



Health and Welfare
Summary Plan Description

For coverage effective January 1, 2011

Citi *for you.*
HEALTH

Summary Plan Description for Health and Welfare

This is the Summary Plan Description (“SPD”) for the Citi health and welfare benefit plans. This SPD describes the health and welfare benefits available effective January 1, 2011.

The SPD provides general information that will help you understand how the plans work so you can make the most of your benefits.

More details

If you do not find the information you want in the SPD, additional details about the Citi benefits are available at www.benefitsbookonline.com, available from the Citi intranet and the Internet.

In the SPD

The SPD is composed of:

- About this SPD
- 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 Web access?

If you do not have access to the Citi intranet or the Internet, you can request a copy of the SPD 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.

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About this SPD

This document describes health and welfare benefits for certain U.S. employees of Citigroup Inc. (“Citigroup” or “Citi”) and its participating companies (collectively the “Company”) as in effect January 1, 2011. The benefits described in this document 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 (a UnitedHealthcare company) PPO;
 - UnitedHealthcare Hawaii Health Plan;
 - Citigroup Prescription Drug Program administered by Express Scripts; and
 - On-site medical clinics.
- Citigroup Dental Benefit Plan
 - CIGNA Dental HMO; and
 - MetLife Preferred Dentist Program (PDP).
- Citigroup Vision Plan.
- Citigroup Employee Assistance 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.

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 about your prescription drug coverage. See the Health Care Benefits section for details.

This summary 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 above (the “Citigroup Health and Welfare Plans” or collectively the “Plans” and individually a “Plan”). This document is intended to be only a summary of the major highlights of the Plans. Details can be found in the Plan documents, which are available at the Benefits Handbook website at www.benefitsbookonline.com.

If you do not have access to the Citi intranet or the Internet, you can request a copy of the Plan documents 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.

The Plans are subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), with the exception of DCSA and TRIP. This document serves as a summary plan description (SPD) for the Plans subject to ERISA. To the extent applicable, the Plans will be interpreted and administered in accordance with ERISA, the Internal Revenue Code of 1986, as amended (the “Code”), and applicable law.

No general explanation can adequately give you all the details of the Plans. This general explanation does not change, expand, or otherwise interpret the terms of the Plans. If there is any conflict between these summaries, or any written or oral communication by an individual representing the Plans, and the Plan documents (including any related insurance contracts), the terms of the Plan documents — including any related insurance contracts as interpreted in the sole discretion of the Plan

About this SPD

Administrator — will be followed in determining your rights and benefits under the Plans.

Citi may change or discontinue the Plans, or any part thereof, at any time for any reason.

This document is neither a contract nor a guarantee of continued employment for any definite period of time. Your employment is always on an at-will basis.

This document 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.

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the covered person and shall not constitute an assignment of benefits under the Plan.

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

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: business travel accident coverage 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;
- **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, if your total compensation is less than or equal to \$50,000.99.

Additional benefits to consider that require active enrollment:

- Benefits paid with pretax dollars:
 - Medical;
 - 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); see "Enrolling in TRIP," immediately below, for additional information.
- 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 and Participation

Enrolling in TRIP

The Transportation Reimbursement Incentive Program (TRIP) allows you to purchase transit/parking passes to use while traveling to and from work. You can enroll any time. *TRIP elections are not part of annual enrollment.*

Eligibility 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 hours or more 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 or
- You are employed by a Participating Employer.

Note: If you are on an approved leave of absence, you are eligible to enroll in Citi benefits (other than the spending accounts, GUL, and Long-Term Care insurance); other enrollment restrictions may apply.

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.

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 are being 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 noted above.

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.

Extension of dependent coverage to age 26

Adult children of employees who were denied coverage or whose coverage ended, or dependents who were not eligible for coverage due to their age or student status, may be eligible for health care coverage under the

Citigroup Health Benefit Plan (the “Plan”) effective January 1, 2011.

You may refer to your annual enrollment materials or the “For dependents” section, below, for the updated description of dependent eligibility.

For dependents

Effective January 1, 2011 employees hired on or after January 1, 2011, or add a new dependent on or after January 1, 2011, regardless of your date of hire, 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 new hire dependent/new 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:

- 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 can cover a spouse/civil union partner or a domestic partner but not both;

Note: Because civil union partnerships are recognized by certain states and generally provide the same protection as marriage, civil union partnerships are not subject to the domestic partnership certification process. However, under federal law, civil union partnerships are subject to the same tax treatment as domestic partnerships. Alternatively, if your domestic partnership is registered in any state or under any local government authority authorized to provide such registration, documentation of such registration will be accepted as proof of your domestic partnership, without satisfying the listed requirements for non-registered domestic partners.

- Your domestic partner;
- Your domestic partner’s eligible dependents;
- Your children up to age 26 who are:
 - Your biological children;

- Your legally adopted children;
- 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 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 benefits.

Note: Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age. However, for some HMOs, coverage ends on the last day of the month in which the child reaches the maximum age. For more specific information, contact your HMO directly. For more information on when coverage ends, see “When coverage ends” beginning on page 16.

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 SPD.

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.

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 both of you will be required to either 1) complete a domestic partner affidavit stating that you both meet the criteria below or 2) if your domestic partnership is registered, please provide a copy

Eligibility and Participation

of the certificate. The criteria if you are not registered are:

- 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 were married, 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 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. If your domestic partnership ends, you and your domestic partner must attest to 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.

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 16.

Enrollment

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.

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.

As a new hire or newly eligible for benefits

As a new 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.* If you do not enroll, you will have the core coverage, described in the "Benefits overview" section on page 5.

Medical, dental, and/or vision coverage

You must enroll during your initial enrollment period to have coverage.

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.
- If you missed your enrollment deadline and later decided you want Citi coverage but do not want to wait until annual enrollment the following year, you may enroll in either one of the High Deductible Health Plans-Basic or Premier, MetLife Preferred Dentist Program (PDP), and/or the Vision Plan for the remainder of the calendar year. You must speak with a Citi Benefits Center representative to enroll. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" options.

Long Term Disability coverage

Effective January 1, 2011, you will automatically be enrolled in LTD coverage, if as a new hire, your total compensation exceeds \$50,000.99 or if your total compensation, for benefits purposes in the 2011 plan year and beyond, increases to \$50,001 or above.

If you do not want LTD coverage, you may contact the Benefits Center to decline coverage. If, at a later date however, you decide to enroll in LTD coverage, you will be asked to provide evidence of good health before coverage can be approved.

During annual enrollment

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.

Eligibility and Participation

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.

Long-Term Disability coverage

Company-paid LTD coverage is available only to employees whose total compensation is less than or equal to \$50,001.

If your total compensation increases to \$50,001 or above in any year, you will be automatically enrolled in LTD coverage for the following year and applicable contributions will be withheld from your pay. (Evidence of good health will not be required at this time.)

If you do not want LTD coverage, you must choose “no coverage” when you make your elections during annual enrollment. However, you will have until March 30 of the following year to decline coverage and receive a refund on any premiums you have paid. After this date, you can still decline coverage, but you will not receive a refund of your premiums.

If, at a later date, you decide to enroll in LTD coverage, you will be asked to provide evidence of good health before coverage can be approved.

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 home 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. If you enroll online during annual enrollment, a confirmation

statement will be mailed to your home 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 default statement will be mailed to your home after your enrollment period ends. The default 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. From the “Quick Links” page, click on “Your Benefits Resources™.” You also can 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 the Citi intranet at www.citigroup.net/human_resources/form.htm and return it to MetLife at the address on the form. You

also can enroll or change your beneficiary at www.metlife.com/mybenefits. Your beneficiary for GUL insurance also is 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.

Total compensation and your benefits

Total compensation is used to determine:

- Medical contributions;
- LTD benefits and, where applicable, LTD contributions;
- Basic Life/AD&D insurance benefits;
- GUL/Supplemental AD&D insurance and costs;
- Eligibility for the DCSA subsidy;
- STD 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 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.

If you are enrolling during the annual enrollment period

If you are enrolling during the annual enrollment period for coverage effective January 1, 2011, your total compensation for purposes of benefits enrollment is made up of the following:

1. Annual base pay as of June 30, 2010;
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, 2009, will be used for the 2011 annual enrollment calculation;
3. Cash bonus (other than the cash portion of any annual discretionary 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, 2009, excluding the cash portion of the annual discretionary award package dated January 2009, will be used for the 2011 annual enrollment calculation;
4. Annual discretionary award/retention package dated in the year of enrollment includes, as applicable, cash bonus; Common Stock Equivalent (CSE1); Capital Accumulation Program (CAP) Award; Common Stock Equivalent 2 (CSE2); Common Stock Equivalent 3 (CSE3); Stock Incentive Awards (SINC); Stock Incentive Program Awards (SIPP); Deferred Cash Stock Units; and Deferred Cash Award. Annual discretionary award/retention award packages dated January 2010 will be used for the 2011 annual enrollment calculation;
5. Guaranteed bonus effective in 2010;
6. Short-Term Disability benefits paid from January 1, 2009-December 31, 2009, for employees paid on commissions only;
7. Salary stock paid on any of the following three days: November 30, 2009; December 30, 2009, or January 18, 2010; and
8. Long Term Restricted Stock (LTRs).

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 benefits

Citi offers benefits coverage to your certified unmarried domestic partner of the same or opposite sex. Citi also offers benefit coverage to your civil union partner.

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

- Medical,
- Dental;
- Vision;
- Health Care Spending Account, provided your domestic partner/civil union partner and his or her eligible children are considered tax dependents under Section 152 of the Code;
- Limited Purpose Health Care Spending Account, provided your domestic partner/civil union partner and his or her eligible children are considered tax dependents under Section 152 of the Code;
- GUL/Supplemental AD&D insurance for domestic partners/civil union partners and life insurance for children;
- Long-Term Care insurance.

You may enroll your domestic partner/civil union partner 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 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 for 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 are:

- 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 application forms. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" options.

Cost of civil union partner/domestic partner benefits

If your domestic partner/civil union partner and his or her children:

- **Qualify** as your dependents under Section 152 of the Code, your contributions for their medical, dental, and/or vision coverage will be deducted from your pay before taxes are withheld.
- **Do not qualify** as dependents under Section 152 of the Code, you will pay for their medical, dental, and/or vision care 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 in Citi coverage. This summary plan description 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.

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

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

If your civil union partner/domestic partner and his or her children qualify as dependents under Section 152 of the

Code, 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 benefits will affect your taxes.

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 and his/her dependent children qualify as dependents under Section 152 of the Code. If no certification is on file with Citi, the default is that the benefits are taxable.

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

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

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 will be treated as taxable income to you. This amount is known as imputed income, and you will be taxed on this amount.

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. 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.

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. 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 Section 152 dependent. 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

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" below.

Eligibility and Participation

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, change, 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 existing 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 the first, second, or third events below apply.)

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/civil union partner's/domestic partner's or other employer's plan;
6. The death of a spouse/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 for the 2011 plan year and thereafter increases such that you become ineligible for Basic Life/AD&D, this loss of coverage constitutes a qualified change in status for enrollment in Group Universal Life (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 currently 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 request coverage within 60 days of being determined eligible for premium assistance.

How to report a qualified change in status event

You have 31 days from the date of the event to report a qualified change in status event and, if applicable, make changes to 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. You will be sent a dependent verification package requesting that you send in a copy of the birth certificate. If proof is not submitted by the deadline in the package the child will be dropped from coverage.

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.

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.

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

- Call 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. From the "Quick Links" page, click on "Your Benefits Resources™."
- To enroll in Group Universal Life (GUL) insurance, call MetLife at 1-800-523-2894.

Change in Status Worksheet

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, at www.citigroup.net/human_resources/life_events.htm (intranet only).

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 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.*

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 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 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.

Eligibility and Participation

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 you to show 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 if 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:

- 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.

CIGNA administers the AD&D portion 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. You must be actively at work for coverage to be effective. Your eligible dependents must be not disabled on the date their coverage is to become effective. John Hancock 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 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, you die, or you otherwise cease to be eligible for coverage;
- 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 ends on the last day of the month in which your employment is terminated.

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 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; 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.
- The date defined in the dependent verification package if proof of eligibility is not received by the deadline.

You and your eligible covered dependents may be able to continue coverage under COBRA. See “COBRA” beginning on page 20.

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.

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 the end of the calendar year, whichever comes first.

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

Medical: Coverage will continue for 52 weeks, including the 13-week period of 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 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).

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 exceeded the maximum LTD benefit

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 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, which is described in the LTD plan document.

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, Medicare will become your primary medical coverage while benefits under the Citi plan become secondary.

Eligibility and Participation

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 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.

Coverage for surviving dependents

When an active employee dies, the surviving spouse, 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

Citi's COBRA administrator will send your dependents a COBRA notification package. For your dependents 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. See “COBRA” beginning on page 20.

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/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 differently.

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 dependents 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.

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 also may 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

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. 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

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.

Eligibility and Participation

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 on or after January 1, 2010, you are entitled to receive a taxable distribution of your Health Care Spending Account or Limited Purpose Spending Account 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.

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 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 (or 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 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;
2. The termination of your spouse's employment (for reasons other than your spouse's gross misconduct) or a reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse'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 also are 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 also is 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 given 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 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.

Eligibility and Participation

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

Early termination of COBRA

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.

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, the Plan may terminate your COBRA coverage.

COBRA and FMLA

A leave that qualified 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 dependent is covered by the Plan on the day before the leave begins (or you or your dependent 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 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 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.

Eligibility and Participation

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 also may 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

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 medical and 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 Plan documents.

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.
- **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.

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.

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

If you are actively employed and you or your eligible dependent is enrolled in Medicare and Citi coverage, generally the Citi Plan is primary.

How to file a claim

Most medical and dental benefits are paid directly to the providers. Listed below are the forms needed to claim benefits that are not paid directly. 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 the “Forms” section of the Citi intranet at www.citigroup.net/human_resources/form.htm Or Visit Your Benefits Resources™ through Total Comp @ Citi at www.totalcomponline.com . From the “Quick Links page, click on “Your Benefits Resources™.” You also can 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 ChoicePlan (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.	

Eligibility and Participation

Name of Plan	Name/form number and when to use the form	How to obtain a form
<i>MetLife Dental</i>	MetLife Dental Claim Form (Form 304) Use the form to file a claim for covered dental expenses.	Visit the "Forms" section of the Citi intranet at www.citigroup.net/human_resources/form.htm Or Visit Your Benefits Resources™ through Total Comp @ Citi at www.totalcomponline.com . From the "Quick Links" page, click on "Your Benefits Resources™." You also can go directly to http://resources.hewitt.com/citigroup .
<i>Express Scripts</i>	Express Scripts Prescription Drug Claim (Form 310) Use the form to file a claim for a 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 .
<i>Vision Plan</i>	Claim form to be reimbursed for out-of-network expenses.	Visit www.aetnavision.com .
<i>Health Care Spending Account (HCSA)</i>	If you do not use your Spending Account Reimbursement Card, you can file a claim using the HCSA Reimbursement Request Form (Form 316). Use the form to submit eligible health care claims for reimbursement.	Visit the "Forms" section of the Citi intranet at www.citigroup.net/human_resources/form.htm Or Visit Your Benefits Resources™ through Total Comp @ Citi at www.totalcomponline.com . From the "Quick Links" page, click on "Your Benefits Resources™." You also can go directly to http://resources.hewitt.com/citigroup .
<i>Limited Purpose Health Care Spending Account (LPSA)</i>	LPSA Reimbursement Request Form (Form 315) Use the form to submit eligible vision, dental, or preventive care health care claims for reimbursement.	
<i>Dependent Day Care Spending Account (DCSA)</i>	DCSA Reimbursement Request Form (Form 317) Use the form to submit eligible dependent care claims for reimbursement.	
<i>Transportation Reimbursement Incentive Program (TRIP)</i>	Not applicable.	

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.

Health Care Benefits

Your Citi health care benefits are composed of:

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

Medical

Administrator of the ChoicePlans and Preferred Provider Organization (PPO)

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.

Citi offers the following non-HMO Plans and fully insured HMOs:

Non-HMOs:

- ChoicePlan 500;
- Oxford Health Plans Preferred Provider Organization (PPO);
- High Deductible Health Plan-Basic;
- High Deductible Health Plan-Premier; and
- Hawaii Health Plan.

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).

The ChoicePlan is administered by Aetna and Empire BlueCross BlueShield throughout the United States. The ChoicePlan 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™, available from the “Quick Links” page of Total Comp @ Citi at www.totalcomponline.com, available from the Citi intranet and the Internet.

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)	
	<i>Network</i>	<i>Out of network</i>	<i>Network</i>	<i>Out of network</i>
Annual deductible (in and out of network combined)				
<i>Individual</i>	\$500	\$1,500	\$500	\$1,500
<i>Maximum per family</i>	\$1,000	\$3,000	\$1,000	\$3,000
Annual out-of-pocket maximum (includes deductible; in and out of network combined)				
<i>Individual</i>	\$3,000	\$6,000	\$3,000	\$6,000
<i>Maximum per family</i>	\$6,000	\$12,000	\$6,000	\$12,000
Lifetime maximum	None	None	None	None
Professional care (in office)				
<i>Doctor/primary care physician (PCP) visits</i>	90% after deductible	70% after deductible	90% after deductible	70% after deductible
<i>Specialist visits</i>	90% after deductible; 95% after deductible for Aetna Aexcel specialists	70% after deductible	90% after deductible	70% after deductible
Preventive care, subject to frequency limits				
<i>Well-adult visits and immunizations</i>	100%, no deductible	100%, no deductible up to \$250 maximum, then covered at 70%; immunizations covered at 70%, no deductible	100%, no deductible	100%, no deductible up to \$250 maximum, then covered at 70%; immunizations covered at 70% no deductible
<i>Well-child visits and immunizations</i>	100%, no deductible	100%, no deductible up to \$250 maximum, then covered at 70%; immunizations covered at 70%, no deductible	100%, no deductible	100%, no deductible up to \$250 maximum, then covered at 70%; immunizations covered at 70%, no deductible
<i>Routine cancer screenings (Pap test, mammogram, sigmoidoscopy, colonoscopy, PSA screening)</i>	100%, no deductible	100%, no deductible up to \$250 maximum, then covered at 70%	100%, no deductible	100%, no deductible up to \$250 maximum, then covered at 70%

		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
Hospital emergency room					
<i>No coverage in any medical option if not a true emergency</i>	\$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)	
Urgent care center					
	90% after deductible	90% after deductible	90% after deductible	90% after deductible	90% after deductible
Hospital inpatient and outpatient					
<i>Semiprivate room and board, doctor's charges, lab, and X-ray</i>	90% after deductible; precertification required for hospitalization and certain outpatient procedures	70% after deductible; precertification required for hospitalization and certain outpatient procedures	90% after deductible; precertification required for hospitalization and certain outpatient procedures	70% after deductible; precertification required for hospitalization and certain outpatient procedures	
Mental health and substance abuse					
<i>Inpatient</i>	90% after deductible, precertification required	70% after deductible, precertification required	90% after deductible, precertification required	70% after deductible, precertification required	
<i>Outpatient</i>	90% after deductible, precertification recommended	70% after deductible	90% after deductible, precertification recommended	70% after deductible	
Therapies					
Physical/speech/occupational therapy (all therapies combined): Limited to 60 visits a year for network and out of network combined (30 visits a year in 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	90% after deductible; 70% after deductible for approved visits over Plan limits	70% after deductible; 50% after deductible for approved visits over Plan limits	90% after deductible; 70% after deductible for approved visits over Plan limits	70% after deductible; 50% after deductible for approved visits over Plan limits	
<i>Chiropractic therapy:</i> limited to 20 visits per calendar year in and out of network combined.	90% after deductible	70% after deductible	90% after deductible	70% after deductible	

Medical

High Deductible Health Plan Administered by Aetna and Empire BlueCross Blue Shield					Hawaii Health Plan administered by UnitedHealthcare
	BASIC		PREMIER		
	Network	Out of network	Network	Out of network	
Annual deductible (in and out of network combined)					
<i>Individual</i>	\$2,100	\$3,100	\$1,200	\$2,400	\$200
<i>Maximum per family (no benefits will be paid to an individual until the family deductible has been met)</i>	\$4,200	\$6,200	\$2,400	\$4,800	\$600
	Includes prescription drug expenses	Includes prescription drug expenses	Includes prescription drug expenses	Includes prescription drug expenses	
Out-of-pocket maximum (includes deductible; in and out of network combined)					
<i>Individual</i>	\$5,000	\$7,500	\$2,500	\$5,000	\$1,000
<i>Maximum per family</i>	\$10,000	\$15,000	\$5,000	\$10,000	\$2,000
	Includes prescription drug expenses	Includes prescription drug expenses	Includes prescription drug expenses	Includes prescription drug expenses	
<i>Lifetime maximum</i>	None	None	None	None	None
Professional care (in office)					
<i>Doctor/primary care physician (PCP) visits</i>	80% after deductible	70% after deductible	90% after deductible	70% after deductible	90% after deductible when using network providers; 80% after deductible when using out-of-network providers
<i>Specialist visits</i>	80% after deductible	70% after deductible	90% after deductible	70% after deductible	
Preventive care, subject to frequency limits					
<i>Well-adult visits and immunizations</i>	100%, no deductible	100% of maximum allowed amount, no deductible	100%, no deductible	100% of maximum allowed amount, no deductible	100%, no deductible when using network providers; 80% after deductible when using out-of-network providers
<i>Well-child visits and immunizations</i>	100%, no deductible	100% of maximum allowed amount, no deductible	100%, no deductible	100% of maximum allowed amount, no deductible	100%, no deductible when using network providers; 80% after deductible when using out-of-network providers

High Deductible Health Plan Administered by Aetna and Empire BlueCross Blue Shield					Hawaii Health Plan administered by UnitedHealthcare
	BASIC		PREMIER		
	Network	Out of network	Network	Out of network	
<i>Routine cancer screenings</i> (Pap test, mammogram, sigmoidoscopy, colonoscopy, PSA screening)	100%, no deductible	100% of maximum allowed amount, no deductible	100%, no deductible	100% of maximum allowed amount, no deductible	100%, no deductible when using network providers; 80% after deductible when using out-of-network providers
<i>Hospital emergency room</i>					
<i>No coverage in any medical option if not a true emergency</i>	80% after network deductible, precertification required if admitted	80% after network deductible, precertification required if admitted	90% after network deductible, precertification required if admitted	90% after network deductible, precertification required if admitted	90% after deductible for doctor; 80% after deductible for hospital
<i>Urgent care center</i>					
	80% after deductible	80% after deductible	90% after deductible	90% after deductible	90% after deductible when using network providers; 80% of maximum allowed amount after deductible when using out-of-network providers

Medical

High Deductible Health Plan Administered by Aetna and Empire BlueCross Blue Shield					Hawaii Health Plan administered by UnitedHealthcare
	BASIC		PREMIER		
	Network	Out of network	Network	Out of network	
Hospital inpatient and outpatient					
<i>Semiprivate room and board, doctor's charges, lab, and X-ray</i>	80% after deductible; precertification required for hospitalization and certain outpatient procedures	70% after deductible; precertification required for hospitalization and certain outpatient procedures	90% after deductible; precertification required for hospitalization and certain outpatient procedures	70% after deductible; precertification required for hospitalization and certain outpatient procedures	90% after deductible when using network doctors, 80% after deductible when using out-of-network doctors; 80% after deductible when using network hospitals, 80% after a \$100 confinement deductible and calendar-year deductible when using out-of-network hospitals; notification required for hospitalization and certain outpatient procedures

High Deductible Health Plan Administered by Aetna and Empire BlueCross Blue Shield					Hawaii Health Plan administered by UnitedHealthcare
	BASIC		PREMIER		
	Network	Out of network	Network	Out of network	
<i>Mental health and substance abuse</i>					
Inpatient	80% after deductible, precertification required	70% after deductible; precertification required	90% after deductible, precertification required	70% after deductible; precertification required	90% after deductible when using network doctors, 80% after deductible when using out-of-network doctors; 80% after deductible when using network hospitals, 80% after a \$100 confinement deductible and calendar-year deductible when using out-of-network hospitals; notification required
Outpatient	80% after deductible; precertification recommended	70% after deductible; precertification recommended	90% after deductible; precertification recommended	70% after deductible; precertification recommended	90% after deductible when using network providers; 80% after deductible when using out-of-network providers; notification recommended

Medical

High Deductible Health Plan Administered by Aetna and Empire BlueCross Blue Shield					Hawaii Health Plan administered by UnitedHealthcare
	BASIC		PREMIER		
	Network	Out of network	Network	Out of network	
Therapies					
Physical/speech/occupational therapy (all therapies combined): Limited to 60 visits a year in and out of network combined (30 visits a year in and out of network combined for the Hawaii Health Plan; separate chronic/ developmental delay benefit of 24 visits a year in 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% after deductible; 50% after deductible for approved visits over Plan limits	90% after deductible; 70% after deductible for approved visits over Plan limits	70% after deductible; 50% after deductible for approved visits over Plan limits	90% network after deductible, 80% 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 in and out of network combined (30 visits a year in and out of network combined for the Hawaii Health Plan)	80% after deductible	70% after deductible	90% after deductible	70% after deductible	90% network after deductible; 80% out of network after deductible

For in-network covered expenses, the Plan pays a percentage of discounted rates while for out-of-network charges, the Plan pays a percentage of the maximum allowed amount.

Preventive care

Preventive care services are available in all non-HMO 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-care services and routine pediatric care and immunizations for children, excluding travel immunizations; and
- Routine well-woman exams.

Contact the Plan for details.

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, estimate conservatively. See the *Spending Accounts* section for details.

Routine cancer screenings

In the ChoicePlan 500 and Oxford Health Plans PPO, cancer-screening tests are covered as follows:

- When performed by network providers: 100% with no deductible to meet
- When performed by out-of-network providers: 100% up to \$250, then covered at 70% of maximum allowed amount, with no deductible to meet

See the *Hawaii Health Plan* and *High Deductible Health Plan* sections for information on how routine cancer screenings are covered in those Plans.

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, 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 also will 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.

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 available to you.

Precertification requirements for ChoicePlan 500 and High Deductible Health Plan administered by Aetna

You are encouraged to notify your Plan of a scheduled inpatient admission date at least 14 days prior to the date of admission. If you do not know your admission date at least 14 days prior to the date of admission, call your Plan as soon as the admission date is set.

You are encouraged to call before:

- A scheduled hospital admission, including admission to a mental health or substance abuse treatment facility;
- A scheduled admission to a skilled nursing facility or hospice care facility;
- Receiving home health care; or
- Receiving private-duty nursing.

For outpatient services and diagnostic testing

You are encouraged to notify your Plan at least five business days before receiving any of the services listed below.

- Breast reconstruction (other than following surgery for cancer) and breast reduction;
- Bunionectomy (surgical removal of a bunion);
- Hammertoe repair;
- Carpal tunnel surgery (surgical treatment of carpal tunnel syndrome);

- Colonoscopy;
- Coronary angiography (examination of vessels using radiographic imaging technology);
- CT scans of the spine (cross-sectional exam of the spine);
- Dilation and curettage (D&C) (surgical scraping of the uterus);
- Hemorrhoidectomy (surgical removal of hemorrhoids);
- Knee arthroscopy (interior examination of the knee joint);
- Laparoscopy (interior examination of the abdomen);
- MRI of the knee (examination of the knee using imaging technology);
- MRI of the spine (examination of the spine using imaging technology);
- Nasal endoscopy;
- Rehabilitation care;
- Rhinoplasty;
- Septoplasty (surgery of the nasal wall);
- Tympanostomy (insertion of a tube in the middle ear);
- Upper eyelid surgery; and
- Upper gastrointestinal endoscopy (interior examination of the stomach and intestines).

Outpatient physical, occupational, and speech therapy: No precertification is needed. Treatment is limited to 60 network and out-of-network visits per calendar year for the above therapies combined. Your Plan may approve additional visits based on medical necessity at a reduced level of coverage.

Precertification for ChoicePlan 500 and 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:

- Inpatient facility admissions, including emergency admissions and inpatient physical rehabilitation;
- Home health care services, including private-duty nursing;
- Hospice care;
- Admission to a skilled nursing facility;
- Air ambulance;
- Maternity admissions exceeding 48 hours for normal delivery/96 hours for cesarean section; and
- Organ and tissue transplants.

Precertification for Oxford Health Plans PPO

Call your Plan for details.

ChoicePlan 500

Each time you need treatment, you choose whether to use network or out-of-network providers. 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

- When you visit a network provider, you do not have any claim forms to complete.
- ChoicePlan 500 has no lifetime maximum benefit other than for infertility coverage.
- You will pay a network deductible for all services — with the exception of preventive care — before the Plan will pay benefits. Once you meet your network deductible, the Plan will pay 90% of covered charges while you will pay 10% of covered charges (your coinsurance), up to your annual out-of-pocket maximum. Any amounts that count toward the network deductible also count toward the out-of-network deductible.
- Preventive care: Routine periodic exams (well adult and well child), well-child immunizations and routine cancer screenings are covered at 100% (no deductible to meet).
- Allergy injections: Allergy injections for which you are not charged for an office visit will be covered at 100%, and the deductible and coinsurance will be waived.
- Prescription drugs are covered under the Citigroup Prescription Drug Program administered by Express Scripts. You must meet a separate deductible for drugs purchased at a retail network pharmacy before the Plan will pay benefits. You do not need to meet a deductible to order prescription drugs through the Express Scripts Home Delivery program and CuraScript. See *Prescription Drugs* section.

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

You can visit your ChoicePlan 500 administrator's website to review its list of providers. When you are prompted to enter the name of your Plan and network, enter the name below:

- Aetna: Open Access Plans; Aetna Choice POS II or
- Empire BlueCross BlueShield: PPO/EPO.

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 must file a claim to be reimbursed for covered expenses. See "How to file a claim" in the *Eligibility and Participation* section.
- The Plan has no lifetime maximum benefit other than for infertility coverage.
- Routine periodic exams (well adult and well child) are covered at 100% up to \$250 (with no deductible to meet) and then covered at 70% of maximum allowed amount; immunizations for children are covered at 70% of maximum allowed amount with no deductible to meet.
- Other than for preventive care services, you must meet an annual deductible before ChoicePlan 500 will pay benefits. The network deductible also counts toward the out-of-network deductible.
- Most covered expenses are reimbursed at 70% of maximum allowed amount after the annual deductible is met.
- You must notify your Plan before undergoing certain procedures and services, according to your Plan's rules, or you may pay a penalty. This process is known as "precertification."

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.
- Second procedure: The Plan will allow 50% of the negotiated or maximum allowed amount.
- Additional procedures: The Plan will allow 50% of the negotiated or maximum allowed amount for each additional procedure.
- Bilateral and separate operative areas: The Plan will allow 100% of the negotiated or maximum allowed amount for the primary procedure and 50% of the secondary procedure and 50% of the negotiated or maximum allowed amount 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.

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.

For a list of providers, visit the Oxford Health Plans website at www.oxhp.com or call Oxford member services at 1-800-396-1909.

Oxford Health Plans PPO features

- Network: Your annual deductible is \$500 for an individual/\$1,000 family maximum. After meeting your annual deductible, the Plan will pay covered services at 90% of the cost while you will pay 10% (your coinsurance). Your annual out-of-pocket maximum is \$3,000 for an individual/\$6,000 maximum for a family.
- Out of network: Your annual deductible is \$1,500 for an individual/\$3,000 family maximum. After meeting your annual deductible, covered services are paid at 70% of maximum allowed amount (MAA) while you will pay 30% (your coinsurance). Your annual out-of-pocket maximum is \$6,000 for an individual/\$12,000 maximum for a family.
- Prescription drug coverage is administered by Medco. Retail prescriptions at network pharmacies are subject to a \$10 copay for tier 1, \$20 copay for tier 2 and \$40 copay for tier 3 prescription drugs up to a 30-day supply. Mail order prescriptions are subject to a \$20 copay for tier 1, \$40 copay for tier 2 and \$80 copay for tier 3 prescription drugs up to a 90-day supply.
- You do not need to select a primary care physician (PCP) or obtain a referral to a specialist. You can visit any doctor or specialist.
- Since infertility coverage varies by state, contact the Plan for details.
- Therapy visits over the Plan limit may be approved after a medical necessity review.
- A vision exam by a network or out-of-network provider is covered once every 24 months.

Fully insured health maintenance organizations (HMOs)

Citi offers the following fully insured HMOs: Coventry Health Care of Iowa; Geisinger Health Plan; Health Plan Hawaii Plus (HMSA); SelectHealth; Independent Health; Kaiser FHP of California – Northern; Kaiser FHP of California – Southern; Kaiser FHP of Colorado; Kaiser FHP of Georgia; Kaiser FHP of Hawaii; Kaiser FHP of the Mid-

Medical

Atlantic States; Presbyterian Health Plan; and Sanford Health Plan).

HMO features

- You must use network providers; no out-of-network benefit is available.
- You must choose a primary care physician (PCP) before obtaining any medical services.
- Your deductible is \$500 for an individual/\$1,000 maximum for a family. After meeting your deductible, the Plan will pay covered services at 90% while you will pay 10% (your coinsurance). Your annual out-of-pocket maximum is \$3,000 for an individual/\$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. Call the HMO for more information.

High Deductible Health Plan—Basic and Premier

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 pretax 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. **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 maximum allowed amount when using out-of-network providers with no deductible to meet.
- Routine cancer screenings are covered at 100% when using network providers and 100% of maximum allowed amount when using out-of-network providers with no deductible to meet. Cancer screening tests are the Pap smear, mammography, sigmoidoscopy, colonoscopy, and PSA test.

- 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 below.
- 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/citigroup2011>.
- 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 AT A GLANCE				
	HIGH DEDUCTIBLE HEALTH PLAN - PREMIER		HIGH DEDUCTIBLE HEALTH PLAN - BASIC	
	<i>Network</i>	<i>Out of network</i>	<i>Network</i>	<i>Out of network</i>
<i>Company contribution to your HSA</i>	\$500 Employee Only/ \$1,000 all other coverage categories		\$500 Employee Only/ \$1,000 all other coverage categories	
<i>Deductible</i>	\$1,200/\$2,400	\$2,400/\$4,800	\$2,100/\$4,200	\$3,100/\$6,200
<i>Out-of-pocket maximum (including deductible)*</i>	\$2,500/\$5,000	\$5,000/\$10,000	\$5,000/\$10,000	\$7,500/\$15,000
<i>Coinsurance</i>	90%	70%	80%	70%
<i>Prescription drug coverage for generic, preferred, and non-preferred medications</i>				
<i>Retail</i>	\$5/\$30/50% up to a \$50 minimum/\$150 maximum after the annual deductible has been met	Covered at 50% after the annual deductible has been met	\$5/\$30/50% up to a \$50 minimum/\$150 maximum after the annual deductible has been met	Covered at 50% after the annual deductible has been met
<i>Mail order</i>	\$12.50/\$75/50% up to a \$125 minimum/ \$375 maximum after the annual deductible has been met	Not applicable	\$12.50/\$75/50% up to a \$125 minimum/ \$375 maximum after the annual deductible has been met	Not applicable

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

Health Savings Accounts (HSAs)

An HSA is used in conjunction with a qualified High Deductible Health Plan, such as the Basic and Premier Plans offered by Citi.

When you enroll in either High Deductible Health Plan, 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 by a High Deductible Health Plan, and you cannot be enrolled in "impermissible medical care coverage," such as a Health Care Spending Account, any other medical coverage, or Medicare or receive Social Security benefits.

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 Health Savings Account, 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 High Deductible Health Plan-Basic or Premier for 2011, 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 up to \$500 for Employee Only coverage and up to \$1,000 for any other coverage category.

The maximums that can be contributed to an HSA for 2011 are:

- \$3,050 for an eligible individual with Employee Only coverage and
- \$6,150 for an eligible individual enrolling in any other coverage category.

Under federal law, individuals who are 55 or older by December 31, 2011, can make a catch-up contribution of an additional \$1,000 for 2011 and each year going forward.

If you do not enroll in a High Deductible Health Plan, by law you cannot establish a Health Savings Account.

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 Health Benefit Plan or any other employee benefit plan sponsored by Citi.

The HSA and the LPSA

If you enroll in a High Deductible Health Plan and make tax-free contributions to an HSA you cannot participate in a Health Care Spending Account (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 High Deductible Health Plan 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 also may 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)

You can save money by using network providers who agree to charge discounted fees to members. When you use a network provider, most covered expenses are paid at 80% or 90% of the negotiated fee after the annual deductible has been met. The Plan is administered by UnitedHealthcare.

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

Hawaii Health Plan features

- You must meet an annual \$200 individual deductible (\$600 family) before the Plan will pay benefits.
- Your annual individual out-of-pocket maximum, including the deductible, is \$1,000 (\$2,000 family).
- Most covered network expenses are reimbursed at 90% after the annual deductible has been met. Claims submitted by an out-of-network provider are reimbursed at 80% of maximum allowed amount after the annual deductible has been met.
- Routine physical exams for adults and children and well-woman exams are covered at 100% with no deductible to meet when using network providers. Claims when submitted by an out-of-network provider are reimbursed at 80% of maximum allowed amount after the annual deductible has been met.
- Routine cancer screenings are covered at 100% with no deductible to meet when using network providers. Claims when submitted by an out-of-network provider are reimbursed at 80% of maximum allowed amount after the annual deductible has been met. Routine cancer screening tests are the Pap smear,

mammography, sigmoidoscopy, colonoscopy, and PSA test.

- Immunizations for children are covered at 100% with no deductible to meet when using network providers. Claims when submitted by an out-of-network provider are reimbursed at 80% of maximum allowed amount after the annual deductible has been met.
- Prescription drugs are covered under the Hawaii Prescription Plan of the Citigroup Prescription Drug Program administered by Express Scripts. You must meet a separate annual deductible for drugs purchased at a retail network pharmacy before the Plan will pay benefits. However, you do not have to meet an annual deductible to order prescription drugs through the Express Scripts Home Delivery program and CuraScript. See *Prescription Drugs* section.

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

ChoicePlan 500, Hawaii Health Plan, and 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.*

Medical

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 ChoicePlan 500 and High Deductible Health Plan-Basic and Premier in 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 PPO 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.

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 also will provide immediate assistance and, if necessary, arrange for treatment at an appropriate facility.

You must call your Plan before seeking treatment for 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 select 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 CareSM 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 center of excellence of bone marrow and organ transplant program offered through participating Blue Cross Blue Shield 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 offers 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.

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 also can 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.urncrs.com. You are not charged for this service, and you have no obligation to use a Cancer Resource Services center.

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.

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 is an over-the-counter (OTC) product of the same chemical equivalents are not covered under this program. These decisions are made at the discretion of Express Scripts. The majority of the 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. A network of retail pharmacies nationwide where you can obtain prescription drugs for your immediate short-term needs, such as an antibiotic to treat an infection
2. Express Scripts Home Delivery through which 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.*

Prescription drug benefits at a glance

PRESCRIPTION DRUG PROGRAM AT A GLANCE			
	<i>ChoicePlan 500</i>	<i>High Deductible Health Plan-Basic and Premier*</i>	<i>Hawaii Health Plan</i>
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			
<ul style="list-style-type: none"> Generic drug** 	\$5		\$10
<ul style="list-style-type: none"> Preferred brand name or formulary drug*** 	\$30		\$20
<ul style="list-style-type: none"> 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 \$50/\$100 deductible
Copayment for a 90-day supply through the Express Scripts Home Delivery program (no deductible to meet)			
<ul style="list-style-type: none"> Generic drug** 	\$12.50		\$25
<ul style="list-style-type: none"> Preferred brand name or formulary drug*** 	\$75		\$50
<ul style="list-style-type: none"> 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
Benefits at an out-of-network pharmacy	50% of your cost after you meet the deductible; you must file a claim for reimbursement		

PRESCRIPTION DRUG PROGRAM AT A GLANCE

	<i>ChoicePlan 500</i>	<i>High Deductible Health Plan-Basic and Premier*</i>	<i>Hawaii Health Plan</i>
Copayment for a 30-day supply of specialty medication through the CuraScript Specialty Pharmacy or at a retail network pharmacy (no deductible to meet if purchased through CuraScript) <ul style="list-style-type: none"> • Generic drug** • Preferred brand name or formulary drug*** • Non-preferred brand name or non-formulary drug 	\$5 \$30 50% of the cost of the drug with a minimum payment of \$50 to a maximum of \$150 after you meet the deductible	\$10 \$20 50% of the cost of the drug with a minimum payment of \$40 to a maximum of \$100 after \$50/\$100 deductible	

* 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 medications 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 generic copayment.

***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 under ChoicePlan 500 and Hawaii Health Plan do not count toward the satisfaction of 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.

Retail network pharmacies

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).

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.

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. If you do not present your prescription drug ID card at the time of service during this initial 45-day period, you still will 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 for reimbursement.

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.

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

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 using either 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

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. You can purchase a 30-day supply of specialty medication through CuraScript.

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

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 to the pharmacy or to Express Scripts before it can dispense your medication(s).

'Generics Preferred'

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

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. (If you are covered under the Oxford Plan, obtain the appropriate telephone number from Oxford.) 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.

Medical necessity review (for non-formulary drugs)

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 also can visit www.express-scripts.com. From the Benefit Overview menu, select “Coverage & Copayments.”

If, for 2010, 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 2011, visit <https://member.express-scripts.com/preview/citigroup2011> to view the 2011 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.

Dental

Citi offers two dental options: MetLife Preferred Dentist Program (PDP) and CIGNA Dental HMO.

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.

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

CIGNA Dental HMO costs less than 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 59.

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.

Dental options at a glance

What each option provides

	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)

MetLife PDP offers:

- Total freedom of choice; you can visit any dentist at any time;
- A nationwide network of more than 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;
- 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 participating PDP dentist, you are responsible only for the difference between the Plan's benefit payment amount and the PDP 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.

How the Plan works

MetLife PDP allows you to receive care from a MetLife preferred dentist and any other licensed dentist. At the time you need dental care, you decide whether to visit a preferred dentist or go to a dentist outside the preferred dentist program. The Plan provisions (deductibles, coinsurance, and annual and lifetime maximums) will be the same whether your dentist is a participating provider or not. However, using preferred dentists can reduce your out-of-pocket costs.

Covered charges

After you have met the deductible, MetLife PDP reimburses covered charges for out-of-network dentists at a percentage of maximum allowed amount (MAA). MetLife PDP determines MAA charges based on the amounts charged for a specific service by most dentists in the same geographic area in which you receive care. For network charges, the percentage of reimbursement is based on a percentage of the reduced negotiated fees 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

For example, if the orthodontic expense submitted is \$5,000, 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 \times 20\% = \$1,000 \times 50\% \text{ benefit} = \500
- First payment will be \$500

Coverage for monthly payments:

- $\$5,000 - \$1,000 = \$4,000$
- $\$4,000 \div 24 \text{ months} = \$167 \times 50\% \text{ 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 orthodontic 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 plan pays 50% coinsurance, after the annual deductible is met, up to a \$3,000 lifetime orthodontia maximum. Orthodontic 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.

Covered services

Preventive and diagnostic services

- Routine oral exams, maximum of two exams per calendar year;
- 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;

Dental

- 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.

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

You can find the list of procedures and services that are not covered on the Benefits Handbook website at www.benefitsbookonline.com. No password is required.

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 alternate 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

See "How to file a claim" in the Eligibility and Participation section.

CIGNA Dental HMO

CIGNA Dental HMO Care 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. See the CIGNA Dental HMO Patient Charge Schedule.

Is your dentist in the CIGNA Dental HMO network?

If you want to enroll in the CIGNA Dental HMO but have a dentist whom you want to continue using, you should verify that your dentist 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.mycigna.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 copay; charges are listed on the 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.

Limitations on covered services

- **Frequency:** See the Patient Charge Schedule for limitations on frequency of covered services, such as cleaning.
- **Specialty care:** You must obtain payment authorization from the CIGNA Dental HMO to have covered services performed by a network specialist.
- **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.

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.mycigna.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, see the Plan document on the Benefits Handbook website at www.benefitsbookonline.com, available from the Citi intranet and the Internet. No password is required. If you do not have access to the Citi intranet or the Internet, you can request a copy at no cost to you by speaking with a Citi Benefits Center representative through ConnectOne. Call 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Procedures and services that are not covered

You can find the list of procedures and services that are not covered on the Benefits Handbook Web site at www.benefitsbookonline.com, available from the Citi intranet and the Internet. No password is required.

Vision

The Aetna VisionSM 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 an ID card 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 adjudication and other administrative services are provided by First American Administrators, Inc., an affiliate of EyeMed Vision Care, LLC.

Benefits at a glance

The following table summarizes the vision benefits available to you and your eligible dependents:

Network benefit	Coverage
Routine eye exam	<ul style="list-style-type: none"> Covered at 100% including dilation, one exam per calendar year
Frames and lenses	<ul style="list-style-type: none"> Frames covered at 100% up to the frame allowance below; one pair of frames and lenses per calendar year Lenses covered at 100%; one pair of frames and lenses per calendar year \$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)	<ul style="list-style-type: none"> Covered at 100%; limit 1 pair/supply per calendar year in lieu of eyeglasses \$130 allowance for conventional and/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 with prior approval

Network benefit	Coverage
Laser vision correction (Lasik)	<ul style="list-style-type: none"> 15% off retail price or 5% off promotional price; must use the U.S. Laser Network to receive discount
Maximum benefit	<ul style="list-style-type: none"> The most the Plan will pay for the service or benefit; excludes copayments and allowances
Out-of-network benefit	Coverage
Routine eye exam	<ul style="list-style-type: none"> Up to \$50
Frames/lenses	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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.

To locate a network provider:

- If you are a member:** 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.

Vision

- 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 8 a.m. to 11 p.m. Eastern time 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 Citi employee's member ID number. If you are calling for services for your 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;
- 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) 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 your 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;
- 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 an employer is required to provide under a labor agreement, or is required by any law of a government;
- The cost of prescription sunglasses or light-sensitive lenses 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.

Refer to your *Vision Plan* document for additional information.

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.

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.

CITI LIVE WELL PROGRAM AT A GLANCE			
<i>Live Well tools and resources</i>	<i>Description</i>	<i>Who participates</i>	<i>How to access</i>
<i>Health Advocate</i>	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 (same or opposite sex)/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.
<i>Health Assessment on the Citi Live Well Portal</i>	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.	Citi Live Well Portal via Total Comp @ Citi at www.totalcomponline.com ; your spouse/partner can go to www.myactivehealth.com/citi .

Wellness benefits

CITI LIVE WELL PROGRAM AT A GLANCE

<i>Live Well tools and resources</i>	<i>Description</i>	<i>Who participates</i>	<i>How to access</i>
<i>Personal Health Record on the Citi Live Well Portal</i>	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 .
<i>Live Well Health Management Program</i>	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 .
<i>24-Hour Nurseline</i>	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
<i>Lifestyle Management Tools</i>	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 same or opposite sex 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, described below.

An alert will be sent to you and your doctor if your Health Assessment report indicates an opportunity to improve your care. You also may receive an outreach call from a nurse, if applicable.

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 to 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 activities to 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 (same or opposite sex)/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 1-800-490-3054 to terminate your access to the database.

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. 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. These Care Considerations identify an opportunity to improve your health care. 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 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.

During 2011, Citi is offering Live Well Rewards. If you complete four telephone sessions with a nurse or health coach during 2011, you will receive a \$150 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. ActiveHealth will notify the benefits administrator quarterly that you have completed your fourth telephone session with a nurse and the annual credit will be applied for the remaining pay periods of 2011. Employees as well as spouse/partners who are covered under a medical Plan offered by Citi are eligible to earn the Live Well Rewards.

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 on more than 2,000 health topics and accessible on demand through any touch-tone in both English and Spanish. For a list of topics, visit the Citi Live Well Portal at www.myactivehealth.com/citi, and, from the top of the page, click on "24-Hour Nurseline."

Call 1-866-494-7879 to access the 24-Hour Nurseline and audio health library.

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 potentially change certain behaviors. Because the tools are online, you can take advantage of them on your own schedule and at your own pace. To make these tools work even better for you, if you have not done so already, be sure to complete the Health Assessment on the 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 Personal Health Record (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 for the PHR above.

Important information about the Citi Live Well Program

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, 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 Aetna, Empire BlueCross BlueShield, or the 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.

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.

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 goal targets. All 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 for the surrounding geographic area and 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:

Albuquerque, NM; Getzville (Amherst), Long Island City, and New York, NY; Bayamon, PR; Blue Ash, OH; Meridian (Boise), ID; Elk Grove Village, IL; Florence and Louisville, KY; Mcleansville (Greensboro), NC; Hagerstown, MD; Irving and San Antonio, TX; Jacksonville and Tampa, FL; Kansas City, MO; Las Vegas, NV, Mississauga, Ontario; Sioux Falls, SD; and Warren, NJ. More information is available on the Citi intranet at

www.citigroup.net/human_resources/chs/.

Employee Assistance Program (EAP)

The EAP is a confidential, professional counseling service designed to help you and your family resolve issues that affect your personal lives or interfere with job performance. You may call the EAP 24/7 for help with issues such as anxiety or depression, substance or alcohol abuse, emotional and physical abuse, domestic conflict, and other issues.

When you or an immediate family member calls the EAP, you will speak with a professional counselor who will listen to your concern and, if warranted, refer you to an appropriate counselor in your community. You can attend up to three in-person counseling sessions with a program counselor at no cost to you before your referral. If you require additional counseling, you will be responsible for any fees. Expenses for subsequent counseling may be covered by other Citi health plans.

All EAP services are completely confidential.

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. Citi provides an employee assistance program through a contract with Harris Rothenberg International, LLC.

Contact the EAP as follows:

1-800-952-1245
TTY: 1-800-256-1604
www.hriworld.com
Username: resources
Password: for_you

Elder and geriatric assistance

When an older relative's physical or mental health changes or her or his ability to handle day-to-day routine activities is impaired, the stress on you and your family can be significant. Few of us have the expertise to determine which concerns require immediate care. The situation can be 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 trained counselor to provide answers to the most common care-giving questions;
- Assistance with assessment and care planning including a full assessment of the adult's health and living situation (in the home or facility);
- Facility review: Identify, evaluate, and compare the quality of care in different facilities; and
- Care coordination: Implement and coordinate 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 Work/Life program

Work/Life Program

Citi's Work/Life Program is designed to save you time, provide expert advice, and provide peace of mind. All Work/Life services are completely confidential. Whether you are researching options for child care, need to speak with a financial counselor, or dealing with the concerns of your elderly parent, Citi's Work-Life Program can help.

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 pretax 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.*
- **Limited Purpose Health Care Spending Account (LPSA):** Use the LPSA if you are enrolled in a High Deductible Health Plan-Basic or Premier and establish a Health Savings Account (HSA) 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 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. **Reminder:** 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.

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. Pretax, 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**. From the “Quick Links” page, click on “Your Benefits Resources™.”
- 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 2011 contributions you elect will be posted to your account January 1.
- **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.

If you enroll as a new hire:

- **HCSA and LPSA:** The entire amount of the 2011 contributions you elect will be posted to your account within 31 days after you enroll.
- **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.

Spending Accounts

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, at

www.citigroup.net/human_resources/form.htm (intranet only).

Legal requirement: Save your receipts

Each time you “swipe” the Your Spending Account™ Card (described in “Your Spending Account™ Card” on page 79), 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, 2012, to resolve any 2011 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 2012 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 your direct deposit account information, visit Your Benefits Resources™ through Total Comp @ Citi at

www.totalcomponline.com, available from the Citi intranet and the Internet. From the “Quick Links” page, click on Your Benefits Resources™. You also can go directly to <http://resources.hewitt.com/citigroup>.

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 Your Spending Account™ Card may be subject to suspension or termination.

Spending accounts at a glance

SPENDING ACCOUNTS AT A GLANCE				
	<i>Health Care Spending Account (HCSA)</i>	<i>Limited Purpose Health Care Spending Account (LPSA)</i>	<i>Dependent Day Care Spending Account (DCSA)</i>	<i>Transportation Reimbursement Incentive Program (TRIP)¹</i>
<i>Why enroll?</i>	To reduce your taxes by paying for eligible expenses with pretax dollars			
<i>What is reimbursed</i>	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.

SPENDING ACCOUNTS AT A GLANCE

	<i>Health Care Spending Account (HCSA)</i>	<i>Limited Purpose Health Care Spending Account (LPSA)</i>	<i>Dependent Day Care Spending Account (DCSA)</i>	<i>Transportation Reimbursement Incentive Program (TRIP)¹</i>
<i>Contribution limits</i>	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 \$120 per month pretax Parking: Up to \$230 per month pretax
<i>Forfeiture provisions</i>	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.
<i>Changing your election</i>	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.
<i>Filing a claim</i>	You must file claims for 2011 expenses so they are postmarked no later than June 30, 2012.	You must file claims for 2011 expenses so they are postmarked no later than June 30, 2012.	You must file claims for 2011 expenses so they are postmarked no later than June 30, 2012.	Not applicable

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 pretax 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. 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 IRS guidelines, the Plan Administrator, in its discretion, 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, 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 such contributions.

Spending Accounts

Rules and features

General rules about expenses

Most health care expenses that the Internal Revenue Service (IRS) considers as deductible on your 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 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 drugs and medicines, excluding insulin, 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 and medicines

You may be reimbursed for over-the-counter medicines through your HCSA in instances when a doctor has prescribed the medicine or the medicine is insulin.

Note: You cannot use the YSA™ Card to pay for these items. You will need to pay out of pocket and then submit a paper claim. Remember to keep your receipt and prescription in case documentation is needed to substantiate reimbursement or payment.

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; and
- Long-term-care services including insurance premiums for long-term care insurance.

The following over-the-counter items are covered under the HCSA only when accompanied by a diagnosis of medical condition from a licensed physician. The physician's note must indicate your specific medical condition and that the over-the-counter item is the recommended treatment:

- Medicated shampoos (diagnosis of specific scalp infection other than dry scalp or dandruff);
- Weight-loss drugs/programs (items which replace normal food are not eligible)
- Feminine hygiene products;
- Sunscreen;
- Acne treatment;
- Glucosamine/chondroitin for arthritis;
- St. John's Wort;
- OTC hormone therapy;
- Dietary supplements/fiber supplements/vitamins are rarely reimbursable, but they may be eligible if they are used to treat a specific medical condition and are not for general health purposes (requires note from licensed physician); and
- Hormone therapy creams.

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.

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.

YSA™ Card transaction(s) of \$100 or more require 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 at in the "Spending Accounts" section of the Citi intranet at www.citigroup.net/human_resources/materials/materials_us.html.

Automatic claims submission

The following Plans will submit your claims to the HCSA administrator so you will be reimbursed automatically for many eligible expenses without having to file a claim:

- Aetna and Empire BlueCross BlueShield ChoicePlan 500;
- Oxford Health Plans PPO;
- 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. Instead, claims submitted automatically will be used only to validate purchases made with the YSA™ card. You will then need to file a claim for any 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.

You may access the YSA Web site through Your Benefits Resources™. Visit Total Comp @ Citi at www.totalcomponline.com. From the "Quick Links" page, click on "Your Benefits Resources™." 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."

Spending Accounts

Reimbursements

At any time, 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. 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 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 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 retirement benefits also may 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 2011 claims, your envelope must be postmarked no later than June 30, 2012.

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 pretax 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.

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 the maximum allowed amount only. As a result, not all preventive care charges may be covered.

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 Health Savings Account;
- 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 Health Savings Account also enroll in an LPSA to pay for eligible health care expenses with pretax 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 a Health Savings Account (as long as you are enrolled in the High Deductible Health Plan).

Spending Accounts

Note: Employees who enroll in a High Deductible Health Plan or who establish a Health Savings Account are *not* eligible to enroll in a Health Care Spending Account.

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 the 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 expenses out of pocket and submit qualified expenses for reimbursement using the LPSA Claim Form (Form 315).

Reimbursements

At any time, 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

If you terminate employment with Citi, you can continue your LPSA coverage under COBRA through the end of the calendar year in which your employment was terminated. If you do not continue coverage under COBRA, you cannot use the account for expenses incurred beyond your termination date. However, you will have until the following June 30 to submit your claims.

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 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 retirement benefits also may 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 2011 claims, your envelope must be postmarked no later than June 30, 2012.

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.

Dependent Day Care Spending Account (DCSA)

You can contribute between \$120 and \$5,000 a year on a pretax 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 84.

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 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.

Spending Accounts

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, and who have gross income of less than the dependency exemption threshold (\$3,750 in 2011).

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.

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 retirement benefits also may be reduced.

Using DCSA after your termination of employment

You may submit claims for eligible expenses incurred after your termination date but within 2011. You must submit any eligible 2011 claims no later than June 30, 2012.

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:	
	<i>For full-time employees</i>	<i>For part-time employees</i>
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, 2012, to file claims for reimbursement of expenses incurred in 2011. (Your envelope must be postmarked no later than June 30, 2012.)

Note: You cannot submit claims for reimbursement more than two weeks in advance of the service date. Claims submitted more than two weeks 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.

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 to be used on business travel, for example, to use public transportation to attend a business meeting.

The first \$120 of the cost of your transit and/or the first \$230 of the cost of your parking pass will be deducted from your pay before taxes are withheld. Any amount of your pass(es) that exceeds \$120 for transit or \$230 for parking 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 transportation 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.

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 transit and/or parking passes 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 link from Your Benefits Resources™.	No later than the 10 th 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 TRIP parking using the parking voucher, parking debit card, or the pay provider 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 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

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

Transit Account

- 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

- Non-work-related parking expenses;
- Parking at or near your residence;
- Parking for which you receive a pretax benefit;
- Parking paid for by your employer;
- Parking expenses incurred by family members; and
- Expenses eligible to be reimbursed from the Transit Account.

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. Then 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.

Spending Accounts

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. From the "Quick Links" page, click on "Your Benefits Resources™." From the "Manage your spending accounts" section, click on the link for "Your Spending Accounts."

Tax exemptions

TRIP 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 TRIP 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.

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."

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.

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.

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. Call MetLife to report your disability through ConnectOne at 1-800-881-3938. From the ConnectOne main menu choose the "Managed Disability" option. You also can call MetLife directly at 1-888-830-7380.

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.

STD SCHEDULE OF BENEFITS FOR BENEFITS-ELIGIBLE SALARIED EMPLOYEES*

<i>Years of service</i>	<i>Weeks at 100% of base salary</i>	<i>Weeks at 60% of base salary</i>	<i>Total weeks of base salary</i>
<i>Less than 3 months</i>	0	0	0
<i>3 months to less than 1 year</i>	1	12	13
<i>1 year to less than 2 years</i>	4	9	13
<i>2 years to less than 3 years</i>	6	7	13
<i>3 years to less than 4 years</i>	8	5	13
<i>4 years to less than 5 years</i>	10	3	13
<i>5 or more years</i>	13	0	13

* If you were hired on or before December 31, 2010, you'll only need to satisfy one month of service to be eligible for Short-Term Disability.

For Account Executives in the Institutional Clients Group the following schedule of benefits applies:

<i>Years of service</i>	<i>Minimum benefit (% of total compensation)</i>	<i>Plus additional benefit</i>	<i>Maximum benefit (% of total compensation)</i>
<i>Less than 3 months</i>	0	0	0
<i>3 months to less than 3 years</i>	60%	Commissions	100%
<i>3 years to less than 7 years</i>	70%	Commissions	100%
<i>7 or more years</i>	80%	Commissions	100%

Disability Coverage

Pregnancy leave for benefits-eligible salaried employees

<i>Years of service</i>	<i>Weeks at 100% of base salary</i>	<i>Weeks at 60% of base salary</i>	<i>Total weeks of benefit</i>
<i>Less than 3 months</i>	0	0	0
<i>3 months to less than 1 year</i>	1	12	13
<i>1 or more years</i>	13	0	13

Pregnancy leave for benefits-eligible commission-paid Account Executives

<i>Years of service</i>	<i>Minimum benefit (% of total compensation)</i>	<i>Plus additional benefit</i>	<i>Maximum benefit (% of total compensation)</i>	<i>Total weeks of benefit</i>
<i>Less than 3 months</i>	0	0	0	0
<i>3 months to less than 1 year</i>	70%	Commissions	100%	13
<i>1 or more years</i>	80%	Commissions	100%	13

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 or New Jersey, in which case you will receive benefits under your state plan only.

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).

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 "Managed Disability" option. You also can call MetLife directly at 1-888-830-7380.

Long-Term Disability (LTD)

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, as set forth in the MetLife certificate. For purposes of calculating your LTD benefit, total compensation is limited to a maximum of \$500,000.

Citi provides Company-paid LTD coverage to employees whose total compensation is less than or equal to \$50,000.99. Effective January 1, 2011, if as a new hire, your total compensation exceeds \$50,000.99 or if your total compensation increases to \$50,001 or above for this or the subsequent plan year, you will be automatically enrolled in LTD coverage so your coverage continues uninterrupted. The cost of LTD coverage will be deducted from your pay beginning January 1 of the next plan year unless you decline coverage. Refer to the Your Benefits Resources™ website during annual enrollment for the cost.

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

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.

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 to \$50,001 or above, you will be enrolled in LTD coverage automatically for the following year. Effective January 1 of the following year, the cost of coverage will be deducted from your pay. If you do not want LTD coverage for the following year, you must elect "no coverage" during annual enrollment. If you do not select "no coverage" during annual enrollment, you will have 90 days beginning January 1 to decline coverage. If you decline coverage within the 90-day period, these contributions will be refunded to you. If you decline coverage after the 90-day period, your contributions will not be refunded.

You may be eligible to receive LTD benefits after 13 weeks of an approved STD leave. 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. You will be billed for your health and welfare benefits, to the extent you are enrolled. The cost of benefits is not deducted from your LTD benefit. For details, see the Managed Disability brochure on the Citi intranet at

www.citigroup.net/human_resources/materials.htm.

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.

If your total compensation is \$50,001 or above, you do not have to enroll in LTD coverage, despite the automatic enrollment described above. 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.

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

LTD BENEFITS	
<i>Age when total disability begins</i>	<i>Date monthly LTD benefits will stop</i>
<i>Under 60</i>	Upon attaining age 65
<i>60</i>	The date the 60 th monthly benefit is payable
<i>61</i>	The date the 48 th monthly benefit is payable
<i>62</i>	The date the 42 nd monthly benefit is payable
<i>63</i>	The date the 36 th monthly benefit is payable
<i>64</i>	The date the 30 th monthly benefit is payable
<i>65</i>	The date the 24 th monthly benefit is payable

Disability Coverage

LTD BENEFITS	
<i>Age when total disability begins</i>	<i>Date monthly LTD benefits will stop</i>
66	The date the 21 st monthly benefit is payable
67	The date the 18 th monthly benefit is payable
68	The date the 15 th monthly benefit is payable
69 or over	The date the 12 th monthly benefit is payable

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.

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.

The receipt of STD and LTD benefits is subject to the terms and conditions of the applicable Plan. For related benefit offsets, exclusions, and limitations, see the Plan document on the Benefits Handbook website at www.benefitsbookonline.com, available from the Citi intranet and the Internet, and the insurance certificate. This section is not intended to be a substitute for the actual Plan documents.

If you do not have access to the Citi intranet or the Internet, you can request a copy of the Plan document 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.

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 (same or opposite sex)/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.

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 next \$1,000, to a maximum of \$200,000. Total compensation is recalculated each year, and the new amount is effective each 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 MetLife;
- 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.

Insurance Benefits

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.

Converting to an individual policy

You can convert your Basic Life/AD&D to an individual policy by contacting 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 rounded up to the next \$1,000, up to a maximum coverage amount of \$5 million.

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 outside your initial eligibility period (31 days from your date of hire/date you are eligible to enroll in Citi benefits), or for an amount greater than three times your compensation or \$1.5 million, you must provide evidence of good health and be actively at work before coverage will be effective. “Actively at work” means that you are regularly scheduled to work in the office or at home 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 for GUL coverage through Citi. Instead, you enroll in GUL coverage by contacting MetLife. Visit Total Comp @ Citi at www.totalcomponline.com. From the “Quick Links” page, click on the “MetLife MyBenefits” website or submit an enrollment form, which you can obtain by calling MetLife at 1-800-523-2894. Spouse (same or opposite sex)/civil union partner/domestic partners 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.

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 MetLife;
- 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 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 the 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.

Coverage for your spouse/civil union partner/domestic partner

You can enroll in GUL insurance coverage for your spouse (same or opposite sex)/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 (same or opposite sex)/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 or 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 (provided by MetLife), 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.

Insurance Benefits

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 you or your spouse (same or opposite sex)/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. From the ConnectOne main menu, choose the “health and welfare benefits” option.

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/civil union partner/domestic partner has a coverage amount of \$150,000.
- Each eligible dependent child 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 insurance. If you do not have Basic Life insurance, the beneficiary is your spouse (same or opposite sex)/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 cannot be more than the amount of your employee coverage.

Long-Term Care (LTC) insurance

You can purchase LTC coverage for you and eligible members of your family at any time. Coverage is provided by the John Hancock Life Insurance Company.

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 (same or opposite sex), civil union partner/domestic partner;
 - Coverage is not available to domestic partners residing in Louisiana.
- Your parents or 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.
- 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 (same or opposite sex)/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.

Insurance Benefits

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
<i>Nursing home DMB</i>	\$115	\$175	\$230	\$290	\$345	\$405
<i>Alternate care facility DMB</i>	\$115	\$175	\$230	\$290	\$345	\$405
<i>Community-based professional care DMB**</i>	\$86.25	\$131.25	\$172.50	\$217.50	\$258.75	\$303.75
<i>Informal care DMB</i>	\$28.75	\$43.75	\$57.50	\$72.50	\$86.25	\$101.25
<i>Informal care calendar year maximum</i>	\$862.50	\$1,312.50	\$1,725	\$2,175	\$2,587.50	\$3,307.50
<i>Lifetime maximum benefit (excluding stay-at-home benefit)</i>	\$209,875	\$319,375	\$419,750	\$529,250	\$629,625	\$739,125
<i>Stay-at-home lifetime maximum</i>	\$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 also can 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.

Insurance Benefits

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://groupitc.jhancock.com> (the user name is "groupitc," 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.

	Percentage of premium returned upon death
<i>65 or younger</i>	100%
<i>66</i>	90%
<i>67</i>	80%
<i>68</i>	70%
<i>69</i>	60%
<i>70</i>	50%
<i>71</i>	40%
<i>72</i>	30%
<i>73</i>	20%
<i>74</i>	10%
<i>75 or older</i>	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.

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 by the insured 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 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 documents, sponsors, and Claims Administrators.

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" on page 103.

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 also may 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.*

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, HCSA, and 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 108.

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

Administrative Information

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. If the Plan uses or discloses protected health information for underwriting purposes, the Plan will not use or disclose protected health information that is your genetic information for such purposes.

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.

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 also may 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 also may 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 also may 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 also may 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 also may 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 also may 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.

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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" section on page 106. Component Plans also may 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 108.

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 108.

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 108.

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 108, 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 108. 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 108.

Administrative Information

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 108. Component Plans will not penalize you for filing a complaint.

Changes to this notice

Component Plans reserve the right to change the provisions of this notice and to make the new provisions effective for all 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:
<p>Citigroup Health Benefit Plan*</p> <ul style="list-style-type: none"> Citigroup Dental Benefit Plan Citigroup Vision Benefit Plan Health Care Spending Account Limited Purpose Health Care Spending Account 	<p>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.</p> <p>From outside the United States: Call the Citi Employee Services</p>

IF YOU ARE ENROLLED IN ANY OF THESE PLANS:	CALL:
<p>*Note: If you are enrolled in an HMO, call your HMO.</p>	<p>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.</p> <p>For TDD users Call the Telecommunications Relay Service at 711. Then call ConnectOne as instructed above.</p>

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 also may 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 than 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, 2011, 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.

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 also might 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 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 Medical 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 Medical Plan, you should consider how Citi coverage would affect the benefits you receive under the Medicare prescription drug plan.

Administrative Information

- 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 November 15-December 31 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 also may 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.

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 also may 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 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 joining 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 join a Medicare prescription drug plan when you first become eligible for Medicare and each year from November 15-December 31. 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.

Administrative Information

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 November 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 also may be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug coverage:

- 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 also may 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 also may 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 the "Claims and appeals" section beginning on page 116.

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.

Administrative Information

Answers to your questions

If you have questions about the Plans, contact the Plan Administrator listed under “Plan administration” on page 121.

If you have any questions about this SPD 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 also may 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 covered person is obligated to cooperate with the Plan and its agents to protect the Plan's subrogation rights. Cooperation means 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; 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.

The costs of legal representation retained by the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation retained by the covered person shall be borne solely by the covered person.

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 Accounts 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

If you do not receive a benefit to which you believe you are entitled under any Citigroup Health and Welfare Plan 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 121 and the list of Claims Administrators under “Plan Information” on page 121.

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 the Plan documents available at www.benefitsbookonline.com.

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

You also can call the Plan Administrator to request a copy of the Plan document without charge.

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 or in the Plan document 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.

Administrative 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 116) 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 116) 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:

1. The specific reason or reasons for the denial of the appeal;
2. Reference to the specific Plan provisions on which the benefit determination is based;
3. 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;
4. 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;
5. 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
6. 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 also may file an appeal if the Committee denies your claim.

To file an enrollment-related claim and for information on the claim review process, 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.

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:

1. The specific reasons for the denial;
2. The specific reference to the Plan documentation that supports these reasons;
3. The additional information you must provide to perfect your claim and the reasons why that information is necessary;
4. 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
5. 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.

Administrative Information

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:

1. The specific reason or reasons for the denial of the appeal;
2. Reference to the specific Plan provisions on which the benefit determination is based;
3. 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;

4. 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
5. 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.

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.

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, including the Plans described in this SPD in whole or in part, at any time, for any reason.

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 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.

Plan Information

<i>Plan sponsor</i>	Citigroup Inc. 75 Holly Hill Lane Greenwich, CT 06830
<i>Employer identification number</i>	52-1568099
<i>Participating employers</i>	Citigroup Inc. and any of its [U.S.] subsidiaries in which at least an 80% interest is owned.

Administrative Information

<i>Plan Administrator</i>	Plans Administration Committee of Citigroup Inc. 1 Court Square, 46 th 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.
<i>Type of administration</i>	The Plans are administered by the Plans Administration Committee. However, the final decision on the payment of claims under certain Plans rests with the Claims Administrators.
<i>Agent for service of legal process</i>	Citigroup Inc. General Counsel, HR 1 Court Square, 9 th Floor Long Island City, NY 11120
<i>Plan year</i>	January 1-December 31
Plan Names and Numbers	
<i>Medical Plan:</i> Self-funded ChoicePlan 500, High Deductible Health Plan-Basic and Premier, Hawaii Health Plan, Oxford Health Plans PPO, and HMOs, including prescription drugs; medical clinics	Citigroup Health Benefit Plan, Plan #508
<i>Dental Plan</i>	Citigroup Dental Benefit Plan, Plan #505
<i>Vision Plan</i>	Citigroup Vision Plan, Plan #533
<i>Employee Assistance Program</i>	Citigroup Employee Assistance Program, Plan #521
<i>Health Care Spending Account and Limited Purpose Health Care Spending Account</i>	Citigroup Flexible Benefits Plan, Plan #512
<i>Dependent Day Care Spending Account</i>	Not applicable (DCSA is not an ERISA plan)
<i>Transportation Reimbursement Incentive Program</i>	Not applicable (TRIP is not an ERISA plan)
<i>Basic Life insurance/AD&D and GUL/Supplemental AD&D Business Travel Accident/Medical insurance Long-Term Care insurance</i>	Citigroup Life Insurance Benefits Plan, Plan #506 Citigroup Business Travel Accident/Medical Plan, Plan #510 Citigroup Long-Term Care Insurance Plan, Plan #535
<i>Short-Term Disability and Long-Term Disability</i>	Citigroup Disability Plan, Plan #530

Funding	
<p><i>Medical Plan</i></p> <p><i>Dental Plan</i></p> <p><i>Vision Plan</i></p> <p><i>Employee Assistance Program</i></p> <p><i>Health Care Spending Account (HCSA)</i></p> <p><i>Limited Purpose Health Care Spending Account (LPSA)</i></p> <p><i>Basic Life/AD&D insurance</i></p> <p><i>GUL/Supplemental AD&D insurance</i></p> <p><i>Business Travel Accident/Medical insurance</i></p> <p><i>Disability Plan</i></p>	<p>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 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.</p> <p>The cost of medical and dental coverage is shared by Citigroup and the participant. The cost of the Vision Plan and medical spending accounts is provided by employee contributions. Citigroup pays for the Employee Assistance Program.</p> <p>Basic Life/AD&D, GUL/Supplemental AD&D, and Business Travel Accident 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.</p> <p>STD benefits are paid from the general assets of the Company. STD coverage is provided by Citigroup; no employee contributions are required.</p> <p>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.</p>
<p><i>Long-Term Care insurance (LTC)</i></p>	<p>LTC benefits are fully insured. The cost of LTC coverage is provided by employee contributions.</p> <p>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.</p>
<p><i>On-site medical clinics</i></p>	<p>On-site medical clinics are funded from the general assets of Citigroup Inc.</p>

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		
<i>ChoicePlan 500</i>	<p>Aetna Citigroup Claims Division P.O. Box 981106 El Paso, TX 79998-1106 1-800-545-5862</p> <p>Empire BlueCross BlueShield P.O. Box 5072 Middletown, NY 10940-9072 1-866-290-9098</p> <p>(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.)</p>	
<i>High Deductible Health Plan - Basic and Premier</i>	<p>Aetna Citigroup Claims Division P.O. Box 981106 El Paso, TX 79998-1106 1-800-545-5862</p>	<p>Empire BlueCross BlueShield P.O. Box 5072 Middletown, NY 10940 9072 1-866-290-9098</p>
<i>Oxford Health Plans PPO</i>	<p>Oxford Health Plans Attn: Claims Department P.O. Box 7082 Bridgeport, CT 06601-7082 1-800-396-1909</p>	
<i>Hawaii Health Plan</i>	<p>UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845</p>	
<i>For fully insured HMOs</i>	Call the HMO directly at the telephone number on your ID card.	
<i>Prescription Drug Program</i>		
Paper claims address	<p>Express Scripts Pharmacy P.O. Box 66583 St. Louis, MO 63166</p>	
Home delivery service	<p>Express Scripts Pharmacy Home Delivery Service P.O. Box 510 Bensalem, PA 19020 0510</p>	

DENTAL PLAN	
<i>MetLife Preferred Dentist Program</i>	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
<i>CIGNA Dental HMO</i>	CIGNA Dental HMO / Member Services 1571 Sawgrass Corporate Parkway Suite 140 Sunrise, FL 33323 1-800-244-6224
VISION	
<i>Vision Plan</i>	Aetna Vision Plan P.O. Box 8504 Mason, OH 45040-7111 1 877 787 5354 www.AetnaVisionOE.com/avp1 Members: www.aetnavision.com
SPENDING ACCOUNTS	
<i>Health Care Spending Account Limited Purpose Health Care Spending Account Dependent Day Care Spending Account Transportation Reimbursement Incentive Program</i>	Citi Benefits Center 2300 Discovery Drive P.O. Box 785004 Orlando, FL, 32878-5004 Call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Administrative Information

OTHER INSURANCE	
<i>Basic Life</i>	Metropolitan Life Insurance Co. 200 Park Ave. New York, NY 10166 1-800-638-6420
<i>Group Universal Life</i>	Metropolitan Life Insurance Co. Group Plan # 96731 P.O. Box 3016 Utica, NY 13504 1-800-523-2894
<i>Accidental Death and Dismemberment and Supplemental AD&D</i>	Life Insurance Company of North America (CIGNA) 1601 Chestnut St. Philadelphia, PA 19192 215-761-1000
<i>Business Travel Accident/Medical</i>	ACE American Insurance Company Accident & Health Claims 1 Beaver Valley Road, P.O. Box 15417 Wilmington, DE 19850 1-800-336-0627
<i>Short-Term Disability Long-Term Disability</i>	Metropolitan Life Insurance Co. P.O. Box 14590 Lexington, KY 40511-4590 1-888-830-7380
<i>Long-Term Care</i>	John Hancock Life Insurance Co. Group Long-Term Care, B-6 200 Berkeley St. Boston, MA 02117 1-800-222-6814
<i>Agent for Service of Legal Process</i>	Citigroup Inc. General Counsel HR 1 Court Square, 9th Floor Long Island City, NY 11120
<i>Plan Year (for all Plans)</i>	January 1 — December 31
<i>Type of Administration</i>	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.

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)

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.

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 the maximum allowed amount (MAA). If the expenses incurred are higher than the MAA, the individual receiving the service is responsible for

Glossary

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.

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 examinations based on guidelines from the American Medical Association 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 examinations based on the 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.

For More Information

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 “Quick Links” page, you can link to some of the Citi benefits providers without an additional login.

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.

For information about these topics, plans, or programs	Contact	Telephone number/Web address
<p>Beneficiary designations</p> <ul style="list-style-type: none"> • Basic Life/AD&D, Citigroup 401(k) Plan, Citibuilder 401(k) Plan for Puerto Rico, and Citigroup Pension Plan • Group Universal Life (GUL)/Supplemental AD&D insurance 	<p>Citi Benefits Center</p> <p>MetLife (GUL)</p>	<p>Call ConnectOne. From the ConnectOne main menu, choose the “pension and retiree health and welfare” option.</p> <p>Visit Total Comp @ Citi at www.totalcomponline.com. From the “Quick Links” page, click on “Your Benefits Resources™.”</p> <p>1-800-523-2894</p> <p>Visit Total Comp @ Citi at www.totalcomponline.com. From the “Quick Links” page, click on “MetLife MyBenefits” website.</p>
<p>Benefits (health and welfare)</p>	<p>Citi Benefits Center</p>	<p>Call ConnectOne. From the ConnectOne main menu, choose the “health and welfare benefits” option.</p> <p>Visit Your Benefits Resources through Total Comp @ Citi at www.totalcomponline.com. From the “Quick Links” page, click on “Your Benefits Resources™.”</p>
<p>Citi Live Well Program</p>	<p>Health Advocate and ActiveHealth</p>	<p>1-866-449-9933</p> <p>Visit the Citi Live Well Portal through Total Comp @ Citi at www.totalcomponline.com or www.MyActiveHealth.com/citi.http</p>
<p>COBRA coverage (Consolidated Omnibus Budget Reconciliation Act)</p>	<p>Citi Benefits Center</p>	<p>Call ConnectOne. From the ConnectOne main menu choose the “health and welfare benefits” option.</p> <p>Visit Total Comp @ Citi at www.totalcomponline.com. From the “Quick Links” page, click on “Your Benefits Resources™.”</p>

For More Information

For information about these topics, plans, or programs	Contact	Telephone number/Web address
Dental	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	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 . From the "Quick Links" page, click on "Your Benefits Resources™."
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 "Managed Disability" option. 1-888-830-7380 Visit Total Comp @ Citi at www.totalcomponline.com . From the "Quick Links" page, click on "MetLife MyBenefits" website.
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.harrisrothenberg.com User ID: resources Password: for_you
General information Eligibility, enrollment, general information about the health and welfare benefits plans, status changes, and continuing coverage after a termination of employment	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 . From the "Quick Links" page, click on "Your Benefits Resources™."
Group Universal Life (GUL)/Supplemental AD&D insurance	MetLife (GUL)	1-800-523-2894 Visit Total Comp @ Citi at www.totalcomponline.com . From the "Quick Links" page, click on "MetLife MyBenefits" website.
Health Savings Account	ConnectYourCare	1-888-846-6414 www.connectyourcare.com

For information about these topics, plans, or programs	Contact	Telephone number/Web address
HIPAA Certificate of Creditable Coverage	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu choose the "health and welfare benefits" option.
HMOs	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu, choose the "health and welfare benefits" option.
Insurance <ul style="list-style-type: none"> • 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.
Limited Purpose Health Care Spending Account	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 . From the "Quick Links" page, click on "Your Benefits Resources™."
Long-Term Care insurance	John Hancock Life Insurance Co.	1-800-222-6814 http://groupitc.jhancock.com User name: groupitc Password: mybenefit
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 or 1-800-444-6222 www.oxhp.com
	UnitedHealthcare (Hawaii Health Plan)	1-877-311-7845 1-800-842-0090 (TDD) www.provider.uhc.com/citigroup (public site for Citi employees) www.myuhc.com/groups/citi (participants only)
Plan documents For the health and welfare plans	Benefits Handbook website	www.benefitsbookonline.com If you do not have access to the Citi intranet or the Internet, you can request a copy of the Plan documents at no cost to you by speaking with a Citi Benefits Center representative through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

For More Information

For information about these topics, plans, or programs	Contact	Telephone number/Web address
<p><i>Prescription Drug Program</i> (ChoicePlan 500, High Deductible Health Plan - Basic and Premier, and Hawaii Health Plan)</p> <p>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</p>	Express Scripts	<p>1-800-227-8338</p> <p>1-800-899-2114 (TDD)</p> <p>https://member.express-scripts.com/preview/citigroup2011 (public site for Citi employees)</p> <p>www.express-scripts.com (participants only)</p> <p>1-800-224-5498</p>
<p><i>Transportation Reimbursement Incentive Program (TRIP)</i></p>	Citi Benefits Center	<p>Call ConnectOne. From the ConnectOne main menu choose the "health and welfare benefits" option.</p> <p>Visit Total Comp @ Citi at www.totalcomponline.com. From the "Quick Links" page, click on "Your Benefits Resources™."</p>
<p><i>Vision Plan</i> <i>For Plan information and laser vision correction providers/arrangements</i></p>	Aetna	<p>1-877-787-5354</p> <p>www.AetnaVisionOE.com/avp1 Members: www.aetnavision.com</p>
<p><i>Workers' Compensation</i></p>	Constitution State Services Co.	1-800-243-2490

CITI ON-SITE MEDICAL CLINICS	
<i>Jacksonville, FL</i>	
14000 Citicards Way	904-954-8262
Medical emergency number	904-954-8911
<i>Tampa, FL</i>	
Citibank Center, Building C	813-604-4333
Medical emergency number	611
<i>Warren, NJ</i>	
283 King George Road, Building C	908-563-5401
Medical emergency number	908-563-5412
<i>New York City</i>	
399 Park Ave., Level A/Zone 11, New York City	212-559-3981
Medical emergency number	212-559-4357 (5-HELP)
111 Wall St., 23 rd Floor, Zone 12, New York City	212-657-7478
Medical emergency number	212-657-4357 (6-HELP)
388 Greenwich St., 5 th Floor, New York City	212-816-1460
Medical emergency number	212-816-1300
One Court Square, 9 th Floor, Zone 7, Long Island City	718-248-2709
Medical emergency number	718-248-4357 (4-HELP)
<i>San Antonio, TX</i>	
100 Citibank Drive, Building 3	210-357-8275

CITI HEALTH AND FITNESS CENTERS	
<i>Florida</i>	
14000 Citicards Way, Bldg. A, Jacksonville	904-954-2630
3800 Citibank Center Tampa	813-604-4348
<i>Albuquerque, NM</i>	
9521 San Mateo N.E.	505-797-6198
<i>Warren, NJ</i>	
283 King George Road	908-563-9534
<i>New York City</i>	
388 Greenwich St., 5 th Floor, New York City	212-816-0523
One Court Square, 5 th Floor, Long Island City	718-248-9571
<i>Getzville, NY</i>	
580 CrossPoint Parkway	716-730-7926
<i>Texas</i>	
100 Citibank Drive, San Antonio	210-677-6991
6400 Las Colinas Blvd, Irving	972-653-8890
3950 Regent Blvd, Irving	469-220-4177

For More Information

CITI HEALTH AND FITNESS CENTERS	
<i>Blue Ash, OH</i>	
9997 Carver Rd	574-993-1032
<i>Meridian, ID</i>	
2200 South Cobalt Way	208-822-2331
<i>Elk Grove Village, IL</i>	
50 Northwest Point Blvd	224-222-2509
<i>Kentucky</i>	
4600 Houston Rd, Florence	859-283-3882
12501 Lakefront Place, Louisville	502-522-2401
<i>McLeansville, NC</i>	
5450 Millstream Road	336-522-1702
<i>Hagerstown, MD</i>	
14700 Citicorp Drive	301-714-5738
<i>Kansas City, MO</i>	
7920 NW 110 th Street	816-420-1275
<i>Las Vegas, NV</i>	
8725 W. Sahara Blvd.	702-797-4855
<i>Sioux Falls, SD</i>	
701 East 60 th Street N.	605-331-1922