About Your Health Care Benefits

Amended and Restated as of January 1, 2005

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Introduction

This document is a component of the plan document (hereinafter referred to as the “document”) for the Citigroup Medical Plan, Citigroup Dental Benefit Plan, Citigroup Vision Care Plan and the Health Care Spending Account (hereinafter referred to as the “health care plans”) for eligible employees of Citigroup and its participating companies (hereinafter referred to as Citigroup, unless otherwise specified). **Citigroup reserves the right to change or discontinue any or all of the benefits coverage or programs described here at any time, with or without notice.**

The benefits and programs described in this document are, in effect as of January 1, 2005. The terms and conditions of these plans may also be further prescribed in insurance policies or administrative services agreements, the provisions of which, as may be amended from time to time, are hereby incorporated by reference.

This document is intended to comply with the requirements of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) and other applicable laws and regulations. It does not create a contract or guarantee of employment between Citigroup and any individual. Your employment is always on an at-will basis. In addition, benefits provided under the plans described in this document are not in any way subject to your or your dependent’s debts or other obligations and may not be voluntarily or involuntarily sold, transferred, alienated, or encumbered.

As you read the document you will see some terms that are bold and underlined. This means that the term is a reference to another section of the document.

This document provides no guarantee that you are eligible to participate in every benefit or program described. Each plan may have its own eligibility requirements, so be sure to review individual eligibility requirements carefully. In addition, Citigroup in no way guarantees the payment of any benefit which may be or become due to any person under the plan.

If you have any questions about this document or certain provisions of your benefit plans, or would like to receive copies of an insurance policy or other agreement forming a part of any plan described in this document, please call the Benefit Service Center at ConnectOne at 1-800-881-3938 and select the Health Benefits options.

Eligibility

Citigroup provides benefits coverage for you, your **spouse** or **qualified domestic partner**, and/or **eligible dependents**.

For employees

You are only eligible to participate in the health care plans (as defined above) if you work for a "participating company" as defined below, in the United States for a regular semimonthly or monthly paycheck as either an active full-time employee regularly scheduled to work 40 hours or more a week or an active part-time employee regularly scheduled to work 20 hours or more a week.

Participating companies include American Health and Life Company; Citibank, N.A. and Participating Companies; CitiFinancial; Citigroup Corporate Center; Citigroup Global Corporate and Investment Bank; Global Wealth Management; Citigroup Investment Group; CitiStreet Institutional Division; CitiStreet Total Benefits Outsourcing Division; CitiStreet Retirement Services Division; Primerica Financial Services; National Benefit Life Insurance Company; and Travelers Life and Annuity.

For purposes of determining whether you are an eligible employee under the health care plans, you are an "active" employee if you are working for your employer doing all the material and substantial duties of your occupation at your usual place of business or some other location that your employer's business requires you to be or absent from work solely due to vacation days, holiday, scheduled days off or approved leaves of absence not due to disability.

You are not an eligible employee and can not participate in the Plans if:

- your compensation is not reported on a Form W-2 Wage and Tax Statement issued by a participating company;
- you are employed by a Citigroup subsidiary or affiliate that is not a participating company;
- you are engaged under an agreement that states you are not eligible to participate in the Plans;
- you are a non-resident alien performing services outside the United States;
- you are classified by Citigroup as an independent contractor or consultant, or as being employed on a temporary basis; .

If you are a US citizen or legal resident employed outside the United States in an expatriate classification, your eligibility will be determined in accordance with practices and procedures established under the Plans.

If you both work for Citigroup

If both you and your spouse or qualified domestic partner are employed by Citigroup or a participating company, neither of you can be covered both as an employee and a dependent for *any* Citigroup benefit plan.

- **Medical, dental, and vision care —** Each of you may be covered under the medical and dental plans as either an employee or a dependent but not both. Either of you may cover your children, but they cannot be covered by both of you.
- **Health Care Spending Account —** Either of you may be covered under a Health Care Spending Account but you may not file more than once for reimbursement of the same eligible expense. Your qualified domestic partner and his/her eligible child(ren) are eligible, provided they are considered "dependents" within the meaning of section 152 of the Internal Revenue Code of 1986, as amended (the "Code"), as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.

For dependents

Your eligible dependents are:

- Your lawfully married spouse or state-recognized common-law spouse; if you are legally separated, your spouse is not an eligible dependent unless mandated by state law.
- Each of your children who is unmarried and a "qualifying child" as defined in section 152(c) of the Code. Generally, a qualifying child must share your residence for more than half the year, must not provide over one-half of his or her own financial support, and:
  - will attain age 18* as of the close of the plan year or is younger; or
  - will attain age 23* as of the close of the plan year or is younger, and is a full-time student (meaning the student is enrolled in courses for at least 5 months during the plan year) attending an accredited school or college. Upon request, you must provide proof of student status in writing to the Claims Administrator. The names, addresses and phone numbers of the health care Claims Administrators are listed in the **Plan information** section of this document.
- Each of your children who is unmarried, is a "qualifying relative" as defined in section 152(d) of the Code as determined without regard to subsection(d)(1)(B), does **not** share your residence for more than half the year, and :
  - will attain age 19* as of the close of the plan year or is younger; or
  - will attain age 25* as of the close of the plan year or is younger, and a full-time student (meaning the student is enrolled in courses for at least 5 months during the plan year) who is attending an accredited school or college. Upon request, you must provide proof of student status in writing to the Claims Administrator. The names, addresses and phone numbers of the health care Claims Administrators are listed in the **Plan information** section of this document.

  Generally, for you to have a qualifying relative as described above, **you** must be providing over one- half of your relative's financial support.

  * Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student. 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. If the child gets married or obtains a full-time job, coverage generally will remain in effect through the end of the month in which this occurs

To be an eligible dependent, your children must be either:

- Your natural children;
- Your legally adopted children (For purposes of coverage under the health care plans, adopted children will be considered eligible dependents when they are lawfully placed in your home for adoption or when the adoption becomes final, whichever occurs first.);
- Your stepchildren; and
- A child permanently residing in your household for whom you are the legal guardian. You must provide proof of guardianship in writing to the Claims Administrator.

Eligible dependents also include an employee's domestic partner and/or his or her dependent children, provided the children of the domestic partner meet all the qualifications of eligible dependent children as described in this section. Please note that not all HMOs cover domestic partners or their children. For more specific information, contact your HMO directly.

If one of your eligible dependent children becomes permanently and totally disabled and is covered under the health care plans before reaching the applicable maximum age as described above, this child may continue to be considered an eligible dependent under the health care plans beyond the date his/her eligibility for coverage would otherwise end. You must provide written proof of this incapacity to the Claims Administrator within 31 days after the date eligibility would otherwise end and as requested thereafter. This eligible dependent must still meet all other eligibility qualifications for coverage to be continued.

No person will be covered under this plan both as an employee and as an eligible dependent or as an eligible dependent of more than one employee.

Eligible dependents must be U.S. citizens or legal residents.

Qualified Medical Child Support Orders

As required by the Federal Omnibus Budget Reconciliation Act of 1993, any child of a plan participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) will be considered as having a right to dependent coverage under the medical and dental plans. 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. Contact the Plans Administration Committee to receive, free of charge, a detailed description of the procedures for a QMCSO.

Dependent notification

The first time you enroll in Citigroup benefits, you will be asked to report information about each of your eligible dependents such as name, date of birth, Social Security number and, if over age 19, whether the child is a full-time student or has a mental or physical disability. *Without this information on file, you cannot enroll in any dependent coverage.*

If your dependent does not have a Social Security number at this time, you can enter dependent information and report the Social Security number after you obtain it.

You also must keep your dependent information current:

- When you enroll during the annual open enrollment period, you will be prompted to make changes to your dependent information; and
- You must report changes in dependent information to the Benefit Service Center when you want to make changes to your coverage or coverage category as a result of a qualified status change.

Dependents no longer eligible

Your spouse or qualified domestic partner is eligible for coverage until the last day of the month in which you become legally separated or divorced or submit a Domestic Partnership Termination Form.

Coverage for your dependant children will end:

- The last day of the month in which they:
  - Become employed full time;
  - Get married; or
  - Become eligible for coverage under any plan as employees; or
  - December 31 of:
  - the calendar year in which they lose full-time student status or
  - the calendar year prior to the year in which they fail to meet other eligibility criteria:

Newborns/newly adopted children

Even if you are not enrolled for dependent coverage, Citigroup will pay medical benefits for your newborn child from birth through 31 days. However, if you have Citigroup medical coverage, you must report this family status change within 31 days of the child's birth to add the child to your coverage. If you do not report the addition of your child during the first 31 days, benefits *will not* be payable for the child after the 31 days following the date of the child's birth, and you will generally have to wait until the next annual open enrollment period to enroll the child in medical coverage unless another event occurs that would permit coverage to begin at an earlier time. In this case, no payment will be made for any day of confinement, treatment, services, or supplies given to the child after these initial 31 days. No other benefit or provision of the medical plan will apply to the child.

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

- Extension of benefits; and
- Continuation of coverage.

Remember, you must report information to the Benefit Service Center about a new dependent even if you already have family coverage, or else your new dependent won't be covered.

For domestic partners

Where available, Citigroup allows you to cover your domestic partner and/or his or her children in the following plans:

- Medical (domestic partner benefits are not available through some HMOs);
- Dental;
- Health Care Spending Account, provided your domestic partner and eligible dependent child(ren) are considered tax dependents under section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof; and
- Vision care plan.

You cannot cover both a spouse and a domestic partner. To enroll a domestic partner and/or his or her children, an employee must sign an affidavit affirming that he or she meets Citigroup's eligibility criteria for domestic partner coverage, and complete a Certification of Domestic Partner's Tax Status. This form is available on **www.citigroup.net** or by calling the Benefit Service Center.

Your domestic partner can be of the same or opposite sex. To qualify for coverage as a domestic partner, you and your domestic partner must meet all of the following criteria:

- You currently reside together and intend to do so permanently;
- You have lived together for at least six consecutive months prior to enrollment and intend to do so permanently;
- You have mutually agreed to be responsible for each other's common welfare;
- You are both at least 18 years of age and mentally competent to consent to contract;
- You are not related by blood to a degree of closeness that would prohibit marriage if you and your partner were of opposite sexes;
- Neither you nor your partner is legally married to another person;
- Neither you nor your partner is in a domestic partner relationship with anyone else; and

- You are in a relationship that is intended to be permanent and in which each of you is the sole domestic partner of the other.

To qualify for coverage, your domestic partner's unmarried child(ren) must:

- Be the biological or adopted child of your domestic partner, a child for whom your domestic partner has legal guardianship, or a child who has been placed in your home for adoption; and
- Satisfy all other qualifications of eligible dependent children as described above.

Your domestic partner and his or her unmarried children must be U.S. citizens or legal residents to qualify for coverage.

Termination of relationship

If you have enrolled your domestic partner and his or her children for medical, dental, and/or vision care coverage and you terminate your domestic partnership, you must notify Citigroup by completing a Termination of Domestic Partnership Form within 31 days of the event. Contact the Benefit Service Center for this form. As a result, your domestic partner will be eligible to continue medical, dental, vision care, and/or Health Care Spending Account coverage at his or her expense for a period of 36 months.

This coverage will be similar to COBRA coverage offered to spouses and other covered dependents, excluding domestic partners and their children. See the **COBRA** section for more information.

If you enroll a partner and terminate the domestic partner relationship, you must wait six months before enrolling a new domestic partner in a medical, dental, or vision care plan sponsored by Citigroup.

Enrollment

You can enroll in Citigroup coverage within 31 days of the time you first become eligible or during the annual open enrollment period. The coverage available to you will be listed on your enrollment materials along with the enrollment deadline and how to enroll. You can enroll in any or all of the plans offered to you.

For the medical and dental plans, you must choose a "coverage category." The four coverage categories are:

- Employee only;
- Employee + child(ren);
- Employee + spouse or domestic partner; and
- Employee + family.

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

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

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

Other coverage

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

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

When coverage begins

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

Changing your coverage

During the year, you may want to change your coverage or coverage category. Citigroup has specific rules about when you can change your coverage.

For medical, dental, and vision care coverage and the Health Care Spending Account — the coverages you pay for with before-tax dollars — you can make changes only during the open enrollment period or as a result of certain events, such as marriage, the birth or adoption of a child, divorce, or the death of a dependent. These events are called qualified status changes. You must make any qualified status change-related changes to your coverage within 31 days of the event. See **Qualified status changes**.

Type of coverage:	When you can change your coverage or coverage category:
Medical and dental	The annual open enrollment period or within 31 days of a qualified status change. Note: You can change your medical or dental plan election only as a result of your relocation out of your medical or dental plan's service area.
Vision care	The open enrollment period or within 31 days of a qualified status change.
Health Care Spending Accounts	The annual open enrollment period or within 31 days of a qualified status change.

Midyear election changes

The federal government recently clarified the rules that govern when you can change benefit coverage elections outside of open enrollment. These rules apply to coverage elections you make for your medical, dental, vision care, and the health care spending account coverage. In general, the benefit plans and coverage levels you choose at open enrollment remain in effect for the following calendar year. However,

you may be able to change your elections between annual enrollment periods if you have a qualified status change or other applicable event, as further explained below.

Qualified status changes

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

- **Legal marital status.** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, or annulment;
- **Domestic partnership status.** You enter into or terminate a domestic partnership;
- **Number of dependents.** Any event that changes your number of tax dependents, including birth, death, adoption, and placement for adoption;
- **Employment status.** Any event that changes your, your spouse's, or your other dependent's employment status that results in gaining or losing eligibility for coverage. Examples include:
  - Beginning or terminating employment;
  - A strike or lockout;
  - Starting or returning from an unpaid leave of absence;
  - Changing from part-time to full-time employment or vice versa; and
  - A change in work location.
- **Dependent status.** Any event that causes your tax dependent to become eligible or ineligible for coverage because of age, student status, or similar circumstances;
- **Residence.** A change in the place of residence for you, your spouse, or another dependent if outside your medical or dental plan's network service area.

Consistency requirements

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

Effect on eligibility

The qualified status change must affect eligibility for coverage under the plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the qualified status change results in an increase or decrease in the number of your dependents who may benefit from coverage under the plan.

Corresponding election change

The election change must correspond with the qualified status change. For example, if your dependent loses eligibility for coverage under the terms of the health plan, you may cancel medical coverage only for that dependent. Additionally, you may decrease or end contributions to a Health Care Spending if you have or adopt a child or a child is placed with you for adoption. The Plan Administrator will determine whether a requested change is due to a qualified status change and is consistent with the qualified status change.

Coverage & cost events

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

Coverage events

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

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

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

If another employer's plan allows your spouse or other dependent to make a mid-year change to his or her elections in accordance with IRS regulations, you may make a corresponding midyear election change to your coverage.

Cost events

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

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

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

Other rules

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

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

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

Changing your coverage status

You must make changes to your health benefits *within 31 days* of a qualified status change by calling the Benefit Service Center. The change will be effective on the date of your status change.

Your contributions

Your contributions for medical, dental, and vision care are based on the plan chosen and the coverage category. Your medical contribution also depends on your total compensation and which total compensation band applies to you. The compensation bands for 2004 are shown in the table below. Contributions for your Health Care Care Spending Account are determined by your contribution amount.

Total compensation bands on which employee contributions for medical coverage are based:
$20,000 or less
$20,001 – $25,000
$25,001 – $40,000
$40,001 – $60,000
$60,001 – $80,000
$80,001 – $100,000
$100,001 – $150,000
$150,001 – $250,000
$250,000 +

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

With respect to the current plan year, total compensation consists of (a) the annual rate of regular base pay based on scheduled work hours, excluding any shift differentials, as of July 1 of the calendar year (the "Prior Year") which precedes the current plan year; (b) any commissions paid during the calendar year which precedes the Prior Year; (c) any non-annual cash bonuses paid during the calendar year which precedes the Prior Year; and (d) any annual bonus earned during the calendar year which precedes the Prior Year and that is paid in cash or in the form of an equity award under the Core Capital Accumulation Program during such calendar year or the Prior Year.

For example, the total compensation for the 2005 plan year includes:

- Base pay annualized as of July 1, 2004 (excluding shift differentials);
- Commissions paid from January 1 – December 31, 2003;
- Cash bonuses paid from January 1 – December 31, 2003 (excluding any annual bonus); and
- 2003 annual bonus (paid in 2003 and 2004).

If you were hired or rehired on or after July 1, 2004, yout total compensation is your annualized base pay as of your date of hire.

If you are a part-time employee, your total compensation will be calculated as follows:

- Hourly rate of pay as of July 1, 2004 × 52 weeks × the number of hours scheduled to work

For Smith Barney financial consultants

In your first year of employment, your total compensation is considered to be $60,000. If you earned more than $60,000 in a previous brokerage firm in the prior year and want your insurance coverage to represent your prior earnings, you must provide a copy of your previous year's Form W-2 wage reporting statement to your HR representative within 30 days of your hire date. Your medical contributions will also be based on the higher amount.

Note: Actual contribution amounts are shown on the annual enrollment worksheet, which is provided to all eligible employees during each Annual Enrollment period.

Before-tax contributions

When you choose coverage that requires a payroll contribution, most of your contributions are made with before-tax dollars. This means your contributions come out of your pay before federal income and employment taxes are deducted. Before-tax contributions reduce your gross salary, which lowers your taxable income and, therefore, the amount of income tax you must pay. Contributions may, however, be subject to state or local income taxes in certain jurisdictions.

Social Security taxes

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

Domestic partners

The cost of coverage for a domestic partner is the same as the cost for a spouse. The cost of coverage for a domestic partner's child(ren) is the same as the cost for a dependent child. For the cost of domestic partner coverage in a particular plan, call the Benefit Service Center.

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

Tax implications

According to federal tax law, your taxes may be affected when you enroll your domestic partner in Citigroup coverage.

If your domestic partner does NOT qualify as a tax dependent: If your domestic partner and his or her child(ren) do not qualify as dependents for federal income tax purposes as described above, the cost of any medical, dental, and/or vision care coverage for your domestic partner and/or his or her child(ren) is considered "imputed income" and will be shown on your pay statement and Form W-2. You will pay taxes on the amount of imputed income.

If your domestic partner qualifies as a tax dependent: If your domestic partner and his or her child(ren) qualify as dependents for federal income tax purposes as described above, your contributions for their medical, dental, and/or vision care coverage will be taken before taxes are withheld, and there are no tax implications for you.

Since the tax requirements are complex, you should consult a tax professional for advice on your personal situation.

To review the qualifications of a section 152 dependent, see IRS Publication 501 at **www.irs.gov/formspubs/index.html**.

Coordination of benefits

Coordination of benefits provisions apply to the medical and dental plans only and are described in this section.

All payments under the plans described in this document will be coordinated with benefits payable under any other group benefit plans that provide coverage for you or your dependent(s). Coordination of benefits prevents duplication and works to the advantage of all members of the group.

When you or your dependent(s) are eligible for benefits under another group plan, the eligible expenses under this plan will be determined. One of the plans involved will pay benefits first — the primary plan — and the other plan(s) will pay benefits next — the secondary plan(s).

The following definitions apply to terms used in this section:

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

The Citigroup plan will be the primary plan on 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, the birthdays of the parents are used to determine which coverage is primary. 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 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.

When the Citigroup plan is the primary plan, it will pay benefits first. Benefits will be calculated according to the terms of the plan and will not be reduced due to benefits payable under other plans.

When the Citigroup plan is the secondary plan, benefits under the Citigroup plan may be reduced. The Claims Administrator will determine the amount the Citigroup plan normally would pay. Then the amount payable under the primary plan for the same expenses will be subtracted from the amount the Citigroup plan would have normally paid. The Citigroup plan will pay you the difference. If the Citigroup plan is secondary, you will never be paid more for the same expenses under both the Citigroup plan and the primary plan than the Citigroup plan would have paid alone.

When the Citigroup plan is secondary and the patient is covered under an HMO, benefits under the Citigroup plan will be limited to the copayment, if any, for which you would have been responsible under the HMO, whether or not the services provided are rendered by the HMO.

When a child is claimed as a dependent by parents who are 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 Citigroup 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:

- The plan of the parent with custody of the child;
- The plan of the spouse of the parent with custody of the child;
- The plan of the parent not having custody of the child.

In the event that a legal conflict exists between two plans as to which is primary and which is secondary, the plan that has covered the patient 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.

With regard to any governmental health care coverage provided during a military leave, any health care coverage provided under the Citigroup plans (including any such coverage required under USERRA, COBRA or other law or under any Citigroup military leave policy) will be secondary to the governmental health care coverage.

Coordination with Medicare

When you or your eligible dependents are entitled to Medicare and are covered under the Citigroup plan, the Citigroup plan continues to be the primary plan. The Citigroup plan is primary for the following situations:

- Eligible active employees age 65 and over and who are entitled to Medicare benefits;
- Dependent spouses age 65 and over who participate in the Citigroup plan on the basis of current employment status of the employee and who are entitled to Medicare benefits;
- Social Security disabled participants who are covered by the Citigroup plan on the basis of your active employment status with Citigroup and who are entitled to Medicare benefits; and
- For the first 30 months of Medicare entitlement, certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD).

If you are entitled to Medicare and want Medicare as your primary coverage, you must decline Citigroup medical coverage. From that point forward, Medicare will be your only coverage, and no benefits will be provided by the Citigroup plan.

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

No-fault automobile insurance

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

Facility of payment

When benefit payments that would have been made under a Citigroup plan have been made under another plan, the Citigroup plan has the right to pay the other plan the amount that satisfies the intent of

the provision. Any payment made will be considered payment of benefits under the Citigroup plan and, to the extent of such payments, the Citigroup plan's obligation to pay benefits will be satisfied.

Right of recovery

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

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

Release of information

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

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

Recovery provisions

Recovery provisions apply to the medical and dental plans and are described in this section.

Refund of overpayments

Whenever payments have been made by the plan with respect to covered or non-covered expenses in a total amount, at any time, in excess of the maximum amount payable under the plan's provision, the covered person(s) must make a refund to the plan in the amount paid in excess of the amount payable under the plan and help the plan obtain the refund from another person or organization.

If the covered person(s) or any other person or organization that was paid does not promptly refund the full amount, the plan may reduce the amount of any future benefits that are payable. The reductions will equal the amount it should have paid. In the case of recovery from a source other than the plan, the refund equals the amount of recovery up to the amount paid under the plan. The plan may have other rights in addition to the right to reduce future 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 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, verdicts, 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 of 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 Citigroup or its participating companies to the extent necessary to reimburse this plan under the plan's subrogation or reimbursement rights.

In order 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; and
- 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.

The covered person 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 refused 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 who 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 liable for the covered person's injury or illness or for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), 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 in order to protect the plan's subrogation rights. Cooperation means providing the plan or its agents with any 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.

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.

When coverage ends

Your coverage automatically will terminate on the earliest of the following dates:

- The date the Citigroup plan terminates;
- The last day for which the necessary contributions are made;
- Midnight of the last day of the month in which you retire, you die, or you otherwise cease to be eligible for coverage.
- The date benefits paid on behalf of a participant equal the lifetime maximum benefit under the Citigroup plan. Coverage for eligible dependents who have not reached their lifetime maximum will not be affected.
- Midnight of the last day of employment if your termination is due to gross misconduct.

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

- Midnight of the last day of the month in which your coverage terminates;
- The date you elect to terminate your eligible dependent's coverage;
- The last day for which the necessary contributions are made;
- The date the eligible dependent(s) ceases to be eligible for coverage. Coverage will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student. Coverage will remain in effect through the end of the month in which the child gets married or obtains a full-time job;
- The date the eligible dependent(s) is covered as an employee under the plan;
- The date the eligible dependent(s) is covered as the dependent of another employee under the plan;
- The date the eligible dependent(s) enters the armed forces of any country or international organization;
- The date the dependent is no longer eligible for coverage under a QMCSO; or
- Midnight of the last day of the month in which you become legally separated or divorced (this applies to coverage for your spouse or domestic partner)

You and your eligible covered dependents may be able to continue coverage under COBRA. See **COBRA** for more information.

Coverage when you retire

You could be eligible for retiree health care coverage if you are at least age 55 with at least 5 years of service when you leave Citigroup. For more information on eligibility into these plans, contact the Benefits Service Center. You will be required to contribute to the cost of coverage.

Coverage if you become disabled

If you are disabled, you and your eligible dependents may continue medical, dental, and vision care plan coverage and participation in the Health Care Spending Account for up to 13 weeks, as long as you make the active employee contributions. After you have been disabled for 13 weeks, if you are still disabled and/or long-term disability coverage is pending, your coverage will remain in effect and you will be billed for benefits.

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

Medical coverage* will continue for 52 weeks, including the 13-week period of short-term disability, as long as you make the active employee contributions. After that, you may continue medical coverage by making the same contributions as active employees, based on your length of service as shown in the table below. (After 52 weeks of disability, your employment will be terminated.)

Length of recognized Citigroup service as of week 52 from STD date	Medical continuation period after week 52 (the termination of your employment)
Less than two years	Six months
Two years to less than five years	Equal to length of service
Five years or more	As long as you are disabled or have not reached the maximum age limit to receive LTD benefits

At the end of the period, you may continue coverage through COBRA. The continuation period is considered part of the period of COBRA-continued coverage.

Dental coverage will continue for 52 weeks, including the 13-week period of short-term disability, as long as you make the active employee contributions. You may then continue coverage through COBRA. The continuation period is considered part of the period of COBRA-continued coverage.

Vision care coverage will continue for the 13-week period of short-term disability, as long as you make the active employee contributions. You may then continue coverage through COBRA. The continuation period is considered part of the period of COBRA-continued coverage.

Health Care Spending Account participation will continue for the 13-week period of short-term disability, as long as you make the active employee contributions. You may then continue coverage through COBRA for the remainder of the calendar year.

*In the event LTD was not elected and/or preexisting condition causes a denial of LTD benefits, the schedule outlined will apply in those cases and the disability carrier will monitor the disability claim.

Coverage if you take a leave of absence

If you are on an approved leave of absence, call the Benefit Service Center about your rights to continue medical, dental, vision care and/or spending account coverage.

Continuing coverage during FMLA

The federal Family and Medical Leave Act (FMLA) entitles eligible employees to take leave each year for serious illness, the birth or adoption of a child, or to care for a spouse, child, or parent who has a serious health condition. If you are eligible for FMLA, you may take up to a total of 13 weeks of leave each calendar year (except where state law mandates differently).

If you take an unpaid leave of absence that qualifies under FMLA, medical, dental, and vision care coverage for you and your dependents and your participation in the Health Care Spending Account may continue as long as you continue to contribute your share of the cost of coverage during the leave.

Note that your monthly contributions during a leave are made on an after-tax basis.

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

If you do not return to work at the end of your FMLA leave, you will be entitled to purchase COBRA continuation coverage for your medical, dental, vision and Health Care Spending Account benefits. If your employment is terminated while you are on an FMLA leave, you may also be eligible to continue your insurance coverage under COBRA.

During an FMLA leave, you have access to the entire amount of your Health Care Spending Account annual election, less any prior reimbursements that you have received, as long as you continue to make your contributions during your leave of absence. If you stop making contributions, your participation in the Health Care Spending Account will terminate while you are on FMLA leave. In that case, you may not receive reimbursement for any health care expenses you incur after your coverage terminated.

If your Health Care Spending Account participation terminates during your leave, your Health Care Spending Account contributions will begin again if you return to work during the same year in which your leave began. You will have the choice of either resuming your contributions at the same level in effect before your FMLA leave or electing to increase your contribution level to “make up” for the contributions you missed 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. If you elect to make up contributions, then the amount available for reimbursement will be the same amount you could receive immediately before the leave. Regardless of whether you choose to resume your prior contribution level or to make up missed contributions, you may not use your Health Care Spending Account for expenses incurred during the period you did not participate.

Continuing coverage during military leave

If you take a military leave, whether for active duty or for training, you are entitled to continue your health coverage (including medical, dental, vision, and Health Care Spending Account) in accordance with the terms and conditions of your participating company’s paid military leave of absence policy.

In the event such policy expires or otherwise ceases to remain in effect, you are still entitled to continue your health coverage for up to 24 months as long as you give Citigroup advance notice (with certain exceptions) of the leave, and provided that your total leave, when added to any prior periods of military leave from Citigroup, does not exceed five years (with certain exceptions).

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

If you take a military leave, but your coverage under the plan is terminated, for instance, because you do not elect the extended coverage, you will be treated as if you had not taken a military leave upon re-employment when the Plans Administration Committee determines whether an exclusion or waiting period applies once you are reinstated to the plan.

If you are on military leave for less than 18 months and you do not return to work at the end of your leave, you may be entitled to purchase continuation coverage for the remaining months, up to a total of 18 months.

Call your Benefits Service Center or contact your HR representative for more information about a military leave.

Coverage for surviving dependents

When an active employee dies, his or her surviving covered spouse and/or dependent children may be eligible for continued coverage.

- If the employee was not eligible for retiree health care coverage at the time of death, medical and dental coverage will continue for the surviving spouse and/or dependent children for six months at no cost. After the six-month period, they will be eligible to continue coverage through COBRA. The six-month period of continued coverage is considered part of the COBRA period.
- If the employee was eligible for retiree health care coverage at the time of death, the surviving spouse and/or dependent children will be eligible for retiree health care coverage on the same terms as a retired employee.

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that most employers sponsoring group health plans offer employees and eligible dependents the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end (called “qualifying events”). 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 choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. Citigroup reserves the right to terminate your coverage retroactively if you are determined to be ineligible under the terms of the plan.

You will have to pay the entire premium plus a 2% administrative fee for your continuation coverage. There is a grace period of at least 30 days for the payment of the regularly scheduled premium. A 45-day grace period applies for your first premium payment.

Who is covered

If you are covered by a Citigroup-sponsored medical, dental, or vision care plans, or Health Care Spending Account, you have a right to choose this continuation coverage if 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, the event that will trigger continuation coverage is the earlier of the date that you indicate you will not be returning to work following the leave or the last day of the FMLA leave period.

If you are the spouse of an employee and are covered by a Citigroup-sponsored medical, dental, or vision care plans, or Health Care Spending Account on the day before the qualifying event, you are a qualified beneficiary and have the right to choose continuation coverage for yourself if you lose group health coverage under a Citigroup-sponsored group health plan for any of the following four reasons:

- The death of your spouse;
- The termination of your spouse’s employment (for reasons other than your spouse’s gross misconduct) or reduction in your spouse’s hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare.

If you are a covered dependent child of an employee covered by a Citigroup-sponsored medical, dental, or vision care plans, or Health Care Spending Account on the day before the qualifying event, you also are a qualified beneficiary and have the right to continuation coverage if group health coverage under such plan is lost for any of the following five reasons:

- The death of the employee;
- The termination of the employee’s employment (for reasons other than the employee’s gross misconduct) or reduction in the employee’s hours of employment;
- The employee’s divorce or legal separation;
- The employee becomes entitled to Medicare; or
- The dependent ceases to be a “dependent child” under the Citigroup-sponsored medical, dental, or vision care plans, or Health Care Spending Account.

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

If the covered employee fails to notify Citigroup in a timely fashion (in accordance with the terms of the Citigroup-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 dependent has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage, each qualified dependent who is eligible for continuation of 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. Similarly, a spouse or dependent child may elect different coverage than the employee elects.

Your duties

Under the law, the employee or a family member has the responsibility to inform Citigroup of a divorce, legal separation, or a child losing dependent status under the Citigroup-sponsored medical, dental, or vision care plans, or Health Care Spending Account. This notice *must* be provided within 60 days from the date of the divorce, legal separation or a child losing dependent status (or, if later, the date coverage would normally be lost because of the event).

If the employee or a family member fails to provide this notice to Citigroup during this 60-day notice period, any family member who loses coverage will *not* be offered the option to elect continuation coverage. The notice must be in writing. Send the notice to:

If you're an employee of Travelers Life & Annuity or the CitiStreet Retirement Services Division:	**If you're an employee of any other U.S. Citigroup business:**
Citigroup Service Center P.O. Box 56710 Jacksonville, FL 32241-6710	Citigroup Service Center P.O. Box 785004 2300 Discovery Drive Orlando, FL 32878

When Citigroup is notified that one of these events has happened, Citigroup in turn will notify you that you have the right to choose continuation coverage. If you or your family member fails to notify Citigroup 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 losing dependent status, then the employee and family members will be required to reimburse the employer-sponsored group health plans for any claims mistakenly paid.

Citigroup's duties

Qualified dependents will be notified of the right to elect continuation coverage automatically (without any action required by the employee or a family member) if any of the following events occurs that will result in a loss of coverage:

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

Electing COBRA

To elect or inquire about COBRA coverage, contact the Benefit Service Center.

Under the law, you must elect continuation coverage within 60 days from the date you would lose coverage because of one of the events described earlier, or, if later, 60 days after Citigroup provides you 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 choose continuation coverage, Citigroup 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. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified. "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 afforded the opportunity to maintain continuation coverage for 36 months, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) may occur while the continuation coverage is in effect.

These events can result in an extension of an 18-month continuation period to 36 months, but in no event will coverage last beyond 36 months from the date of the event that originally made a qualified dependent eligible to elect coverage. You should notify Citigroup if a second qualifying event occurs during your continuation coverage period.

When coverage ends, generally you can't convert your coverage to an individual medical policy. However, some HMOs do offer conversion to individual coverage. Contact your HMO directly.

Special Rule for HCSA: Except as required by law, the duration of COBRA continuation coverage for the Health Care Spending Account will not extend beyond the plan year in which the qualifying event occurred.

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 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 dependents due to termination or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified dependent must inform Citigroup within 60 days of the Social Security determination of disability and before the end of the original 18-month continuation coverage period. If, during continued coverage, the Social Security Administration determines that the qualified dependent is no longer disabled, the individual must inform

Citigroup of this redetermination within 30 days of the date it is made, at which time the 11-month extension will end.

If a qualified beneficiary is disabled and another qualifying event occurs within the 29-month continuation period, then the continuation coverage period is 36 months after the termination of employment or reduction in hours.

Medicare: If you lose coverage (medical, dental, or vision care plan, or Health Care Spending Account) due to your termination of employment or reduction in hours, your covered family member's COBRA coverage will not end before 36 months from the date you become covered by Medicare.

Early termination of COBRA

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

- Citigroup no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid on time (within the applicable grace period);
- The qualified dependent 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 preexisting condition of the individual;
- The qualified dependent becomes entitled to Medicare after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the disability carrier that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose preexisting condition limitations. If you become covered by another group health plan and that plan contains a preexisting condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's preexisting condition rule does not apply to you by reason of HIPAA's restrictions on preexisting condition clauses, the plan may terminate your COBRA coverage.

COBRA and FMLA

A leave that qualified under the Family and Medical Leave Act (FMLA) does not make you eligible for COBRA coverage. However, regardless of whether you lose coverage because of nonpayment of premium during an FMLA leave, you are still eligible for COBRA on the last day of the FMLA leave, if you decide not to return to active employment. Your continuation coverage will begin on the earliest of the following to occur:

- When you definitively inform Citigroup that you are not returning at the end of the leave; or
- The end of the leave, assuming 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 employment at the end of the FMLA leave.

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 may be required to pay up to 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, Citigroup will notify you of any changes in the cost.

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, please contact the COBRA administrator at the address listed below. Also, if your marital status has changed, or you, your spouse or a dependent have 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 listed below.

All notices and other communications regarding COBRA and the Citigroup-sponsored group health plan should be directed to:

ADP COBRA Services
P.O. Box 27478
Salt Lake City, UT 84127-0478

Or you may call 1-800-422-7608.

Your HIPAA rights (medical only)

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 preexisting conditions. HIPAA also requires plans to provide a Certificate of Creditable Coverage and provide for special enrollment rights as described below.

Creditable coverage

Under HIPAA, when you and your dependents no longer have Citigroup medical coverage, you must receive certification of your coverage from the medical plan in which you were enrolled. You may need this certification in the event you later become covered by a new plan under a different employer, or under an individual policy.

You and/or your dependent(s) will receive a coverage certification when your medical plan coverage terminates, again when COBRA coverage terminates (if you elected COBRA), and upon your request (if the request is made within 24 months following either termination of coverage).

You should keep a copy of the coverage certification(s) you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if you obtain new employment and your new employer's plan has a preexisting condition limitation (which delays coverage for conditions treated before you were eligible for the new plan), the employer may be required to reduce the duration of the limitation by one day for each day you had prior coverage (subject to certain requirements). If you are purchasing individual coverage, you may need to present the coverage certification to your insurer at that time as well.

Your special enrollment rights

If you decline to enroll for Citigroup 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 Citigroup 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 will have to wait until the next open enrollment *period* — or have another qualified status change or special enrollment *right* — to enroll.

To meet IRS regulations and plan requirements, Citigroup 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.

Privacy

The Plan Sponsor shall use and disclose individually identifiable health information ("Protected Health Information") as defined in 45 C.F.R. Parts 160 and 164, and specifically 45 C.F.R. sec. 164.504(f) (the "HIPAA Privacy Rule"), only in its capacity as the Plan Administrator to perform administrative functions on behalf of the Citigroup-sponsored medical, dental, and vision care plans and the Health Care Spending Account. The Plan Sponsor shall not use or disclose such information for any purpose other than as permitted to administer the plans or as permitted by applicable law.

These plans shall disclose Protected Health Information to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the plan document has been amended to incorporate the provisions herein. The Plan Sponsor shall ensure that any agents, including subcontractors, to whom it provides Protected Health Information received from any of these plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. The Plan Sponsor shall not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. The Plan Sponsor shall report to these plans any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for herein of which it becomes aware.

The Plan Sponsor shall make available Protected Health Information to these plans for purposes of providing access to individuals' Protected Health Information in accordance with 45 C.F.R. sec. 164.524. The Plan Sponsor shall make available Protected Health Information to these plans for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. sec. 164.526. The Plan Sponsor shall make available Protected Health Information and any disclosures thereof to these plans as required to provide an accounting of disclosures in accordance with 45 C.F.R. sec. 164.528.

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

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

Claims and appeals

To receive benefits from most of the Citigroup benefit plans, you will need to file a claim.

Medical	
• For all plans other than HMOs	Use one of the following forms available on Citigroup.net to file a claim for a covered out-of-network expense: • 301 — Aetna Claim Form (for ChoicePlans 100, 250, 500 and the Health Plan 2000 participants). • 302 — CIGNA Claim Form (for ChoicePlans 100, 250, 500 and the Health Plan 2000 participants). • 303 — UnitedHealthcare (for ChoicePlans 100, 250, 500, the Health Plan 2000 and Hawaii Plan participants). • 322 — BlueCross BlueShield (for ChoicePlans 100, 250, 500, the Health Plan 2000). • 323 — BlueCross BlueShield (Out-of-Area Plan). • Based on your business group you may obtain forms via the Web **www.citigroup.net/human_resources/form.htm** or through the Forms and LifeTimes option of ConnectOne at 1-800-881-3938.
• HMO participants	• Call your HMO for any claim-filing information.
Dental	
• MetLife 75 with Preferred Dentist Program (PDP)	• Use Form 304 — MetLife Dental Claim form available on **www.citigroup.net**. • Based on your business group you may obtain the form through the Forms and LifeTimes option of ConnectOne at 1-800-881-3938.
• CIGNA Dental Care DHMO	• There are no claim forms to file under this plan.
• Delta Dental	• Use Form 307 — Delta Dental of New York Claim form available on Citigroup.net to file an out-of-network expense.
Vision Care Plan	• Call Davis Vision at 1-800-999-5431 or visit **www.davisvision.com**.

Health Care Spending Account (HCSA)	• If you do not use your Citigroup FlexDirect debit card, you can file a claim by using the HCSA Reimbursement Request Form. However, you may be asked to complete and return the Spending Account Substantiation Form 318 if ADP cannot substantiate a transaction applied to your Citigroup Flex Direct debit card. • Based on your business group you may obtain the form through the Forms and LifeTimes option of ConnectOne at 1-800-881-3938.

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

- Medical, dental, and vision care claims must be filed within two years of the date of service.
- Health Care Spending Account claims must be filed by June 30 of the calendar year following the year in which the expense was incurred.

Claims and appeals for UnitedHealthcare medical plans

As of July 1, 2002, the amount of time UnitedHealthcare will take to make a decision on a claim will depend on the type of claim.

Type of claim	For claims filed on or after July 1, 2002
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Pre-service claims (for services requiring notification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that the claim was improperly filed and how to correct the filing must be given within five days Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*

Urgent care claims (for services requiring notification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision for all other claims made within 15 days for pre-service claims and 30 days for post-service claims

** Time period allowed to make a decision is suspended pending receipt of additional information.*

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

- The specific reasons for the denial;
- The specific references in the plan documentation on which the denial is based;
- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review;
- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the plan's appeals procedure.

If you have a question or concern about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination, you may appeal it as described here, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claims Administrator.

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday. If you are appealing an urgent care claim, contact Customer Service immediately.

UnitedHealthcare level one appeal

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

During the 180-day period, you may review any pertinent documents and information relevant to your claim, if you make a request in writing. This material includes all information that was relied on in making the benefit determination; that was submitted to, considered, or generated by the Claims Administrator in considering the claim; and that demonstrates the Claims Administrator's processes for ensuring proper, consistent decisions.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of pre-service claims, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim.
- For appeals of post-service claims, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

UnitedHealthcare level two appeal

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of first level appeal decision.

For appeals of pre-service claims, the second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims, the second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For pre-service and post-service claim appeals, Citigroup has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the plan. The Claims Administrator's decisions are conclusive and binding. Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

UnitedHealthcare urgent claim appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator

as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the plan. The Claims Administrator's decisions are conclusive and binding.

Claims and appeals for Aetna medical plans

As of July 1, 2002, the amount of time Aetna will take to make a decision on a claim will depend on the type of claim.

Type of claim	For claims filed on or after *July* 1, 2002
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Pre-service claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

* *Time period allowed to make a decision is suspended pending receipt of additional information.*

Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

- The specific reasons for the denial;
- The specific references in the plan documentation on which the denial is based;
- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review;
- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the plan's appeals procedure.

Appeals for Aetna medical plans

Except for urgent care claims, you will have 180 days following receipt of a claim denial to appeal the decision, if the claim was filed on or after July 1, 2002. You will be notified of the decision no later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Claims Administrator provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

For pre-service and post-service claim appeals, Citigroup has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the plan. The Claims Administrator's decisions are conclusive and binding. Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on your identification card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you and your authorized representative and the Claims Administrator by telephone, fax, or other similar method. You will be notified of the decision not later than 72 hours after the appeal is received.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

External Review

An "External Review" is a review by independent physician, with appropriate expertise in the area at issue, of claim denials based upon lack of medical necessity or the experimental or investigational nature of a proposed service or treatment.

You may, at your option, obtain External Review of a claim denial provided that:

- You have exhausted the Aetna appeal process for denied claims, as outlined in this ***Claims and appeals for Aetna medical plans*** section of this document and you have received a final denial;
- The final denial was based upon a lack of medical necessity, or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment at issue exceeds $500.

If you meet the eligibility requirements listed above, you will receive written notice of your right to request an External Review at the time the final decision on your internal appeal has been rendered. Either you or an individual acting on your behalf will be required to submit to Aetna the External Review Request Form (except under expedited review as described below), a copy of the plan denial of coverage letter, and all other information you wish to be reviewed in support of your request. Your request for an External Review must be submitted in writing to Aetna within 60 calendar days after you receive the final decision on your internal appeal.

Aetna will contact the “External Review Organization” that will conduct your External Review. The External Review Organization will then select an independent physician with appropriate expertise in the area at issue for the purpose of performing the External Review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the External Review Request Form, and must follow the applicable plan’s contractual documents and plan criteria governing the benefits.

The External Review Organization will generally notify you of the decision with 30 calendar days of Aetna’s receipt of a properly completed External Review Form. The notice will state whether the prior determination was upheld or reversed, and briefly explain the basis for the determination. The decision of the external reviewer will be binding on the plan, except where Aetna or the plan can show reviewer conflict of interest, bias, or fraud. In such cases, notice will be given to you and the matter will be promptly resubmitted for consideration by a different reviewer.

An expedited review is available when your treating physician certifies on a separate Request For Expedited External Review Form (or by telephone with prompt written follow-up) the clinical urgency of the situation. “Clinical urgency” means that a delay (waiting the full 30-calendar-day period) in receipt of the service or treatment would jeopardize your health. Expedited reviews will be decided within five calendar days of receipt of the request. In the case of such expedited reviews, you will initially be notified of the determination by telephone, followed immediately by a written notice delivered by expedited mail or fax.

You will be responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization. The professional fee for the External Review will be paid by Aetna.

In order for an individual to act on your behalf in connection with an External Review, you will need to specifically consent to the representation by signing the appropriate line on the External Review Request Form.

Your may obtain more information about the External Review process by calling the toll-free Member Services telephone number listed on your ID card.

Claims and appeals for CIGNA medical plans

As of July 1, 2002, the amount of time CIGNA will take to make a decision on a claim will depend on the type of claim.

Type of claim	For claims filed on or after *July* 1, 2002
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Pre-service claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

* *Time period allowed to make a decision is suspended pending receipt of additional information.*

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

- The specific reasons for the denial;
- The specific references in the plan documentation on which the denial is based;
- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review;
- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the plan's appeals procedure.

The CIGNA medical plans have a two-step appeals procedure for coverage decisions. To appeal the denial of a claim, you must submit a request for an appeal in writing to CIGNA within 180 days after receiving notice of the denial of your claim. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CIGNA to register your appeal by calling the toll-free number on your CIGNA HealthCare ID card. You may also register your appeal by an arranged appointment or walk-in interview.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Claims Administrator provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

CIGNA level one appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving medical necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, CIGNA will respond in writing with a decision within 15 calendar days after receiving an appeal for a pre-service or concurrent coverage determination, and within 30 calendar days after receiving an appeal for a post-service coverage determination. If more time or information is needed to make the determination, CIGNA will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if:

- the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your physician would cause you severe pain which cannot be managed without the requested services; or
- Your appeal involves non-authorization of an admission or continuing inpatient hospital stay.

The CIGNA Medical Director, in consultation with the treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

CIGNA level two appeal

If you are dissatisfied with the level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving medical necessity or clinical appropriateness, the committee will consult with at least one physician in the same or similar specialty as the care under consideration, as determined by the CIGNA Medical Director. You may present your situation to the committee in person or by conference call.

For level two appeals CIGNA will acknowledge in writing that your request was received and will schedule a committee review. For pre-service and concurrent care coverage determinations the committee review will be completed within 15 calendar days; for post-service claims, the committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, CIGNA will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information

needed by the Appeal Committee to complete the review. You will be notified in writing of the Appeal Committee's decision within five business days after the committee meeting, and within the committee review time frames above if the Appeal Committee does not approve the requested coverage.

For pre-service and post-service claim appeals, Citigroup has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the plan. The Claims Administrator's decisions are conclusive and binding. Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

You may request that the appeal process be expedited if:

- the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your physician would cause you severe pain which cannot be managed without the requested services; or
- your appeal involves non-authorization of an admission or continuing inpatient hospital stay.

The CIGNA Medical Director, in consultation with the treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

CIGNA independent review procedure

If you are not fully satisfied with the decision of CIGNA's level two appeal review regarding your medical necessity or clinical appropriateness issue, you may request that your appeal be referred to an independent review organization. The independent review organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

Generally, there is no charge for you to initiate this independent review process. However, you must provide written authorization permitting CIGNA to release the information to the independent reviewer selected.

CIGNA will abide by the decision of the independent review organization.

For more information about CIGNA's independent review procedure, contact CIGNA. You may also contact your state's Department of Insurance for assistance.

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the CIGNA appeals procedure. You may not initiate a legal action against CIGNA until you have completed the level one and level two appeals processes.

Claims and appeals for BlueCross BlueShield medical plans

Timing of Appeal Decision

Action	Expedited Appeal	Prospective Standard Appeal	Retrospective Appeal
You may appeal to Empire BlueCross BlueShield, in writing (for an urgent care claim: orally or in writing)	Within 180 days after the date you were notified	Within 180 days after the date you were notified	Within 180 days after the date you were notified
Empire BlueCross BlueShield will notify you about the appeal decision	Within 72 hours after appeal is received	Within 15 days after appeal is received	Within 30 days after appeal is received
You can make a second appeal to Empire BlueCross BlueShield, in writing	Not permitted	Within 60 days after appeal denial is received	Within 60 days after appeal denial is received
Empire BlueCross BlueShield will notify you about the second appeal decision	N/A	Within 15 days after appeal is received	Within 30 days after appeal is received

Timing of initial claim approval or denial

The time within which your claim will be approved or denied will depend on the type of claim you file.

- **For claims involving urgent care,** you will be notified of the approval or denial no later than 72 hours after your claim is received. If your claim did not include enough information to determine whether it should be approved or denied, you will be notified within 24 hours after receiving your claim of the specific information that is necessary. You will have at least 48 hours to provide the specified information. You will be notified of the approval or denial no later than 48 hours after Empire BlueCross BlueShield receives the information or 48 hours after the deadline for providing the information, if earlier. For purposes of these claims procedures, urgent care means medical care or treatment that must be provided without delay to avoid seriously jeopardizing life, health or the ability to regain maximum function, or that must, in the opinion of a physician, be provided without delay to adequately manage severe pain.
- **For medical care requiring pre-certification approval (called a "pre-certification claim"),** you will be notified of the approval or denial of your claim no later than 15 days after your claim is received. Empire BlueCross BlueShield may extend this 15-day period to 30 days if it needs more time to review your claim due to matters outside of its control. If a longer period of time is required, you will be notified within the initial 15-day period of the reasons for the extension and the date by which a decision will be made. You will be notified if your claim did not include enough information

to reach a decision. You will have at least 45 days from receipt of the notice to provide the specified information.

- For care involving an ongoing course of treatment to be provided over a period of time or through a number of treatments (called "concurrent care decisions"), you will be notified in advance of any decision by Empire BlueCross BlueShield to reduce or terminate the course of treatment that would be covered, so that you will have enough time to appeal the decision and receive a determination before the treatment is reduced or terminated. If you wish to extend the course of treatment and the treatment involves urgent care, you will be notified within 24 hours after your claim is received, as long as you make your claim at least 24 hours before the approved course of treatment is scheduled to end.
- **For all other care (e.g., reimbursement for medical services already received),** you will be notified of the approval or denial of your claim no later than 30 days after your claim is received. Empire BlueCross BlueShield may extend this 30-day period to 45 days if it needs more time to review your claim due to matters outside of its control. If a longer period of time is required, you will be notified within the initial 30-day period of the reasons for the extension and the date by which a decision will be made. You will be notified if your claim did not include enough information to make a decision. You will have at least 45 days from receipt of the notice to provide the specified information.

Contents of claim denial notice. If you receive notice that your claim has been denied, either in full or in part, the claim denial notice will include:

- the specific reasons for the denial
- reference to the specific Plan provisions on which the denial is based
- a description of any additional material or information Empire BlueCross BlueShield requires and an explanation of why it is necessary
- a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement that you have the right to bring a civil action under Section 502(a) of ERISA but only after you have followed the Plan's claims procedures
- if an internal rule, guideline or protocol was relied on in making the adverse determination, either a copy of the specific rule, guideline or protocol, or a statement that it will be provided on request, free of charge
- if the denial is based on a medical necessity exclusion, experimental treatment exclusion or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, or a statement that an explanation of the scientific or clinical judgment for the determination will be provided on request, free of charge.

First appeal to Empire BlueCross BlueShield. You have 180 days after receipt of the denial to file an appeal with Empire BlueCross BlueShield. Your appeal must be in writing, except that an appeal of an urgent care claim may be made orally or in writing. Be sure to explain why you think you are entitled to benefits, and attach any documentation that will support your claim.

Approval or denial of appeal. Empire BlueCross BlueShield will send you its decision within the following deadlines: 72 hours for urgent care claims; 15 days for pre-certification claims; and 30 days for all other claims.

If your claim is based on a medical judgment, in reviewing your appeal, Empire BlueCross BlueShield will consult with a health care professional that has appropriate training and experience in the field of medicine involved in the medical judgment and will provide you with the name of the health care professional, upon request.

If Empire BlueCross BlueShield denies your appeal, the denial notice will include:

- the specific reasons for the denial
- reference to the specific Plan provisions on which the denial is based
- a statement that you have the right to bring a civil action under Section 502(a) of ERISA after you have followed the Plan's claims procedures and received an adverse decision on your first appeal (in the case of an urgent care claim) or on your second appeal (in the case of all other claims)
- if an internal rule, guideline or protocol was relied on in making the adverse determination, either a copy of the specific rule, guideline or protocol, or a statement that it will be provided on request, free of charge
- if the denial is based on a medical necessity exclusion, experimental treatment exclusion or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, or a statement that an explanation of the scientific or clinical judgment for the determination will be provided on request, free of charge.

Second appeal to Empire BlueCross BlueShield. For claims other than urgent care claims, if Empire BlueCross BlueShield denies your appeal, you have 60 days from receiving the appeal denial to send a second appeal to Empire BlueCross BlueShield. Your appeal must be in writing. Empire BlueCross BlueShield will send you its written decision within 15 days for pre-certification claims and 30 days for all other claims.

If you are appealing an urgent care claim, Empire BlueCross BlueShield's decision on your first appeal will be final.

Authorized representative. If you appeal an adverse decision to Empire BlueCross BlueShield or the Medical Review Board, you may have an authorized person represent you (at your own expense). You have the right to examine the relevant portions of any documents that Empire BlueCross BlueShield referred to in its review.

Legal action. You must follow these claims procedures completely, which require one appeal to Empire BlueCross BlueShield for urgent care claims and two appeals to Empire BlueCross BlueShield for all other claims, before you can take legal action. After you receive the final decision from Empire BlueCross BlueShield, you can take legal action.

Claims and appeals for the prescription drug program

As of January 1, 2005, the amount of time Medco will take to make a decision on a claim will depend on the type of claim.

Type of claim	For claims filed on or after January 1, 2005
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension due to matters beyond the control of the Claims Administrator (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*

Pre-service claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information

** Time period allowed to make a decision is suspended pending receipt of additional information.*

Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

- The specific reasons for the denial;
- The specific references in the plan documentation on which the denial is based;
- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review;
- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the plan's appeals procedure.

Medco level one appeal

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

During the 180-day period, you may review any pertinent documents and information relevant to your claim, if you make a request in writing. This material includes all information that was relied on in making the benefit determination; that was submitted to, considered, or generated by the Claims Administrator in considering the claim; and that demonstrates the Claims Administrator's processes for ensuring proper, consistent decisions.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim

information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of pre-service claims, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Medco level two appeal

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator as the Plan Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of first level appeal decision.

For pre-service and post-service claim appeals, Citigroup has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the plan. The Claims Administrator's decisions are conclusive and binding. Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Medco urgent claim appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations the appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the plan. The Claims Administrator's decisions are conclusive and binding.

Claims and appeals for MetLife PDP

As of July 1, 2002, the amount of time MetLife will take to make a decision on a claim will depend on the type of claim.

Type of claim	For claims filed on or after *July* 1, 2002
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Pre-service claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

** Time period allowed to make a decision is suspended pending receipt of additional information.*

If a claim for benefits is denied in whole or in part, the claimant will be notified in writing by an Explanation of Benefits Statement or a denial letter from MetLife within 60 days of the denial. You have the right to request a reconsideration of the denied claim by calling or writing MetLife. Any additional information that you feel would support the claim should be provided to MetLife.

If after the review it is determined that the initial denial can be reversed and claim paid, normal processing steps are followed. If after the review it is determined that the original denial stands, a denial letter is written.

Responses to an appeal are conducted by an individual of higher authority than the person who originally denied the claim. The response includes:

- Explanation of why the charges are denied in plain language
- Reference to the plan (booklet) wording which justifies the denial

The appeal request must be submitted in writing to MetLife within 60 days of receipt of the denial letter. As part of this review, you or your legal representative has the right to review all pertinent documents and submit issues and comments in writing to a committee selected by MetLife. The committee consists of senior representatives of MetLife Dental Claims Management and, a Dental Consultant. The plans provide that the committee has the authority and discretion to interpret the plans' provisions and to determine eligibility under the plans to receive benefits. The determination of the committee will be made in a fair and consistent manner in accordance with its interpretation of the plan's terms.

The committee will issue a decision on the case no later than the third meeting of the committee after receipt of the appeal request. The committee usually meets monthly. This decision is sent to the claimant in writing and includes the specific reasons and references to the plan provision on which the decision is based.

Claims and appeals for the CIGNA Dental Care DHMO

If you have a concern about your Dental Office or the Dental Plan, you can call 1-800-367-1037 toll-free and explain your concern to a Member Services Representative. You can also express that concern to CIGNA Dental in writing. Most matters can be resolved with the initial phone call. If more time is needed to review or investigate your concern, CIGNA Dental will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

CIGNA Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to the CIGNA Dental Plan within one year from the date of the initial CIGNA Dental decision. You should state the reason why you believe your request should be approved and include any information supporting your request. If you are unable or choose not to write, you can ask Member Services to register your appeal by calling 1-800-397-1037.

CIGNA Dental level one appeal

Your level one appeal will be considered and the resolution made by someone not involved in the initial decision or occurrence. Issues involving dental necessity or clinical appropriateness will be considered by a dental professional.

If your appeal concerns a denied pre-authorization, CIGNA Dental will respond with a decision 15 calendar days after your appeal is received. For appeals concerning all other coverage issues,CIGNA Dental will respond with a decision within 30 calendar days after your request is received. If the review cannot be completed within 30 days, CIGNA Dental will notify you on or before the 30th day of the reason for the delay. The review will be completed within 15 calendar days after that.

- For New Jersey residents, CIGNA Dental will respond in writing within 15 working days;
- For Colorado residents, CIGNA Dental will respond within 20 working days; and
- For Nebraska residents, CIGNA Dental will respond within 15 working days if your complaint involves an adverse determination.

If you are not satisfied with the decision, you may request a second-level review. To initiate a level two appeal, you must submit your request in writing to CIGNA Dental within 60 days after receipt of CIGNA Dental's level one decision.

CIGNA Dental level two appeal

Second-level reviews will be conducted by CIGNA Dental's Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the appeals committee. For appeals involving dental necessity or clinical appropriateness, the committee will include at least one dentist. If specialty care is in dispute, the committee will consult with a dentist in the same or similar specialty as the care under consideration, as determined by CIGNA Dental.

CIGNA Dental will acknowledge your appeal in writing within five business days and schedule a committee review. The acknowledgment will include the name, address, and telephone number of the appeals coordinator. Additional information may be requested at that time. The review will be held within 30 calendar days. If the review cannot be completed within 30 calendar days, you will be notified in writing on or before the 15th calendar day, and the review will be completed no later than 45 days after receipt of your request.

You may present your situation to the committee in person or by conference call. Please advise CIGNA Dental five days in advance if you or your representative plans to be present. You will be notified in writing of the committee's decision within five business days after the committee meeting. The resolution will include the specific contractual or clinical reasons for the resolution, as applicable.

CIGNA Dental expedited appeal

You may request that the complaint or appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the plan will respond orally with a decision within 72 hours, followed up in writing.

- For Maryland residents, CIGNA Dental will respond within 24 hours; and
- For Texas residents, CIGNA Dental will respond within one business day.

CIGNA Dental independent review

If your appeal concerns a dental necessity issue and the appeals committee denies coverage, you may request that your appeal be referred to an independent review organization. To request a referral to an independent review organization, the reason for the denial must be based on a dental necessity determination by CIGNA Dental. Administrative, eligibility, or benefit coverage limits are not eligible for additional review under this process.

There is no charge to initiate this independent review process; however, you must provide written authorization permitting CIGNA Dental to release the information to the independent review organization. The independent review organization is composed of persons who are not employed by CIGNA Dental or any of its affiliates. CIGNA Dental will abide by the decision of the independent review organization.

To request a referral to an independent review organization, you must notify the appeals coordinator within 60 days of receipt of your level two decision. CIGNA Dental will then forward the file to the independent review organization within 30 days.

The independent review organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your dental condition, as determined by the plan's dental director, the review shall be completed within three to five days.

The independent review program is a voluntary program arranged by the plan and is not available in all areas.

Appeals to the state

You have the right to contact your state's Department of Insurance or Department of Health for assistance at any time.

CIGNA Dental will not cancel or refuse to renew coverage because you or your dependent has filed a complaint or appealed a decision made by CIGNA Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

Claims and appeals for Delta Dental

The amount of time Delta Dental will take to make a decision on a claim will depend on the type of claim.

Type of claim	Process
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period.) Notice that more information is needed must be given within 30 days. You have 45 days to submit any additional information needed to process the claim.*
Pre-service claims (for services requiring precertification of services)	Not applicable. Delta does not condition the receipt of a benefit, in whole or in part, upon approval of the benefit in advance of obtaining dental care.
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Not applicable. Urgent care claims do not ordinarily arise in the context of a fee-for-service plan involving dental care, such as Citigroup's dental plan.
Concurrent care claims (for ongoing treatment)	Not applicable. Concurrent care claims do not occur in the context of a fee-for-service dental plan.

** Time period allowed to make a decision is suspended pending receipt of additional information.*

If a claim is denied in whole or in part, the claimant will receive a notice of payment or action that outlines the specific reason(s) and the specific plan provision(s) on which the determination was based. Upon request and free of charge, Delta will provide the claimant a copy of any internal rule, guideline or protocol, and/or an explanation of the scientific or clinical judgment if relied upon in denying the claim.

If the claimant or his/her attending dentist wants the denial of benefits reviewed, the claimant or his/her attending dentist must write to Delta **within one hundred eighty (180) days of the date on the Notice of Payment or Action. Failure to comply with such requirements may lead to forfeiture of the claimant's right to challenge the denial, even when a request for clarification has been made.**

The claimant's letter should state why the claim should not have been denied. Also, any other documents, data, information or comments that are thought to have bearing on the claim including the denial notice, should accompany the request for review.

The claimant or his/her attending dentist is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether the information was submitted or considered initially.

The review will be conducted for Delta by a person who is neither the individual who made the claim denial that is the subject of the review, nor the subordinate of the individual. If the review of a claim denial is based in whole or in part on a lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the contract, Delta will consult with a dentist who has appropriate training and experience in the pertinent field of dentistry who is neither the Delta dental consultant who made the claim denial nor the subordinate of the dental consultant. The identity of the dental consultant will be available upon request whether or not the advice was relied upon. In making the review, Delta will not afford deference to the initial adverse benefit determination.

If after review, Delta continues to deny the claim, Delta will notify the claimant or his/her attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received. Delta will send the claimant or his/her attending dentist a notice, similar to this notice. If in the opinion of the claimant or his/her attending dentist, the matter warrants further consideration, the claimant should advise Delta in writing as soon as possible.

The matter will be immediately referred to Delta's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta's Dental Affairs Committee if requested by the claimant or his/her attending dentist.

The Dental Affairs Committee will render a decision within thirty (30) days of the claimant's request for further consideration. The decision of the Dental Affairs Committee will be final insofar as Delta is concerned. Recourse thereafter would be to the state regulatory agency, a designated state administrative review board or to the courts with an action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) or other civil action.

Claims and appeals for the vision care plan

As of July 1, 2002, the amount of time Davis Vision will take to make a decision on a claim will depend on the type of claim.

Type of claim	For claims filed on or after *July* 1, 2002
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*

Pre-service claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

** Time period allowed to make a decision is suspended pending receipt of additional information.*

You have the right to voice a grievance or complaint against Davis Vision at any time. Davis Vision will not retaliate or take any discriminatory action against you because you have filed a grievance, complaint or appeal. A grievance is a complaint that may or may not require specific corrective action and is made:

- Via the telephone;
- In writing to Davis Vision; or
- Via the Davis Vision Web site.

Claims include but are not limited to the following:

- Benefit denials;
- An adverse determination as to whether a service is covered pursuant to the terms of the contract;
- Difficulty accessing or utilizing a benefit, and issues regarding the quality of vision care services;
- Challenges with provided vision care services or products received; and
- Dissatisfaction with the resolution of a grievance, “adverse determination.”

You may file a grievance by

- contacting Davis Vision’s toll free hot line 24 hours a day at 1-800-584-1487;
- sending a letter via U.S. mail or overnight delivery; or
- logging on to the Web site: **www.davisvision.com**.

Written grievances should be sent to:

Davis Vision
159 Express Street
Plainview, NY 11803
Attention: Quality Assurance/Patient Advocate Department

A written grievance will be acknowledged within five business days.

Davis Vision level one appeal

You will be contacted by a Davis Vision associate within five business days of receipt of a concern or grievance to confirm that the concern was received and is being investigated. A designated Davis Vision associate will review the appeal with you and may request additional information. You will be provided with the Associate's name, phone number, department and the estimated time needed to perform the research (for pre-service appeals, 15 days; for post-service appeals, 30 days) and when you can expect a determination. You will also be informed of your right to have a representative, including your provider, present during the review of the concern and final outcome of the investigation. You also will be informed of your right to appeal to an external review organization at any time during the grievance procedure or as required by state statute.

When grievances pertain to clinical decisions, the review committee will include a licensed (peer) health care professional. All decisions are reviewed and approved by the Vice President of Professional Affairs, a licensed optometrist.

The investigation may involve contacting the provider or the point-of-service location to determine the root cause of the concern. When warranted the Regional Quality Assurance Representative (RQAR) or Professional Field Consultant (PFC) will be contacted and a site visit may be scheduled. When further information is required, Davis Vision will contact you and inform you of the status of the investigation and/or the need for more information.

At the conclusion of the investigation, the determination will be communicated within 15 days for pre-service claims and 30 days for post-service claims, or as required by state statute, (or an additional 10 days may be requested in order to complete further research). The appeal determination will include the following:

- Outcome of the investigation and a summary of the material facts related to the issue;
- Criteria that were utilized and a summary of the evidence, including the documentation supporting the decision;
- Statement indicating that the decision will be final and binding unless you appeal in writing to the Quality Assurance/Patient Advocate Department within 15 business days of the date of the notice of the decision;
- Copy of the appeals process, if applicable; and
- Name, position, phone number and department of the person(s) who was responsible for the outcome.

The decision of the Quality Assurance/Patient Advocate Department is final and binding unless you appeal to Davis Vision within 15 business days of the date of notice of the decision.

Davis Vision level two appeal

Should Davis Vision uphold a denial, as the result of a level one review, you have the right to request a level two appeal.

A level two appeal will not include any associate(s) or licensed (peer) health care professional(s) that were involved in the level one review.

A level two appeal requires you to contact Davis Vision in writing or by telephone within 15 days following your receipt of the level one summary statement.

If you are requesting a level two appeal, you must indicate the reason you believe the denial of coverage/ benefit was incorrect. Davis Vision reserves the right to solicit further information from you and/or the provider.

Davis Vision has 30 days, or as required by state statue, from the date the requested information is received, to respond to the level two review, or 45 days, or as required by state statute, if it is a post-service review. The Vice President of Professional Affairs will review all clinical appeals. A Davis Vision associate(s) and a Regional Quality Assurance Representative(s) (RQAR), a licensed optometrist, not involved in the initial determination will review the level one decision. If the level two appeal upholds the level one determination you will be notified in writing within 5 days.

Notification will include, but may not be limited to:

- The outcome of the investigation and a summary stating the nature of the concern and the material facts related to the issue;
- Criteria that were utilized and a summary of the evidence, including documentation that was used to support the decision;
- A statement indicating that the decision will be final and binding unless you appeal in writing or by telephone to the Quality Assurance/Patient Advocacy Department within 45 days of the date of the notice of the level two decision;
- A copy of the appeals process, if applicable; and
- The name, position, phone number and department of person(s) who was responsible for the outcome.

External review

Davis Vision gives you, as required by state statute, an opportunity to request an impartial review of concerns that resulted in coverage denials. If you have utilized and exhausted the internal appeals process, you may appeal the final decision if the denial for services exceeds $250 and was not deemed medically necessary or the requested service was deemed investigational or experimental.

An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organization will have up to 30 days, or as required by state statute, to make a determination.

Davis Vision, a national provider of vision care benefits, recognizes that each state has implemented an external review process that is unique to their residents. Individual states have mandated the use of their own external review process for appeals based on medical necessity. You can call the Member Service Department at 1-800-999-5431 for information unique to your state of residence. You also have the right to contact your state insurance or health department for further information.

You have the right to an external review of a denial of coverage. You have the right to an external review of a final adverse decision under the following circumstances:

- You have been denied a vision care service, which should have been covered under the terms of the vision care plan;

- Services were denied on appeal on the basis that requested services were not medically necessary;
- A treatment or service that will have a significant positive impact on you has been denied and any alternative service or treatment will not affect your ocular health and/or will produce a negative outcome;
- The services denied are related to a current illness or injury;
- The cost of the requested services will not exceed that of any equally effective treatment;
- The denied service, procedure, or treatment is a covered benefit under the vision care plan; or
- You have exhausted all internal appeal processes with an adverse determination upheld at each level.

The vision care provider may contact the appropriate state agency to determine if other documentation may be required for the appeal process.

The external review representative must make a decision within 30 days of receipt of documentation, or as required by state statute, and notifies you within two business days of a determination. Notification must be in writing and include an explanation and the clinical criteria utilized in the decision.

Claims and appeals for Plans administered by ADP

If you are denied a benefit under the Health Care Spending Account, you should proceed in accordance with the following procedures.

Step 1:*Denial Notice is received from ADP.* If your claim is denied, you will receive written notice from ADP that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of ADP, ADP may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which ADP must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2:*Review your notice carefully*. Once you have received your notice from ADP, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures;
- a right to request all documentation relevant to your claim;

Step 3: *If you disagree with the decision, file an appeal.* If you do not agree with ADP's decision, you may file a written appeal. You should file your appeal no later than 180 days after receipt of the notice described in Step 1. You should file your appeal with ADP at the address provided below. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

ADP Claim Appeals
P.O. Box 1801
Alpharetta, GA 30023-1801

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing. The notice will be sent no later than 30 days after receipt of the appeal by ADP.

Step 5: *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the third party administrator.

Step 6: *If you still disagree with ADP's decision, file an appeal with Citigroup.* If you still do not agree with the ADP's decision, you may file a written appeal with Citgroup at the address listed below within 60 days after receiving the latest denial notice from ADP. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If Citgroup denies your Appeal, you will receive notice within 30 days after the Citigroup receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Citigroup Inc.
125 Broad Street, 8th Floor
New York, NY 10004

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- The Plan Administrator is required to give the participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination;
- You cannot file suit in federal court until you have exhausted these appeals procedures, however, you have the right to file suit under ERISA Section 502 following an adverse appeal decision;
- Each participant has the right to request and obtain documents, records and other information as it pertains to their Benefit Plan(s).

ERISA information

As a participant in Citigroup benefit plans, you have rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

You may examine all plan documents (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 Pension and Welfare Benefit Administration) such as annual reports (Form 5500 Series) and plan descriptions. You can review these documents at no cost to you at the location of the plan sponsor.

You may obtain copies of all plan documents and other plan information upon written request to the Plans Administration Committee. The Plans Administration Committee may charge a reasonable fee for copying the documents.

You may receive a copy of the plan's annual financial reports upon written request to the Plans Administration Committee.

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this document and all other documents governing the plan on the rules governing your continuation coverage rights.

You can reduce or eliminate an exclusionary period of coverage for preexisting 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 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 preexisting 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 plan 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 pension 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 plan review and reconsider your claim. For more information see the **Claims and appeals** section.

Under ERISA, there are steps you can take 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 Plans Administration Committee 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 Plans Administration Committee'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 qualified medical child support order, you may file suit in federal court. If you believe the plan 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.

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 found your suit to be frivolous.

Answers to your questions

If you have questions about the plan, contact the Plans Administration Committee. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plans Administration Committee, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington DC 20210. The Pension and Welfare Benefits Administration's New York City branch is located at 1633 Broadway, Room 226, New York, NY 10019. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications' hotline of the Pension and Welfare Benefits Administration or by accessing the Web site at **www.dol.gov/ebsa**.

Administrative information

This section contains general information about the administration of the Citigroup plans, the plan documents, sponsors, and Claims Administrators. In addition, a statement about the future of the plans and Citigroup's right to amend, modify, suspend, or terminate is outlined in this section.

Future of the plans

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

Citigroup has the right to amend, modify, suspend, or terminate any plan, in whole or in part, at any time without prior notice. Citigroup may make any such amendment, modification, suspension, or termination of the plans.

In the event of the dissolution, merger, consolidation or reorganization of Citigroup, the plan will terminate unless the plan is 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.

No right to employment

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

Plan administration

The Plan Administrator is responsible for the general administration of the plan, and will be the fiduciary to the extent not otherwise specified in this document or in an insurance contract. The Plan Administrator and the Claims Administrator have the 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 plan, and to remedy ambiguities, inconsistencies or omissions, and such determinations shall be binding on all parties.

The plan has designated other organizations or persons to act out specific fiduciary responsibilities in administering the plan including, but not limited to, any or all of the following responsibilities:

- To administer and manage the plan, including the processing and payment of claims under the plan 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 be prepared and disclosed to employees or other persons entitled to benefits under the plan; and
- To act as Claims Administrator and to review claims and claim denials under the plan to the extent an insurer or administrator is not empowered with such responsibility.

The Plan Administrator will administer the plan on a reasonable and nondiscriminatory 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 be controlling in all matters relating to the plan.

Plan information

Employer Identification Number	52-1568099
Participating Companies	American Health and Life Company, CitiFinancial, Citigroup Corporate Staff, Citigroup Investment Group, Primerica Financial Services, and National Benefit Life Insurance Company, Citibank NA and Participating Companies, CitiStreet Institutional Division, and CitiStreet Total Benefit Outsourcing, Salomon Smith Barney Holdings Inc. and its subsidiaries
Plan Names and Numbers	
• Medical plans (self-funded ChoicePlans, Health Plan 2000, Hawaii Health Plan, Out-of-Area Plan, and HMOs) including prescription drugs	Citigroup Health Benefit Plan Plan number 508
• Dental plans	Citigroup Dental Benefit Plan Plan number 505
• Vision care plan	Citigroup Vision Benefit Plan Plan Number is 533
• Health Care Spending Account	Citigroup Flexible Benefits Plan Plan number 512
Plan Administrator	Plans Administration Committee of Citigroup Inc. 125 Broad Street, 8th Floor New York, NY 10004
Plan Sponsor	Citigroup Inc. 75 Holly Hill Lane Greenwich, CT 06830

Claims Administrators

Each of the Claims Administrators has the discretion and authority to render benefit determinations in a manner consistent with the terms and conditions of their respective health care benefit plan — namely, those provisions of the document that apply to the participant and administered by that particular Claims Administrator.

ChoicePlans and Health Plan 2000	Aetna Citibank Claims Division P.O. Box 981106 El Paso, TX 79998-1106 1-800-545-5862 CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200 1-800-794-4953 or P.O. Box 182223 Chattanooga, TN 37422-7223 Empire BlueCross BlueShield P.O. Box 5072 Middletown, NY 10940-9072 1-866-290-9098 UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845
For fully insured HMOs	Call the Citigroup HMO Administrator at 1-800-422-6106
For self-insured HMO plans	Aetna P.O. Box 1125 Blue Bell, PA 19422 1-800-821-3808 CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200 1-800-794-4953 or P.O. Box 182223 Chattanooga, TN 37422-7223 UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845
Hawaii Health Plan	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845

Out-of-Area Plan	Empire BlueCross BlueShield P.O. Box 5072 Middletown, NY 10940-9072 1-866-290-9098
For Prescription Drug Program	
• Retail Pharmacy	Medco Health Prescription Solutions, Inc. P.O. Box 2187 Lee's Summit, MO 64063-2187
• Medco By Mail	Medco By Mail P.O. Box 747000 Cincinnati, OH 45274-7000
For Dental Plans	
• MetLife 75 with Preferred Dentist Program (PDP)	Metropolitan Life Insurance Company MetLife Dental Claims Unit P.O. Box 14093 Lexington, KY 40512-4093 1-888-832-2576
• CIGNA Dental Care DHMO	CIGNA Dental/Member Services 300 NW 82nd Avenue Suite 700 Plantation, FL 33324 1-800-367-1037
• Delta Dental	Delta Dental One Delta Drive Mechanicsburg, PA 17055 1-800-932-0783
For Vision Care Plan	Davis Vision 159 Express St. Plainview, NY 11803 516-932-9500 1-800-DAVIS-2-U
For Health Care Spending Account	ADP Claims Processing Center P.O. Box 1800 Alpharetta, GA 30023-1800 1-800-378-1823 Fax: 678-762-5693
Agent for Service of Legal Process	Citigroup Inc. General Counsel 399 Park Avenue, 3rd Floor New York, NY 10043
Plan Year	January 1 — December 31

Funding	With the exception of the vision care plan, the CIGNA DHMO, and the many fully insured HMOs, all plans are paid from the general assets of Citigroup, providing benefits for medical expenses. The vision care plan and the CIGNA DHMO are funded through an insurance contract. The cost of all plans is shared by Citigroup and the participant.
Type of Administration	The plans are administered by the Plans Administration Committee. However, final decision on the payment of claims rest with the Claims Administrators. Benefits are paid from the general assets provided by the Plan Sponsor and may be from a trust qualified under section 501(c)(9) of the Internal Revenue Code on behalf of the plans in accordance with the terms of their contracts. The Claims Administrators do not guarantee the benefits under the plan.

Notice required by the Florida Insurance Department: Some of these plans are self-insured group health plans not regulated by the Florida Insurance Department. Payment of claims is completely dependent upon the financial solvency of the employer or other entity sponsoring the plans. No guaranty fund exists to cover claims a bankrupt or otherwise insolvent employer or plan sponsor cannot pay.

Citigroup Dental Benefit Plan

Amended and Restated as of January 1, 2005

Citigroup Dental Benefit Plan

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Introduction

This plan document sets forth the terms and conditions of your benefits under the Citigroup Dental Benefit Plan, as amended and restated as of January 1, 2005. Citigroup has entered into an arrangement with MetLife, Delta Dental and CIGNA Dental to administer the plans. This document should be read in combination with “About Your Health Care Benefits” document, amended and restated as of January 1, 2005, which is also a component of the Citigroup Dental Benefit Plan document.

Citigroup offers three dental options to provide dental care for you and your eligible dependents. The three dental options are:

- MetLife 75 with Preferred Dentist Program (MetLife 75);
- Delta Dental; and
- CIGNA Dental Care DHMO (dental health maintenance organization).

As you read the document, you will see some terms that are bold and underlined. This means that the term is a reference to another section of the document.

This section of the document is intended to comply with the requirements of ERISA and other applicable laws and regulations. It does not create a contract or guarantee of employment between Citigroup and any individual.

MetLife 75 with Preferred Dentist Program

MetLife 75 with Preferred Dentist Program (MetLife 75) is a preferred provider organization (PPO) consisting of a nationwide network of general and specialty dentists.

To locate a participating dentist:

- Visit the MetLife Web site at **www.metlife.com/dental/**; or
- Call 1-888-832-2576.

When calling to make an appointment, let the dentist know that you participate in MetLife 75.

The following is a summary of features covered under MetLife 75. Types of services and limitations are outlined in the **Covered services and limitations** section.

Type of service	Coverage*
Annual deductible	$75 per person; $225 per family
Annual maximum (excludes orthodontia)	$2,000 per person
Preventive and diagnostic services	100% of covered expenses with no deductible
Basic services	80% of covered expenses after deductible
Major services	50% of covered expenses after deductible
Orthodontia	50% of covered expenses after deductible
Lifetime orthodontia benefit (for children and adults)**	$2,000 per person

** Network percentages are based on negotiated fees with participating providers. Out-of-network percentages are based on reasonable and customary charges. For more details, see the **Covered charges** section.*

*** For participants in the Citigroup Dental Benefit Plan who switch from Delta Dental to MetLife75, any previous orthodontia benefits paid under Delta Dental for 2004 and future plan years will be combined with any orthodontia benefits paid under MetLife 75, and the combined benefit will be counted towards the lifetime orthodontia benefits maximum.*

Covered services and limitations

Dental services are categorized into four services — preventive and diagnostic, basic, major, and orthodontia services. Below are descriptions of covered services and limitations by category.

Preventive and diagnostic

The following is a list of covered preventive and diagnostic services and limitations:

- Routine oral exams, maximum of two exams per calendar year;
- Routine cleanings, maximum of two cleanings per calendar year;
- Fluoride treatments (age 18 and under), maximum of one application per calendar year;
- Space maintainers (age 18 and under);

- Full mouth series and panoramic x-rays, once every 36 months;
- Bitewing x-rays, up to two bitewing x-rays per calendar year;
- Sealants — permanent molars only (age 16 and under), one application every 36 months; and
- Palliative treatments, emergency treatment only.

Basic services

The following is a list of covered basic services and limitations:

- Fillings (except gold fillings), includes silver (amalgam), silicate, plastic, porcelain and composite fillings to restore injured or decayed teeth. Composite fillings for molars are not covered;
- 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);
- Denture relining, once per 36 months;
- Periodontal treatment, includes scaling and root planning;
- Bruxism appliance; and
- General anesthesia, when medically necessary, as determined by the Plan Administrator and administered in connection with a covered service.

Major services

The following is a list of covered major services and limitations:

- Inlays, onlays, and crowns (including precision attachments for dentures), 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 or addition of teeth to partial removable denture; dentures must be at least 5 years old and unserviceable), limited to once every five years;
- Fixed bridgework, including inlays, onlays, and crowns used to secure a bridge (initial installation);
- Fixed bridgework, including inlays, onlays, and crowns used to secure a bridge (replacement of an existing removable denture or fixed bridgework with new fixed bridgework, or addition of teeth to existing fixed bridgework; bridgework must be at least 5 years old and unserviceable), limited to once every five years; and
- Dental implants (subject to medical necessity and consultant review).

Orthodontia services

The following is a list of covered orthodontia services:

- Orthodontic x-rays;
- Evaluation;

- Treatment plan and record;
- Services or supplies to prevent, diagnosis, 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.

Oral cancer services

Additional dental coverage may be available for those participants diagnosed with oral cancer.

How the Plan works

MetLife 75 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.

Annual deductible and maximum

Before benefits can be paid in a calendar year, you and/or your covered dependent(s) must meet the $75 individual or $225 family deductible. The deductible does not apply to preventive and diagnostic services. However, the deductible does apply to basic, major, and orthodontia services.

You can meet the family deductible as follows:

- Up to three people in a family: each member must meet the individual deductible; or
- Four or more people in a family: expenses can be combined to meet the family deductible. However, no one person can apply more than the $75 individual deductible toward the $225 family deductible.

You and/or your covered dependent(s) have an annual maximum benefit of $2,000 per person.

Covered charges

After you have met the deductible, MetLife 75 reimburses Covered charges for out-of-network dentists at a percentage of reasonable and customary (R&C) charges. MetLife 75 determines R&C 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. For example, if the orthodontic expense submitted is $3,000, the Plan will pay the 50% benefit, as follows:

Coverage for orthodontic appliance:

- $3,000 × 20% = $600 × 50% benefit = $300.
- First payment will be $300.

Coverage for monthly payments:

- $3,000 - $600 = $2,400.
- $2,400 ÷ 24 months = $100 × 50% benefit = $50.
- Monthly payment will be $50.

A monthly payment of $50 will be made over the course of treatment. 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. Orthodontic benefits are subject to the calendar year deductible and the $2,000 lifetime orthodontic maximum. In this example, assuming the annual deductible has been met, the total amount paid will be $1,500.

Coverage for orthodontic work in progress

The MetLife Dental PDP plan pays 50% co-insurance, after the annual deductible is met, up to a $2,000.00 lifetime orthodontia maximum.

Assume Delta has paid $1,000.00 for the orthodontia treatment during 2004, and the participant transfers to the MetLife plan effective 01/01/2005. MetLife will calculate the benefits payable in the following way:

$5,000.00	submitted fee
× 20%	calculation for the appliance (braces)
$1,000.00	appliance
$5,000.00	submitted fee
- $1,000.00	appliance
$4,000.00	is divided equally into the 24 treatment months at $167.00 per month.

As of January 2005, MetLife would deduct $1,000.00 for the appliance from the $5,000.00 submitted fee and $1,000.00 for the 2004 monthly service charges (i.e., $167.00 per month for July through December 2004).

$5,000.00	submitted fee
- $1,000.00	appliance
- $1,000.00	monthly service payment charges for July through December 2004
$3,000.00	is the amount MetLife will consider as covered service charges on 01/01/2005 for the remaining 18 months of treatment.

The employee, or the dentist if benefits have been assigned, would begin to receive $84.00 per month (50% co-insurance for $167.00 covered service charges) in January 2005 for the remaining 18 months of treatment or until the $2,000.00 lifetime orthodontia maximum is reached. If the annual deductible has not been satisfied by another claim, it will be taken from the January payment each year.

Since $1,000.00 was previously paid by Delta for service charges in 2004, the remaining lifetime maximum is an additional $1,000.00. In the example above, MetLife would pay for $84.00 per month for approximately 12 months of treatment ($1,000.00 / $84.00 = 11.9 months) to the $2,000.00 lifetime orthodontia maximum.

Treatment may continue with the 2004 provider, regardless of whether or not they are in the MetLife Provider Network.

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.

Predetermination of benefits

Before starting a dental treatment for which the charge is expected to be $300 or more, you should request a predetermination of benefits using a MetLife dental claim form. Complete the employee section of the form, ask your dentist to itemize all recommended services and costs, and send the form to the Claims Administrator at the address on the form.

The Claims Administrator will notify you and your dentist of the benefits payable under the Plan. You and/or your dependent(s) and the dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed and an estimate of the dentist's fees are not submitted in advance, the Plan reserves the right to determine benefits payable by taking into account alternative procedures, services, or courses of treatment based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable, or may not be paid.

Alternative treatment

Many dental conditions can be treated in more than one way. MetLife 75 has an "alternate treatment" clause that governs the amount of benefits that will be paid for covered treatments.

If you choose a more expensive treatment — recommended by your dentist — than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payable will be based on the cost of the treatment that provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and you and/or your dependent(s) and the dentist decide to use a gold filling, MetLife 75 will base its reimbursement on the

reasonable and customary charge for an amalgam filling. You will pay the difference in cost between the reimbursed amount and the dentist's charge.

Services not covered

Benefits are not provided for services and supplies not medically necessary for the diagnosis or treatment of dental illness or injury. 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.

The following exclusions apply to MetLife 75 and are **not** covered by the Plan:

- Dental care received from a dental department maintained by an employer, mutual benefit association, or similar group;
- Treatment performed for cosmetic purposes;
- Treatment by anyone other than a licensed dentist, except for dental prophylaxis performed by a licensed dental hygienist under the supervision of a licensed dentist;
- Services in connection with dentures, bridgework, crowns, and prosthetics if for:
  - Prosthetics started before the patient became covered;
  - Replacement within five years of a prior placement covered under this Plan;
  - Extensions of bridges or prosthetics paid for under this Plan, unless into new areas;
  - Replacement due to loss or theft;
  - Teeth that are restorable by other means or for the purpose of periodontal splinting; and
  - Connecting (splinting) teeth, changing or altering the way the teeth meet, restoring the bite (occlusion), or making cosmetic changes.
- Any work done or appliance used to increase the distance between nose and chin (vertical dimension);
- Facings or veneers on molar crowns or molar false teeth;
- Training or supplies used to educate people on the care of teeth;
- Charges for crowns and fillings not covered under basic services;
- Any charges incurred for services or supplies not recommended by a licensed dentist;
- Any charges incurred due to sickness or injury that is covered by a Workers' Compensation Act or other similar legislation or arising out of or in the course of any employment or occupation whatsoever for wage or profit;
- Any charges incurred while confined in a hospital owned or operated by the U.S. government or an agency thereof for treatment of a service-connected disability;
- Any charges that, in the absence of this coverage, you would not be legally required to pay;
- Any charges incurred that result directly or indirectly from war (whether declared or undeclared);

- Any charges resulting from injury that is intentionally self-inflicted or from injury sustained while committing an assault or felony;
- Any charges for services and supplies furnished for you or your eligible dependent(s) prior to the effective date of coverage or subsequent to the termination date of coverage;
- Any charges for services or supplies that are not generally accepted in the U.S. as being necessary and appropriate for the treatment of dental conditions including experimental care;
- Any charges for nutritional supplements and vitamins;
- Services covered by motor vehicle liability insurance;
- Services that would be provided free of charge but for coverage;
- Broken appointments;
- Charges for filing claims or charges for copies of x-rays;
- Any charges for services rendered to sound and natural teeth injured in an accident;
- Care and treatment that is in excess of the reasonable and customary charge; and
- Services that, to any extent, are payable under any medical benefits, including HMOs.

Filing claims

When you visit the dentist, you will pay the dentist directly and then submit a claim for benefits. See **Claims and appeals for MetLife PDP** for information about submitting claims and filing an appeal if your claim is denied.

Delta Dental

Delta Dental has two provider networks available to you through Citigroup: DeltaPremier and DeltaPreferred Option.

To locate a participating dentist:

- Visit the Delta Dental Web site at
  - **www.deltadentalpa.org/citigroup**; or
  - Call 1-877-248-4764.

When calling to make an appointment, let the dentist know that you participate in Delta Dental and ask if they are in either the DeltaPremier or DeltaPreferred network.

The following is a summary of features covered under Delta Dental. Types of services and limitations are outlined in the **Covered services and limitations** section.

Type of service	Coverage*
Annual deductible	$50 per person; $150 per family
Annual maximum (excludes orthodontia)	$3,000 per person
Preventive and diagnostic services	100% of covered expenses with no deductible*
Basic services	80% of covered expenses after deductible*
Major services	50% of covered expenses after deductible*
Orthodontia	50% of covered expenses after deductible*
Lifetime orthodontia benefit (for children and adults)**	$3,000 per person

** Delta's participating providers agree to submit claims to Delta and to accept Delta's maximum Plan allowances as payment in full. Participating dentists are paid directly by Delta and, by agreement, cannot bill you more than the applicable deductible or copayment for service. By using a participating dentist, you limit your out-of-pocket costs. For services performed by non-participating dentists, Delta sends the benefit payment directly to you. You are responsible for paying the non-participating dentist's total fee, which may include amounts, such as deductibles and copayments, in addition to your share of Delta's allowance and services not covered by the group dental service contract.*

***For participants in the Citigroup Dental Benefit Plan who switch from MetLife75 to Delta Dental, any previous orthodontia benefits paid under MetLife 75 for 2004 and future plan years will be combined with any orthodontia benefits paid under Delta Dental, and the combined benefit will be counted towards the lifetime orthodontia benefits maximum.*

Covered services and limitations

Dental services are categorized into four services — preventive and diagnostic, basic, major, and orthodontia services. Below are descriptions of covered services and limitations by category.

Preventive and diagnostic

The following is a list of covered preventive and diagnostic services and limitations:

- Oral exams, maximum of two exams per calendar year;
- Routine cleanings, maximum of three cleanings per calendar year;
- Fluoride treatments (to age 18), maximum of one application per calendar year;
- Space maintainers (to age 18);
- Full mouth series and panoramic x-rays, once every 36 months;
- Bitewing x-rays, allowed twice per calendar year;
- Sealants — permanent molars only (to age 16), one application every 36 months; and
- Palliative treatments, emergency treatment only.

Basic services

The following is a list of covered basic services and limitations:

- Fillings (except gold fillings), includes silver (amalgam), silicate, plastic, porcelain and composite fillings to restore injured or decayed teeth. Composite fillings for molars are not covered;
- 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);
- Denture relining, once per 36 months;
- Periodontal treatment, includes gingival curettage;
- Bruxism appliance; and
- General anesthesia, when medically necessary, as determined by the Plan Administrator and administered in connection with a covered service.

Major services

The following is a list of covered major services and limitations:

- Inlays, onlays, and crowns (including precision attachments for dentures), 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 or addition of teeth to partial removable denture), limited to once every five years;
- Fixed bridgework, including inlays, onlays, and crowns used to secure a bridge (initial installation);
- Fixed bridgework, including inlays, onlays, and crowns used to secure a bridge (replacement of an existing removable denture or fixed bridgework with new fixed bridgework, or addition of teeth to existing fixed bridgework), limited to once every five years; and

- Dental implants.
- Temporomandibular joint (TMJ) disorder related services — services and/or supplies to prevent, diagnose, or correct an abnormal functioning of the Temporomandibular joint of the jaw or jaw joint relationship.

Orthodontia services

The following is a list of covered orthodontia services:

- Orthodontic x-rays;
- Evaluation;
- Treatment plan and record;
- Services or supplies to prevent, diagnosis, or correct a misalignment of teeth or bite;
- Removable and/or fixed appliance(s) insertion for interreceptive treatment;
- Harmful habit appliances, includes fixed or removable appliances.

Oral cancer services

Additional dental coverage may be available for those participants diagnosed with oral cancer.

How the Plan works

Delta Dental has two provider networks available to you through Citigroup: DeltaPremier and DeltaPreferred Option. Dentists in both networks agree to accept lower fees for services. The DeltaPremier network is larger, with more than 145,000 dental offices and more than 111,000 providers nationwide. You will receive a deeper discount in the smaller DeltaPreferred Option network, with more than 71,000 offices and more than 50,000 providers nationwide.

Your total out-of-pocket payment is less if you use a DeltaPreferred Option network dentist. You will pay more if you use a DeltaPremier dentist and even more if you use a dentist who is not in either network. You can choose any dentist at the time of service, but you will pay less out of your pocket when you use a Delta participating provider.

Annual deductible and maximum

Before benefits can be paid in a calendar year, you and/or your covered dependent(s) must meet the $50 individual or $150 family deductible. The deductible does not apply to preventive and diagnostic services. However, the deductible does apply to basic, major, and orthodontia services.

You can meet the family deductible as follows:

- Up to three people in a family: each member must meet the individual deductible; or
- Four or more people in a family: expenses can be combined to meet the family deductible. However, no one person can apply more than the $50 individual deductible toward the $150 family deductible.

You and/or your covered dependent(s) have an annual maximum benefit of $3,000 per person.

Covered charges

After you have met the deductible, Delta Dental reimburses Covered charges for out-of-network dentists at the DeltaPremier Maximum Plan Allowance. For network charges, the percentage of reimbursement is based on 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. For example, if the orthodontic expense submitted is $3,000, the Plan will pay the 50% benefit, as follows:

Coverage for orthodontic work in progress:

Delta Dental's liability will be calculated at the copayment of the maximum plan allowance (MPA) giving the benefits of the number of months remaining in treatment. The previous carrier payment will then be factored in to ensure that not more than the submitted fee is paid between the carriers. When present, COB will be handled as Non-Duplication. Examples are as follows (Non-Duplication COB not being a factor)

- Step 1 — $5,000 (submitted amount is within the MPA) x 50% = $2,500 (Delta Dental's liability), with a 24 month treatment plan
- Step 2 — $2,500 divided by the total number of months of treatment ($2,500 divided by 24 = $104.17 per month). That monthly figure is then multiplied by the number of months remaining in treatment after the effective date with Delta Dental, which will equal Delta Dental's payment ($104.17 x the number of months remaining in treatment = Delta Dental's benefit, or for 24 month treatment, with only 18 months remaining while effective with Delta Dental, Delta Dental would pay $104.17 x 18 = $1,875.06)

For new orthodontic claims:

- After the deductible, 50% of Delta Dental's liability will be paid at the date of banding, with the remaining 50% of Delta Dental's liability being paid one year after the date of banding (eligibility must continue for the second payment to be made), up to the $3,000 lifetime maximum.

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.

Predetermination of benefits

Predetermination of benefits enables you and your dentist to know in advance what the Plan will pay for any service. Delta Dental recommends that your dentist submit a claim before performing services that may total more than $300.

Delta Dental will review the claim and return the predetermination voucher to your dentist (with a copy to you) that explains eligibility, scope of benefits, and the definition of a 60-day period for completion of services.

When services are completed, the voucher with the dates of service and signatures should be submitted to Delta Dental for payment. Delta will pay the predetermined amount depending on your continued eligibility for coverage. The payment could be reduced if you are also eligible for coverage under another plan

Alternative treatment

Many dental conditions can be treated in more than one way. The contract with Delta Dental has an "alternate treatment" clause that governs the amount of benefits that will be paid for covered treatments.

If you choose a more expensive treatment — recommended by your dentist — than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payable will be based on the cost of the treatment that provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and you and/or your dependent(s) and the dentist decide to use a gold filling, Delta Dental will base its reimbursement on the reasonable and customary charge for an amalgam filling. You will pay the difference in cost between the reimbursed amount and the dentist's charge.

Services not covered

Benefits are not provided for services and supplies not medically necessary for the diagnosis or treatment of dental illness or injury. 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.

The following exclusions apply to Dental Dental and are **not** covered by the Plan:

- Dental care received from a dental department maintained by an employer, mutual benefit association, or similar group;
- Prescription drugs, premedications;
- Treatment performed for cosmetic purposes;
- Treatment by anyone other than a licensed dentist, except for dental prophylaxis performed by a licensed dental hygienist under the supervision of a licensed dentist;
- Services in connection with dentures, bridgework, crowns, and prosthetics if for:
  - Prosthetics started before the patient became covered;
  - Replacement within five years of a prior placement covered under this Plan;
  - Extensions of bridges or prosthetics paid for under this Plan, unless into new areas;
  - Replacement due to loss or theft;
  - Teeth that are restorable by other means or for the purpose of periodontal splinting; and
  - Connecting (splinting) teeth, changing or altering the way the teeth meet, restoring the bite (occlusion), or making cosmetic changes.

- Any work done or appliance used to increase the distance between nose and chin (vertical dimension);
- Replacing tooth structure lost by attrition;
- Equilibration;
- Periodontal splinting;
- Procedures to correct congenital or developmental malformations except for covered dependent children or newborn children eligible at birth;
- Training or supplies used to educate people on the care of teeth;
- Charges for crowns and fillings not covered under basic services;
- Any charges incurred for services or supplies not recommended by a licensed dentist;
- Any charges incurred due to sickness or injury that is covered by a Workers' Compensation Act or other similar legislation or arising out of or in the course of any employment or occupation whatsoever for wage or profit;
- Any charges incurred while confined in a hospital owned or operated by the U.S. government or an agency thereof for treatment of a service-connected disability;
- Any charges that, in the absence of this coverage, you would not be legally required to pay;
- Any charges incurred that result directly or indirectly from war (whether declared or undeclared);
- Any charges resulting from injury that is intentionally self-inflicted or from injury sustained while committing an assault or felony;
- Any charges for services and supplies furnished for you or your eligible dependent(s) prior to the effective date of coverage or subsequent to the termination date of coverage;
- Any charges for services or supplies that are not generally accepted in the U.S. as being necessary and appropriate for the treatment of dental conditions including experimental care;
- Any charges for nutritional supplements and vitamins;
- Services covered by motor vehicle liability insurance;
- Services that would otherwise be provided free of charge but for coverage;
- Broken appointments;
- Charges for filing claims or charges for copies of x-rays;
- Care and treatment that is in excess of the reasonable and customary charge; and
- Services that, to any extent, are payable under any medical benefits, including HMOs.

Filing claims

See **Claims and appeals for Delta Dental** for information about submitting claims and filing an appeal if your claim is denied.

CIGNA Dental Care DHMO

CIGNA Dental Care DHMO is a managed dental care plan that operates like a health maintenance organization. CIGNA Dental contracts with network dentists in most areas of the country. Network dentists provide covered services to CIGNA Dental members at independently owned network dental offices. You can request a list of network dental offices in your area by calling CIGNA Dental at 1-800-367-1037. You can also find a provider at the CIGNA Web site, **www.cigna.com/health/consumer/dental/index.html**.

As a CIGNA Dental Plan member, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Visit the CIGNA Web site at **www.cigna.com**.

Enrollment in the CIGNA Dental Care DHMO allows the release of the enrolled member's dental records to CIGNA Dental for administrative purposes.

The CIGNA Dental Care DHMO has no annual individual or family deductibles and no lifetime dollar maximums. Most preventive services are 100% paid when you use a network general dentist. You pay a pre-set patient charge when you use a network general dentist for other services. See the Patient Charge Schedule for more information. You can obtain a schedule of charges when you enroll in the CIGNA Dental Care DHMO or by calling CIGNA Dental at 1-800-367-1037 or at **www.mycigna.com** (if you are already a member).

Type of service	Coverage
Annual deductible	None
Annual maximum	None
Preventive and diagnostic services	Most services covered at 100% (certain limitations apply)
Basic services	Based on pre-set patient charges
Major services	Based on pre-set patient charges
Orthodontia	Based on pre-set patient charges
Lifetime orthodontia benefit (for children and adults)	Coverage limited to 24 months of treatment. Atypical cases or cases longer than 24 months require additional payment by the patient.

Limitations and services not covered

Listed below are limitations and services not covered by the CIGNA Dental Care DHMO:

- **Frequency**. The frequency of certain covered services, such as cleanings, is limited. The patient charge schedule lists any limitations on frequency;
- **Specialty care.** A referral from your network dental office is required for coverage of services by a network specialist;

- **Pediatric dentistry.** Coverage for referral to a pediatric dentist ends on an enrolled child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. The network general dentist shall provide care after the child's 7th 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 only for orthodontic reasons; and
- **Orthodontics in progress.** If orthodontic treatment is in progress for you or your dependent at the time you enroll, call Member Services at 1-800-367-1037 to find out if you are entitled to any benefit under the Dental Plan.

Listed below are the services or expenses that are **not** covered under the CIGNA Dental Care Plan DHMO. These services are your responsibility and are billed by the dentist at his/her usual fee:

- Services not listed on the Patient Charge Schedule, as described later in this section;
- Services provided by an out-of-network dentist without CIGNA Dental's prior approval (except **Emergencies**);
- Services related to an injury or illness covered under Workers' Compensation, occupational disease or similar laws (For **Florida** residents, this exclusion relates to such services paid under Workers' Compensation, occupational disease or similar laws);
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program other than Medicaid;
- Services relating to injuries that are intentionally self-inflicted (For **Texas** and **Ohio** residents, this exclusion does not apply);
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war;
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance);
- General anesthesia, sedation and nitrous oxide unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with covered services performed by an oral surgeon or periodontist. (For **Maryland** residents, general anesthesia is covered when medically necessary and authorized by your physician);
- Prescription drugs;
- Procedures, appliances or restorations if the main purpose is to change vertical dimension (degree of separation of the jaw when teeth are in contact); to diagnose or treat abnormal conditions of the temporomandibular joint ("TMJ") unless TMJ therapy is specifically listed on your Patient Charge Schedule; or to restore teeth damaged by attrition, erosion or abrasion and/or abfraction. (For **California** residents, the word "attrition" is modified as follows: except for medically necessary treatment where functionality of teeth has been impaired);
- The completion of crown and bridge, dentures or root canal treatment already in progress on the date you become covered by the Plan (For **Texas** residents, preexisting conditions, including the completion of crown and bridge, dentures, or root canal treatment already in progress on the effective date of your coverage, are not excluded, if otherwise covered under your Patient Charge Schedule);
- Replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen, or damaged due to patient abuse, misuse, or neglect;

- Services associated with the placement or prosthodontic restoration of a dental implant;
- Services considered unnecessary or experimental in nature (For **Pennsylvania** residents, this exclusion applies only to services considered experimental in nature. For **California** and **Maryland** residents, this exclusion applies only to services considered unnecessary);
- Procedures or appliances for minor tooth guidance or to control harmful habits;
- Hospitalization, including any associated incremental charges for dental services performed in a hospital (for **Texas** residents, benefits are available for network dentist charges for covered services performed at a hospital; other associated charges are not covered and should be submitted to your medical carrier for benefit determination);
- Services to the extent you are compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy (For **Arizona** and **Pennsylvania** residents, this exclusion does **not** apply. For **Kentucky** and **North Carolina** residents, this exclusion does **not** apply to services compensated under no-fault auto or insured motorist policies. For **Maryland** residents, this exclusion does **not** apply to services compensated under group medical plans.);
- Crowns and bridges used solely for splinting; and
- Resin bonded retainers and associated pontics.

Except for the limitations listed above, preexisting conditions are not excluded.

How the Plan works

When you enroll in CIGNA Dental Care DHMO, you must select a network dental office. If your first or second choice is not available, the network dental office nearest your home will be selected for you.

You can choose a different dentist in the network for yourself and each of your dependents. When you visit a network office, you will pay the amount shown on your Patient Charge Schedule for covered services. If you undergo a procedure that is not on your Patient Charge Schedule, you will pay the dentist's usual charges. If you visit an office other than your network dental office, you will pay the dentist's usual charges, except for emergencies or as authorized by CIGNA Dental.

Specialized care

If your network general dentist determines that you need specialized dental care, your network general dentist will begin the specialty referral process. Follow your network general dentist's instructions regarding access to specialty care. Care from a network specialist is covered when CIGNA Dental authorizes payment. Treatment by a network specialist must begin within 90 days from the date of CIGNA Dental's authorization. If you are unable to obtain treatment within the 90-day period, call Member Services to request an extension. Your coverage must be in effect when each procedure begins.

You should verify with the network specialist that your treatment plan has been authorized for payment by CIGNA Dental before treatment begins. If you receive specialty care, and payment is not authorized by CIGNA Dental, you may be responsible for the network specialist's usual charges.

Changing your dentist

If you decide to change your network dental office, CIGNA Dental can arrange a transfer. You and your enrolled dependents may each transfer to a different network general dentist. You should complete any dental procedure in progress before transferring to another dental office.

To arrange a transfer, call Member Services at 1-800-367-1037. Your transfer request will take about five days to process. Transfers generally will be effective the first day of the month after the processing of your

request. Unless you have an emergency, you will be unable to schedule an appointment at the new dental office until your transfer becomes effective.

There is no charge to you for the transfer. However, all patient charges that you owe to your current dental office must be paid before the transfer can be processed.

Appointments

To make an appointment with your network general dentist, call the dental office that you have selected. When you call, your dental office will ask for your identification number (Social Security number) and will check your eligibility.

Broken appointments

The time your network general dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your dental office to maintain a schedule that is convenient for you and efficient for the staff. The delay in treatment resulting from a broken appointment can turn a minor problem into a complex one resulting in higher cost to you, your dentist, and CIGNA Dental.

If you or your enrolled dependent breaks an appointment with less than 24 hours' notice to the dental office, you may be charged a broken appointment fee for each 15 minute block of time that was reserved for your care. Consult your patient charge schedule for maximum charges for broken appointments (not applicable in **Texas**).

Patient charge schedule

The patient charge schedule lists the benefits of the CIGNA Dental Care DHMO including covered procedures and patient charges. Patients pay the patient charges listed only when the procedures are performed by a network general dentist. Procedures performed by an out-of-network dentist are not covered, and patients will be charged the dentist's usual fee for those procedures. Procedures not listed on the patient charge schedule are not covered and are the patient's responsibility at the dentist's usual fees. You may request a patient charge schedule when you enroll in the CIGNA Dental Care DHMO or by calling CIGNA Dental at 1-800-367-1037 or at ww.mycigna.com (if you are already a member).

Emergencies

An emergency is a dental condition of recent onset and severity that would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your network general dentist if you have an emergency.

Away from home

If you have an emergency while you are out of your service area or unable to contact your network general dentist, you may receive emergency covered services from any general dentist. Routine restorative procedures or definitive treatment (e.g., root canal) are not considered emergency care. You should return to your network general dentist for these procedures. For emergency covered services, you will be responsible for the patient charges listed on your Patient Charge Schedule. CIGNA Dental will reimburse you the difference, if any, between the dentist's usual fee for emergency covered services and your patient charge, up to a total of $50 per incident.

- For **Arizona** residents: An emergency is a dental problem that requires immediate treatment (includes control of bleeding, acute infection, or relief of pain including local anesthesia). Reimbursement for emergencies will be made by CIGNA Dental in accordance with your plan benefits regardless of the location of the facility providing the services.

- For **Pennsylvania** residents: If any emergency arises and you are out of your service area or are unable to contact your network general dentist, CIGNA Dental covers the cost of emergency dental services so that your are not responsible for greater out-of-pocket expenses than if you were attended by your network general dentist.
- For **Texas** residents: Emergency dental services are limited to procedures administered in a dental office, dental clinic, or other comparable facility to evaluate and stabilize emergency dental conditions of recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would cause a prudent layperson with average knowledge of dentistry to believe that immediate care is needed.

To receive reimbursement, send appropriate reports and x-rays to the CIGNA Dental address listed below.

For residents of California:

CIGNA Dental
400 North brand Blvd., Suite 400
Glendale, CA 91203

For residents of Arizona, Colorado, Kansas, Nebraska and Missouri:

CIGNA Dental
P.O. Box 2125
Glendale, CA 91209-2125

For residents of Connecticut, Delaware, Florida, Kentucky, Maryland, New Jersey, North Carolina, Ohio, Pennsylvainia and Virginia:

CIGNA Dental
P.O. Box 189060
Plantation, FL 33318-9060

For residents of all other states:

CIGNA Dental
600 Campus Circle Dr. East, Suite 100
Irving, TX 75063

After hours

There is a patient charge listed on your patient charge schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable patient charges.

Member Services

If you have any questions or concerns about the CIGNA Dental Care DHMO, Member Services Representatives are just a toll-free phone away. They can explain your benefits or help with matters regarding your dental office or the plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, covered services, plan benefits, ID cards, location of dental offices, conversion coverage or other matters, call Member Services from any location at 1-800-367-1037. The hearing impaired may contact the state TTY toll-free relay service in their local telephone directory.

Filing claims

You do not need to file any claims for benefits. If benefit payment is denied, however, you may file an appeal. See **Claims and appeals for the CIGNA Dental Care DHMO**.

Converting coverage

If you and/or your enrolled dependents are no longer eligible for coverage, you and/or your enrolled dependents may continue dental coverage by enrolling in the CIGNA Dental conversion plan. You must enroll within three months after becoming ineligible for your group's dental plan. Premium payments and coverage will be retroactive to the date coverage under your group's dental plan ended. You and your enrolled dependents are eligible for conversion coverage unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship;
- Fraud or misuse of dental services and/or dental offices;
- Nonpayment of premiums by the subscriber;
- Selection of alternate dental coverage by your employer; or
- Lack of network/service area.

Benefits and rates for conversion coverage and any succeeding renewals will be based on the covered services listed in the then-current standard conversion plan and may not be the same as those for Citigroup. Call the CIGNA Dental Health Conversion Department at 1-800-367-1037 to obtain current rates and make arrangements for continuing coverage.

Extension of benefits

Coverage for a dental procedure, other than orthodontics, which was started before you dropped coverage, will be extended for 90 days after the date coverage ends unless coverage loss was due to nonpayment of premiums.

Coverage for orthodontic treatment started before you dropped coverage will be extended to the end of the quarter or for 60 days after the date coverage ends, whichever is later, unless coverage loss was due to nonpayment of premiums.

Disclosure Statement

CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries. The CIGNA Dental Care Plan is provided by CIGNA Dental Health Plan of Arizona, Inc., CIGNA Dental Health of California, Inc., CIGNA Dental Health of Colorado, Inc., CIGNA Dental Health of Delaware, Inc., CIGNA Dental Health of Florida, Inc., a prepaid limited health services organization licensed under Chapter 636, Florida Statutes, CIGNA Dental Health of Kansas, Inc. (Kansas and Nebraska), CIGNA Dental Health of Kentucky, Inc., CIGNA Dental Health of Maryland, Inc., CIGNA Dental Health of Missouri, Inc., CIGNA Dental Health of New Jersey, Inc., CIGNA Dental Health of New Mexico, Inc., CIGNA Dental Health of North Carolina, Inc., CIGNA Dental Health of Ohio, Inc., CIGNA Dental Health of Pennsylvania, Inc., CIGNA Dental Health of Texas, Inc., CIGNA Dental Health of Virginia, Inc. In other states, the CIGNA Dental Care plan is underwritten by Connecticut General Life Insurance Company and administered by CIGNA Dental Health, Inc.