committee may delegate the discretionary authority to determine medical necessity under the Plans. No benefit will be paid for services that are not considered medically necessary.

Medicare: The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act.

Mental health and chemical dependency treatment: Treatment for both of the following:

- Any sickness identified in the current edition of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM), including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause; and
- Any sickness for which the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

All inpatient services, including room and board, given by a mental health facility or area of a hospital that provides mental health or substance abuse treatment for a sickness identified in the DSM, are considered mental health and chemical dependency treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the sickness that is identified in the DSM is considered mental health and chemical dependency treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered mental health and chemical dependency treatment.

Prescription drugs are not considered mental health and chemical dependency treatment.

Morbid obesity: A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent body mass index (BMI) tables for a person of the same height, age, and mobility as the covered person. For **Aetna and Empire Plans**, the BMI is greater than 40 kilograms per meter squared or equal to or greater than 35 kilograms per meter squared with a co-morbid medical condition, including hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

Network pharmacy: A registered and licensed pharmacy, including a mail-order pharmacy that participates in the network.

Network provider: A provider that participates in the health plan network you enrolled in.

Non-preferred brand-name drug: A brand-name drug that is not a formulary drug. See the definition of preferred brand-name drug.

Nurse-midwife: A person licensed or certified to practice as a nurse-midwife and who fulfills both of these requirements:

- Licensed by a board of nursing as a RN; and
- Has completed a program approved by the state for the preparation of nurse-midwives.

Nurse-practitioner: A person who is licensed or certified to practice as a nurse-practitioner and fulfills both of these requirements:

- Licensed by a board of nursing as a RN; and
- Has completed a program approved by the state for the preparation of nurse-practitioners.

Occupational therapy: Services that improve the patient's ability to perform tasks required for independent functioning when the function has been temporarily lost and can be restored.

Other services and supplies: Services and supplies furnished to the individual and required for treatment, other than the professional services of any physician and any private-duty or special nursing services (including intensive nursing care by whatever name called).

Out-of-network hospital: A hospital (as defined) that does not participate in the Plan's network you enrolled in.

Out-of-network pharmacy: A pharmacy other than an Express Scripts network pharmacy.

Out-of-network provider: A provider that does not participate in the Plan's network you enrolled in.

Outpatient care: Treatment including services, supplies, and medicines provided and used at a hospital under the direction of a physician to a person not admitted as a registered bed patient or services rendered in a physician's office, laboratory or X-ray facility, an ambulatory surgical center, or the patient's home.

Physical therapy: Services that are designed to restore an individual to a level of function present prior to an illness or accidental injury.

Physician: A legally qualified and licensed:

- Doctor of Medicine (MD);
- Doctor of Chiropody (DPM; DSC);
- Doctor of Chiropractic (DC);
- Doctor of Dental Surgery (DDS);
- Doctor of Medical Dentistry (DMD);
- Doctor of Osteopathy (DO); or
- Doctor of Podiatry (DPM).

Care provided by Christian Science practitioners is covered as an out-of-network benefit under ChoicePlan 500.

Plan: The Citigroup Health Benefit Plan, as amended from time to time. For ERISA reporting purposes, the Plan number is 508.

Plan Administrator: The Plans Administration Committee of Citigroup Inc.

Plan year: January 1 - December 31.

Preadmission tests: Tests performed on a covered person in a hospital before confinement as a resident inpatient provided the tests meet all of the following requirements:

- The tests are related to the performance of scheduled surgery;
- The tests have been ordered by a physician after a condition requiring surgery has been diagnosed and hospital admission for surgery has been requested by the physician and confirmed by the hospital; and
- The covered person is subsequently admitted to the hospital, or the confinement is canceled or postponed because a hospital bed is unavailable or because there is a change in the covered person's condition that precludes the surgery.

Preferred brand-name drug: A drug that is prescribed from a list of medications preferred for its clinical effectiveness and opportunity to help contain health care costs. Preferred drugs are part of an incentive program to help control the costs of care and are frequently called formulary drugs.

Prescription drugs: Any drugs that cannot be dispensed without a doctor's prescription. The following will be considered prescription drugs:

- Federal legend drugs. This is any medicinal substance that the federal Food, Drug, and Cosmetic Act requires to be labeled "Caution — federal law prohibits dispensing without prescription";
- Drugs that require a prescription under state law but not under federal law;
- Compound drugs having more than one ingredient; at least one of the ingredients has to be a federal legend drug or a drug that requires a prescription under state law;
- Injectable insulin; and
- Needles and syringes.

Primary care physician (PCP): A physician in general practice or who specializes in pediatrics, family practice, or internal medicine who has agreed with the Claims Administrator to act as the entry point to the health care delivery system and may coordinate the member's care. The PCP is not an agent or employee of the Claims Administrator or Citigroup Inc.

Psychiatrist: A physician who specializes in mental, emotional, or behavioral disorders.

Psychologist: A person who specializes in clinical psychology and fulfills one of these requirements:

- Licensed or certified as a psychologist or
- A member or fellow of the American Psychological Association, if there is no government licensure or certification required.

Rehabilitation facility: A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

Room and board: Room, board, general-duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the hospital as a condition of occupancy of the class of accommodations occupied but not including professional services of physicians or special nursing services rendered outside of an intensive care unit by whatever name called.

Self-insured or self-funded plan: A plan in which no insurance company or service plan collects premiums and assumes risk.

Sickness: Bodily disorder or disease. The term "sickness" used in connection with newborn children will include congenital defects and birth abnormalities, including premature births.

Skilled nursing facility: A facility, if approved by Medicare as a skilled nursing facility, is covered by this Plan. If not approved by Medicare, the facility may be covered if it meets the following tests:

- It is operated under the applicable licensing and other laws;
- It is under the supervision of a licensed physician or RN who is devoting full time to supervision;
- It is regularly engaged in providing room and board and continuously provides 24/7 skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or sickness;

- It maintains a daily medical record of each patient who is under the care of a licensed physician;
- It is authorized to administer medication to patients on the order of a licensed physician; and
- It is not, other than incidentally, a home for the aged, the blind or the deaf; a hotel; a domiciliary care home, a maternity home; or a home for alcoholics or drug addicts or the mentally ill.

A skilled nursing facility that is part of a hospital will be considered a skilled nursing facility for the purposes of the Plan.

Treatment center: A facility that provides a program of effective mental health and chemical dependency treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law;
- It provides a program of treatment approved by a physician and the Claims Administrator;
- It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient;
- It provides at least the following basic services:
  - Room and board (to the extent that this Plan provides inpatient benefits at a Treatment Center);
  - Evaluation and diagnosis;
  - Counseling by a licensed provider; and
  - Referral and orientation to specialized community resources.

Treatment centers that qualify as a hospital are covered as a hospital and not as a treatment center.

Urgent care: Conditions or services that are non-preventive or non-routine and are needed to prevent the serious deterioration of a member's health following an unforeseen illness, injury, or condition. Urgent care includes conditions that could not be adequately managed without immediate care or treatment, but do not require the level of care provided in the emergency room.

Urgent care facility/center

- **Aetna:** Urgent care is the delivery of ambulatory care in a facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room. Often urgent care centers are not open on a continuous basis, unlike a hospital emergency room, which would be open at all times.
- **Empire BlueCross BlueShield:** A facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.
- **Oxford:** A medical care facility that provides care for a condition that needs immediate attention to minimize the severity and prevent complications but is not a medical emergency. Urgent care facilities are covered in or out of the service area. Precertification is not required for Plan urgent care treatment when provided by facilities that are specifically contracted by Oxford as urgent care providers. Members should contact the number on their ID cards for instructions.

Utilization review: A review and determination as to the medical necessity of services and supplies.

For more information

Telephone

ConnectOne: **1-800-881-3938**

- From outside the United States and Puerto Rico: Call the Citi Employee Services (CES) North America Service Center at **1-469-220-9600**. Press 1 when prompted.
- If you use a TDD: Call the Telecommunications Relay Service at 711. Then call ConnectOne at **1-800-881-3938**.

Web

If you have intranet or Internet access, you can review many of your benefits and obtain benefits information and enroll through the Total Comp @ Citi website at **www.totalcomponline.com**, available from the Citi intranet and the Internet. From the "Welcome" page, click on the Health and Welfare Benefits link that appears under "Health & Welfare Benefits".

For information about these topics, plans, or programs	Contact	Telephone number/website
Beneficiary designations for: • Basic Life/AD&D, Citigroup 401(k) Plan, Citibuilder 401(k) Plan for Puerto Rico, and Citigroup Pension Plan	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu, choose the "pension and retiree health and welfare" option. Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Beneficiary designations" under "Health and welfare benefits" or "Retirement and savings."
• Group Universal Life (GUL)/Supplemental AD&D insurance	MetLife (GUL)	**1-800-523-2894** Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Dental/Disability/Group Universal Life (GUL)."
Benefits (health and welfare)	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu, choose the "health and welfare benefits" option. Visit Your Benefits Resources™ through Total Comp @ Citi at **www.totalcomponline.com** and click on "Health and welfare benefits."
Citi Live Well Program	Health Advocate and ActiveHealth	**1-866-449-9933** Visit the **Citi Live Well Portal** through Total Comp @ Citi at **www.totalcomponline.com** or to **www.activehealthportal.net/citi/**.
COBRA coverage (Consolidated Omnibus Budget Reconciliation Act)	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu choose the "health and welfare benefits" option. Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Health and welfare benefits."
Dental Plans	Cigna Dental HMO	**1-800-244-6224** **www.mycigna.com** (participants only)
	MetLife Preferred Dentist Program (PDP)	**1-888-832-2576** **www.metlife.com/dental**
Dependent Day Care Spending Account (DSCA)	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu choose the "health and welfare benefits" option. Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Spending accounts."

For more information

For information about these topics, plans, or programs	Contact	Telephone number/website
Disability To report a disability and for information about the Short-Term Disability (STD) and Long-Term Disability (LTD) Plan and the Family and Medical Leave Act (FMLA) You can also report a disability to MetLife directly by phone or online.	MetLife	Call ConnectOne. From the ConnectOne main menu choose the "Disability" option. **1-888-830-7380** Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Dental/Disability/Group Universal Life (GUL)."
Employee Assistance Program (EAP)	Harris Rothenberg	**1-800-952-1245** **1-800-256-1604** (TDD) Outside the United States, call collect to **212-422-8847**. **www.hriworld.com** Password: for_you
General information Eligibility, enrollment, general information about health and welfare benefits, status changes, and continuing coverage after a termination of employment or while on a leave of absence	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu, choose the "health and welfare benefits" option. Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Health and welfare benefits."
Group Universal Life (GUL)/Supplemental AD&D insurance	MetLife (GUL)	**1-800-523-2894** Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Dental/Disability/Group Universal Life (GUL)."
Health Care Spending Account (HSCA)	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu choose the "health and welfare benefits" option. Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Spending accounts".
Health Savings Account (HSA)	ConnectYourCare	**1-888-846-6414** **www.connectyourcare.com**
HIPAA Certificate of Creditable Coverage	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu choose the "health and welfare benefits" option.
HMOs	Various Sources	Refer to the list under "Health care plans offered by Citi" in the Steps to Enrollment at **https://www.benefitsbookoline.com/enrollment/plans.html**.
Insurance • Basic Life/Accidental Death and Dismemberment (AD&D) insurance • Business Travel Accident/Medical insurance	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu, choose the "health and welfare benefits" option. Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Health and welfare benefits".
Limited Purpose Health Care Spending Account (LPSA)	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu choose the "health and welfare benefits" option. Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Spending accounts".
Long-Term Care (LTC) insurance	John Hancock Life Insurance Co.	**1-800-222-6814** **http://groupltc.jhancock.com** User name: groupltc Password: mybenefit

For information about these topics, plans, or programs	Contact	Telephone number/website
Medical (non-HMOs plans)	Aetna (ChoicePlan 500, High Deductible Health Plan-Basic and Premier)	**1-800-545-5862** **1-800-628-3323** (TDD) **www.aetna.com**
	Empire BlueCross BlueShield (ChoicePlan 500, High Deductible Health Plan-Basic and Premier)	**1-866-290-9098** **www.empireblue.com/citi**
	Oxford Health Plans PPO (CT, NJ, NY tri-state area only)	**1-800-760-4566** (if you are not currently participating in the Plans) or **1-800-396-1909** (if you are currently participating in the Plans)
	UnitedHealthcare (Hawaii Health Plan)	**1-877-311-7845** **1-800-842-0090** (TDD) **www.myuhc.com/groups/citi** (participants only)
Prescription Drug Program (ChoicePlan 500, High Deductible Health Plan-Basic and Premier, and Hawaii Health Plan) To refill an Express Scripts Home Delivery prescription using the automated system; for instructions on how your doctor can fax your prescription to the Express Scripts Pharmacy; to arrange credit card payment for all your Home Delivery pharmacy service orders; For prior authorization	Express Scripts	**1-800-227-8338** **1-800-899-2114** (TDD) **https://member.express-scripts.com/preview/citigroup2012** (public site for Citi employees) **www.express-scripts.com** (participants only) **1-800-224-5498**
Prescription Drug Program (for Oxford PPO plan only)	Medco	**http://www.medcohealth.com**
Transportation Reimbursement Incentive Program (TRIP)	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu choose the "health and welfare benefits" option. Visit Total Comp @ Citi at **www.totalcomponline.com** and click on "Spending accounts".
Vision Plan For Plan information and laser vision correction providers/arrangements	Aetna	**1-877-787-5354** **www.AetnaVisionOE.com/avp1** **Members: www.aetnavision.com**
Workers' Compensation	Constitution State Services Co.	**1-800-243-2490**
Work/Life Program	Health Advocate	**1-866-449-9933,** select option 2 **www.healthadvocate.com/citiworklife** (no password required)

For more information

CITI ON-SITE MEDICAL CLINICS	
Jacksonville, FL	
14000 Citicards Way	**904-954-8262**
Medical emergency number	**904-954-8911**
Tampa, FL	
Citibank Center, Building C	**813-604-4333**
Medical emergency number	**611**
Warren, NJ	
283 King George Road, Building C	**908-563-5401**
Medical emergency number	**908-563-5412**
New York City	
399 Park Ave., Level A/Zone 11, New York City	**212-559-3981**
Medical emergency number	**212-559-4357** (5-HELP)
111 Wall St., 23rd Floor, Zone 12, New York City	**212-657-7478**
Medical emergency number	**212-657-4357** (6-HELP)
388 Greenwich St., 5th Floor, New York City	**212-816-1460**
Medical emergency number	**212-816-1300**
One Court Square, 9th Floor, Zone 7, Long Island City	**718-248-2709**
Medical emergency number	**718-248-4357** (4-HELP)
San Antonio, TX	
100 Citibank Drive, Building 3	**210-357-8275**

CITI HEALTH AND FITNESS CENTERS	
Florida	
14000 Citicards Way, Bldg. A, Jacksonville	**904-954-2630**
3800 Citibank Center, Tampa	**813-604-4348**
Warren, NJ	
283 King George Road	**908-563-9534**
New York City	
388 Greenwich St., 5th Floor, New York City	**212-816-0523**
One Court Square, 5th Floor, Long Island City	**718-248-9571**
Getzville, NY	
580 CrossPoint Parkway	**716-730-7926**
Texas	
100 Citibank Drive, San Antonio	**210-677-6991**
6400 Las Colinas Blvd, Irving	**972-653-8890**
3950 Regent Blvd, Irving	**469-220-4177**
Blue Ash, OH	
9997 Carver Rd	**574-993-1032**
Meridian, ID	
2200 South Cobalt Way	**208-822-2331**
Elk Grove Village, IL	
50 Northwest Point Blvd	**224-222-2509**
Florence, KY	
4600 Houston Rd	**859-283-3882**
McLeansville, NC	
5450 Millstream Road	**336-522-1702**
Hagerstown, MD	
14700 Citicorp Drive	**301-714-5738**
Kansas City, MO	
7920 NW 110th Street	**816-420-1275**
Las Vegas, NV	
8725 W. Sahara Blvd.	**702-797-4855**
Sioux Falls, SD	
701 East 60th Street N.	**605-331-1922**