About Your Health Care Benefits

Amended and Restated as of January 1, 2008

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Introduction

This document is a component of the plan documents for the Citi Health Benefit Plan, the Citi Dental Benefit Plan, the Citi Vision Benefit Plan, the Citi Employee Assistance Program and the Health Care Spending Account (hereinafter referred to as the "Plans") for eligible employees of Citi and its participating employers (hereinafter referred to as "Citi", unless otherwise specified). **Citi 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, 2008. The terms and conditions of these Plans may also be further prescribed in insurance policies, 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. In addition, this document is designed to comply with the requirements of a cafeteria plan under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"). It does not create a contract or guarantee of employment between Citi 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, or in the Plans.

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, Citi in no way guarantees the payment of any benefit which may be or becomes due to any person under the Plans.

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 document forming a part of any Plan described in this document, please call the Benefits Service Center at ConnectOne at 1 800 881 3938 and select the Health Benefits options.

Eligibility

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

For employees

You are only eligible to participate in the Plans (as defined above) if you work for a "participating employer" 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.

A "participating employer" is Citigroup Inc. and any subsidiary in which Citi owns at least an 80% interest. Citi Markets and Banking, Global Wealth Management, the Global Consumer Group, Citi Alternative Investments and Citi Corporate Center are the Citigroup businesses that participate in the Plans.

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

Notwithstanding any provision in the Plans to the contrary, you are eligible to participate in the health care plans if you are receiving severance payments from Citi or a participating employer.

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 employer;
- you are employed by a Citi subsidiary or affiliate that is not a participating employer;
- 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; or
- you are classified by Citi as an independent contractor or consultant, or as being employed on a temporary basis.

If you are a U.S. 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 Citi

If both you and your spouse, civil union partner, or qualified domestic partner are employed by Citi or a participating employer, neither of you can be covered both as an employee and a dependent for any Citi 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.
- General Purpose Health Care Spending Account ("HCSA") — 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. However, your civil union partner, or your qualified domestic partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the

meaning of section 152 of the Code as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.

- Limited Purpose Health Care Spending Account ("LPSA")- If either of you enroll in the Citi Basic or Premier High Deductible Health Plan, may be covered under the Limited Purpose Health Care Spending Account but you may not file more than once for reimbursement of the same eligible expense. Neither of you can enroll in the HCSA, and you may only be reimbursed for dental, vision or preventive care expenses under this account. However, your civil union partner or your qualified domestic partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.
- Employee Assistance Program – both of you and your dependents will be covered under this program.

For dependents

Your eligible dependents are:

- Your lawfully married spouse, state-recognized common-law spouse, or state recognized civil union partner (in the states that recognize such unions). 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" or "qualifying relative" as defined in section 152(c) and 152(d) of the Code, respectively. Generally, a qualifying child up to the age of 18 must have the same principal place of residence as you for more than half the year, must not provide over one-half of his or her own financial support, and a qualifying relative:
  - will attain the maximum age of 19* as of the close of the plan year or
  - will attain the maximum age of 25* as of the close of the plan year, and is a full-time student (meaning the student is enrolled full-time 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 Claim Administrator. The names, addresses and phone numbers of the health care Claim 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 child's financial support.

Please note that insured HMOs made available through the Citi Health Benefit Plan comply with state laws that require less restrictive age and/or income requirements for dependents. These laws apply only to insured health programs and do not apply to the ChoicePlans or other non-insured (self-funded) programs. States that have these laws include Colorado, Georgia, New Mexico, New Jersey, Pennsylvania, Tennessee, and Utah. For more information, contact the insured HMO provider in your state. Coverage may be available only on an after-tax basis if your covered children are not your tax dependents, and other costs may apply.

** 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. You are required to notify the Plans when such events occur in order for your eligible dependents to be eligible for COBRA coverage discussed later in the COBRA section of this document.*

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

- Your natural children;
- Your legally adopted children (for purposes of coverage under the Plans, adopted children will be considered eligible dependents when they are lawfully placed in your home for adoption or when the adoption becomes final, whichever occurs first.);
- Your stepchildren; or
- A child permanently residing in your household for whom you are the legal guardian in accordance with the laws of the state in which you reside. You must provide proof of legal guardianship in writing to the Claim Administrator **upon request**.

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

If one of your eligible dependent children is permanently and totally disabled as defined for purposes of obtaining Social Security benefits and (a) is covered under the Plans before reaching the applicable maximum age as described above, or (b) you enroll this dependent within the first 31 days of your eligibility under the Plans, this child may continue to be considered an eligible dependent under the Plans beyond the date his/her eligibility for coverage would otherwise end. You must provide written proof of this incapacity to the Claim Administrator within 31 days after the date eligibility would otherwise end or as requested thereafter. This eligible dependent must still meet all other eligibility qualifications to continue coverage.

No person will be covered under the Plans 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 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 Plan Administrator to receive, free of charge, a detailed description of the procedures for a QMCSO.

Dependent notification

The first time you enroll in Citi benefits, you will be asked to report information about each of your eligible dependents such as name, date of birth, Social Security number and, if over age 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 Benefits 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, civil union partner, 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 dependent children will end:

- The last day of the month in which they:
  - Become employed full time;
  - Get married;
  - Become eligible for coverage under any plan as employees; or
  - Cease to be “eligible dependents” as defined in the previous section of this Plan document.

Newborns/newly adopted children

Even if you are not enrolled for dependent coverage, Citi will pay benefits under the Health Benefit Plan (self-funded plans) for your newborn child from birth through 31 days. (Note that this eligibility provision does not apply to all insured plans; therefore, you should contact the plan for details). However, if you have coverage under any of Citi’s Plans, you must report this family status change to the Benefits Service Center within 31 days of the child’s birth to add the child to your coverage. If you do not report the addition of your child during the first 31 days, benefits will not be payable for the child after the 31 days following the date of the child’s birth, and you will generally have to wait until the next annual open enrollment period to enroll the child in the Plans 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 after the child’s birth. No other benefit or provision of the Health Benefit Plan will apply to the child.

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

- Extension of benefits; and
- Continuation of coverage.

Remember, you must report information to the Benefits Service Center about a new dependent even if you already have family coverage. Otherwise your new dependent won’t be covered.

For civil union partners/domestic partners

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

- Health Benefit Plan (civil union partner/domestic partner medical benefits are not available through some HMOs);
- Dental Benefit Plan;
- Health Care Spending Account, provided your civil union partner/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 (note: civil union partner/domestic partners who do not meet section 152 cannot have their claims submitted for reimbursement into the Health Care Spending Account);
- Vision Benefit Plan; and
- Employee Assistance Program.

You cannot cover both a spouse, a civil union partner, and a domestic partner. In states where civil unions are recognized, benefits are to be provided on the same basis as they would be for a married spouse. No affidavit with respect to a civil union relationship is required to enroll a civl union partner in the Plans. However, to obtain benefits on a pre-tax basis for your civil union partner and his/her eligible dependents, you must complete a Certification of Civil Union Partner's Tax Status. Otherwise, such benefits are taxable.

To enroll a domestic partner and/or his or her children, an employee must sign an affidavit affirming that he or she meets Citi's eligibility criteria for domestic partner coverage, and complete a Certification of Domestic Partner's Tax Status. The forms discussed above are available on **www.Citigroup.net** or by calling the Benefits 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 (the six months is counted beginning with the date your divorce is final or the date you report your divorce to the Benefits Service Center, whichever is later);
- 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; if you're still married, legally separated or getting divorced, you can't add a domestic partner to your coverage until the later of six months from the date of your divorce or when you notify the Benefits Service Center that you're divorced.
- Neither you nor your partner is in a domestic partner relationship with anyone else
- 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; and
- You are financially interdependent, or your partner is dependent on you for financial support.

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

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

To 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 Citi by completing a Termination of Domestic Partnership Form within 31 days of the event. Contact the Benefits 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, if applicable, coverage at his or her expense for a period of 36 months.

This coverage will be similar to COBRA coverage offered to spouses, civil union partners 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 Citi.

Enrollment

You can enroll in Citi 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, civil union partner, 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 if your spouse’s employer does not offer dental coverage.

Each category has a different cost. In addition, your cost for medical coverage will depend on your total compensation band as defined in **Your contributions**. 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, civil union partner’s or other employer’s plan, you can compare the Citi coverage and costs with the other coverage. You may decide to enroll in some plans offered through Citi and some from the other source. For example, you might enroll in medical coverage elsewhere and in Citi dental coverage.

However, if you are enrolling in coverage from two sources, be sure you understand how benefits are paid when you are covered by two group medical plans or group dental plans. In many instances, you may pay for coverage from two group plans but you will not receive double benefits or even be reimbursed for 100% of your costs as a result of what is called “coordination of benefits.” See Coordination of benefits 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. Citi 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.
Vision care	The annual open enrollment period or within 31 days of a qualified status change.
General Purpose Health Care Spending Accounts/Limited Purpose Health Spending Accounts	The annual open enrollment period or within 31 days of a qualified status change.

Qualified status changes

The rules regarding qualified status changes 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.

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 dependents 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.

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

Consistency requirements

The changes you make to your medical, dental, vision 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 increase or start contributions to a Health Care Spending Account if you add a dependent. The Plan Administrator will determine whether a requested change is due to a qualified status change and is consistent with the qualified status change.

Coverage & 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 Citi adds or eliminates a plan option in the middle of the plan year, or if Citi-sponsored coverage is significantly limited or ends, you and your eligible dependents can elect different coverage in accordance with 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 Citi 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 Citi), you may make a corresponding midyear election change.

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

Cost events

You must contact Citi 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 civil union parter/domestic partner coverage: The events qualifying you to make a midyear election change described in this section also apply to events related to a civil union partner/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 civil union partner/domestic partner, that change must generally be made "on a post-tax basis," unless your civil union partner/domestic partner can be claimed as your dependent for federal income tax purposes. (Exceptions may be made if your civil union partner/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 Benefits 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 required employee contributions to the medical, dental and vision plans increase as compensation increases. The compensation bands for 2008 are shown in the table below. Contributions for your Health Care Spending Account are determined by your contribution amount and not by your compensation band.

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
$250,001 – $500,000
$500,000 +

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 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.

Notwithstanding the foregoing, total compensation shall include severance payments for purposes of individuals who participate in the Plan post-employment while receiving severance pay. The list of items that constitute total compensation under the Plan is exclusive, and shall not include any extraordinary payments, including but not limited to those related to settlements or forgivable loans or any other amounts, unless specifically set forth in the plan document or in an agreement or statement of policy approved or authorized by the Senior Human Resources Officer of Citigroup Inc. or his or her delegate.”

For example, the total compensation for the 2008 plan year includes:

- Base pay annualized as of July 1, 2007;
- Commissions paid from January 1 – December 31, 2006;
- Cash bonuses paid from January 1 – December 31, 2006 (excluding any annual bonus);
- 2006 annual bonus (paid in 2006 and/or 2007); and
- Short-Term Disability benefits paid from January 1, 2006 through December 31, 2006, for employees paid on commissions only.

If you were rehired on or after July 1, 2007, your total compensation is your annualized base pay as of your date of hire.

For new hires: your annualized base pay as of your date of hire and any guaranteed bonus will be considered in the calculation of Total Compensation for benefits purposes.

For Global Wealth Management Financial Advisors

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

If you decide to provide a copy of the form, your Basic Life insurance amount will be set at the higher amount (up to $200,000) shown on the form. Your contributions for medical coverage, Optional GUL amount, and LTD benefits and contributions also will be based on the higher amount.

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

If you became an employee of Citi or a participating employer and are eligible for benefits under Plans as a result of a corporate acquisition during the 2007 plan year, see Appendix A for the definition of Total Compensation for purposes of determining benefits applicable to your employment group.

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.

Civil Union Partners/Domestic partners

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

If your civil union partner/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 civil union partner/domestic partner medical, dental, and/or vision care coverage will be taken on a pre-tax basis. However, if your civil union partner/domestic 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 civil union partner/domestic partner in Citi coverage.

If your civil union partner/domestic partner does NOT qualify as a tax dependent: If your civil union partner/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 civil union partner/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 civil union partner/domestic partner qualifies as a tax dependent: If your civil union partner/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 Health Benefit Plan and the Dental Benefit Plan only and are described in this section.

All payments under these Plans will be coordinated with benefits payable under any other group benefit plans that provide coverage for you or your dependent(s). Coordination of benefits prevents duplication 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 the applicable Citi 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 Citi Plan. When an HMO provides benefits in the form of furnishing services or supplies rather than cash payments, the service or supply will not be considered an allowable expense or a benefit paid.
- **Plan**: Most plans under which group health benefits are provided, including group insurance closed panel or other forms of group or group-type coverage (whether insured or uninsured), medical care components of group long-term care contracts (such as skilled nursing care), medical benefits under group or individual automobile contracts, Workers' Compensation, and Medicare or other governmental benefits, as permitted by law.
- **Primary plan**: A benefit plan that has primary liability for a claim.
- **Secondary plan**: A benefit plan that adjusts its benefits by the amount payable under the primary plan.

The Citi Plan will be the primary plan on claims:

- For you, if you are not covered as an employee by another plan;
- For your spouse, civil union partner or domestic partner, if the same 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 first 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 Citi 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 Citi Plan is the secondary plan, benefits under the Citi Plan may be reduced. The Claim Administrator will determine the amount the Citi Plan normally would pay. Then the amount payable under the primary plan for the same expenses will be subtracted from the amount the Citi Plan would have normally paid. The Citi Plan will pay you the difference. If the Citi Plan is secondary, you will never be paid more for the same expenses under both the Citi Plan and the primary plan than the Citi Plan would have paid alone.

When the Citi Plan is secondary and the patient is covered under an HMO, benefits under the Citi Plan will be limited to the 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. 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;
- The plan of the spouse 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 Citi Plans (including any such coverage required under USERRA, COBRA or other law or under any Citi 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 Citi Plan, the Citi Plan continues to be the primary plan. The Citi Plan is primary for the following situations:

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

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

No-fault automobile insurance

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

Facility of payment

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

Right of recovery

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

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

Release of information

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

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

Recovery provisions

Recovery provisions apply to the Health Benefit Plan and the Dental Benefit Plan and are described in this section.

Refund of overpayments

Whenever payments have been made by a 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, as applicable.

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 been repaid. 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 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 Plans do pay or provide benefits for such an injury, sickness, or other condition, and the covered person subsequently recovers damages by settlement, verdict or otherwise — 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 Citi 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. However, if you fail to perform the obligations stated in this section you may be rendered liable to the Plan for any expenses the Plan may incur including reasonable attorneys fees, in enforcing its rights under this Plan. The costs of legal representation retained by the covered person shall be borne solely by the covered person.

When coverage ends

For any of the Plans, your coverage automatically will terminate on the earliest of the following dates:

- The date the Citi Plan terminates;
- The last day for which the necessary contributions are made;
- Midnight of the last day of the month in which you retire, die, or otherwise cease to be eligible for coverage;
- The date benefits paid on behalf of a participant equal the lifetime maximum benefit under the Citi Plan. Coverage for eligible dependents who have not reached their lifetime maximum will not be affected; or
- 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 (which termination must be in accordance with Plan terms and applicable law);
- The last day for which the necessary contributions are made;
- The date the eligible dependent(s) ceases to be eligible for coverage. In general, 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, whichever occurs first. 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, civil union partner, 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 (i) at least age 55 with at least 5 years of service and (ii) if you are at least age 50 and with at least 10 years of service when you leave Citi. For more information on eligibility for this coverage, 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 the short-term disability coverage ends. After that, you may continue medical coverage by making the same contributions as active employees, based on your years of service as shown in the table below. (After 52 weeks of disability, your employment will be terminated.) For purposes of the Plan, a year of service is any 12 consecutive months in which you have provided 1,000 hours of service.

Years of recognized Citi 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 years of service (including fractions)
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 medical coverage continuation period after your employment terminates after 52 weeks of receiving disability benefits 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 after the short-term disability coverage ends. You may then continue coverage through COBRA.

Vision care coverage will continue for the 13-week period of short-term disability. No contribution is required during this time. You may then continue coverage through COBRA.

General Purpose Health Care Spending Account/Limited Purpose Health Care Spending Account participation will continue for the 13-week period of short-term disability. No contribution is required during this time. 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 go on an approved leave of absence, you may continue coverage under the medical, dental, vision care, and health care spending account. Your reduction in hours (less than 20 hours per week) constitutes a COBRA qualifying event under the plans. See **COBRA** continuation of coverage. You will pay at a rate under the plans determined under a policy established by the Committee or Citi.

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 HCSA/LPSA (through the end of the calendar year for HCSA/LPSA)may continue as long as you agree to contribute your share of the cost of coverage during the leave. Your monthly contributions during a leave are made on an after-tax basis. You will be billed directly.

If you lose any coverage during an FMLA leave because you did not make the required contributions, you may 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 – Citi policy

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 the Citi Military Leave Policy. The policy generally provides for paid leave and subsidized employer contributions to health care continuation coverage for the duration of your leave, and is more generous in many respects than what federal law currently requires of employers. For a copy of the policy, please visit Citi.net. From the home page, use the search function and enter “military leave.” Then click on the most current policy. Employee contributions will be deducted automatically from your pay.

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

You must contact the Benefits Service Center to enroll or stop coverage. If you do not contact the Benefits Service Center, your benefit elections will continue in effect for the remainder of the year in which you are on a military leave (unless coverage stops automatically when your leave ends).

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

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

Continuing coverage during military leave – no Citi policy

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

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire amount (including both 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 Plan Administrator determines whether an exclusion or waiting period applies once you are reinstated to the plan. The Plan Administrator may take other steps to administer the Plans in accordance with USERRA and the Department of Labor regulations thereunder.

If you are on military leave for less than 24 months and you do not return to work at the end of your leave, you may be entitled to purchase COBRA continuation coverage, as your eligibility for COBRA will begin on the date your leave ends.

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

Coverage for surviving dependents

When an active employee dies, and his or her surviving covered spouse or civil union partner and/or dependent children were enrolled in active coverage at the time of the employee's death, the covered individuals will be eligible to continue health care coverage for six months at no cost.

- 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. In order to have the six months of free medical and dental coverage for your spouse and dependents, they must elect COBRA continuation of coverage. 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, medical and dental coverage will continue for the covered spouse and/or dependents for six months at no cost pursuant to the COBRA election noted above. At the end of the six months, the surviving spouse and/or dependent children can either continue COBRA coverage or elect retiree health care coverage. Retiree health care coverage is provided on the same terms as it is for 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. Citi reserves the right to terminate your coverage retroactively if you are determined to be ineligible for COBRA under the terms of the Plans.

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 Citi-sponsored medical, dental, or vision care plan, or HCSA/LPSA, 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, and you do not return to work.

If you are the spouse, civil union partner or domestic partner of an employee and are covered by a Citi-sponsored medical, dental, or vision care plans, or HCSA/LPSA 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 Citi-sponsored group health plan for any of the following four reasons:

- The death of your spouse/civil union partner/domestic partner;
- The termination of your spouse’s/civil union partner’s/domestic partner’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/civil union partner or termination of a domestic partnership; or
- Your spouse/civil union partner/domestic partner becomes entitled to Medicare.

If you are a covered dependent child of an employee covered by a Citi-sponsored medical, dental, or vision care plan, or HCSA/LPSA 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 plans 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 Citi-sponsored medical, dental, or vision care plan, or HCSA/LPSA.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption, or placement for adoption) during that period of continuation coverage, the new child is also eligible to become a qualified beneficiary. 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 Citi of the birth or adoption, within 31 days of the event.

If the covered employee fails to notify Citi in a timely fashion (60 days from the date coverage was lost), 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 right to elect 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 Citi of a divorce, legal separation, or a child losing dependent status under the Citi-sponsored medical, dental, or vision care plan, or HCSA/LPSA. 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 Citi 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 any Citi business
Citi Service Center P.O. Box 56710 Jacksonville, FL 32241-6710

When Citi is notified that one of these events has happened, Citi, in turn, will notify you that you have the right to choose continuation coverage. If you or your family member fails to notify Citi and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation, or a child 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.

Citi'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 Benefits 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 Citi 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, Citi is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. 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 a minimum of 18 months if you lost group health coverage because of a termination of employment or reduction in hours. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent's child's losing eligibility as a dependent child, COBRA continuation coverage is available for up to 36 months.

Additional qualifying events (such as your death, divorce, legal separation, or Medicare entitlement or your child's loss of dependent status) may occur while the continuation coverage is in effect.

If you lost coverage because of a termination of employment or a reduction in hours, these events can (but do not always) result in an extension of an 18-month continuation period to 36 months for your spouse and dependent children, 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 must notify Citi 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/LPSA: Except as required by law, the duration of COBRA continuation coverage for the HCSA/LPSA 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 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 Citi 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 Citi 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.

If you become entitled to 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 and you become entitled to Medicare less than 18 months before the qualifying event, your eligible 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 COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any person who elected COBRA for any of the following five reasons:

- Citi 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 person who elected COBRA becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation for any preexisting condition of that covered individual;
- The person who elected COBRA 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 Citi 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, Citi 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 Plans, you must notify the COBRA administrator in writing immediately at the address listed below.

All notices and other communications regarding COBRA and the Citi-sponsored group health plans 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.

Creditable Coverage Disclosure Notice

For employees and former employees enrolled in Citi medical plans excluding the Premier and Basic High Deductible Health Plans.

This notice, required by Medicare to be delivered to Medicare-eligible individuals, contains information about your current prescription drug coverage with Citi and new prescription drug coverage available to people with Medicare. Keep this notice. If you enroll in Medicare prescription drug coverage, you may be asked to present this notice to prove that you had "creditable coverage" and, therefore, are not required to pay a higher premium than the premiums generally charged by the Medicare Part D plans. You may receive this notice at other times in the future, for example, before the next period in which you can enroll in Medicare prescription drug coverage and/or if your Citi prescription drug coverage changes such that the coverage ceases to be "creditable coverage." You may request another copy of this notice by calling ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative.

Prescription drug coverage and Medicare

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

'Creditable coverage'

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

Understanding the basics

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

You have prescription drug coverage under your current Citi medical plan. Your prescription drug coverage under the Citi medical plan is considered primary to Medicare, if you are a current Citi employee. This means that your Citi plan pays benefits first. Although you can choose to join a Medicare prescription drug plan in addition to your enrollment in a Citi medical plan, you should consider how Citi plan coverage would affect the benefits you receive under the Medicare prescription drug plan. If you drop your Citi prescription drug coverage and enroll in a Medicare prescription drug plan, you may not be able to get your Citi coverage back at a later date if you so choose. You should compare your current coverage carefully — including which drugs are covered — with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Your existing Citi coverage is, on average, at least as good as standard Medicare prescription drug coverage (this is your "creditable" coverage). As a result, you can keep your current Citi coverage and not pay extra if you decide you want to join a Medicare prescription drug plan. People can enroll in a Medicare prescription drug plan when they first become eligible for Medicare.

In addition, people with Medicare have the opportunity to enroll in a Medicare prescription drug plan during an annual enrollment period. If you drop or lose your coverage with Citi and do not immediately enroll in a Medicare prescription drug plan after your current coverage ends, you may pay more to enroll in a Medicare prescription drug plan later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will increase at least 1% for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay for the same coverage. You must pay this higher premium percentage as long as you have Medicare coverage. In addition, you may have to wait until the next annual enrollment period to enroll.

For more information about Medicare

You can obtain more information about Medicare prescription drug plans from these sources:

- Visit **www.medicare.gov** for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for the telephone number).
- See the "Medicare & You" handbook which Medicare mails to you each year.
- Call 1-800-MEDICARE (1-800-633-4227); for TTY service, call 1-877-486-2048.

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

You can find Medicare's income level and asset guidelines at **www.cms.hhs.gov/medicarereform/lir.asp** or by calling 1-800-MEDICARE (1-800-633-4227). If you qualify for assistance, visit the Social Security Web site at **www.socialsecurity.gov** or call 1-800-772-1213 to request an application. **For more information about this notice**, Call ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative. For text telephone service, call the National Relay Services at "711." Then call ConnectOne at 1-800-881-3938 as instructed above.

Non-Creditable Coverage Disclosure Notice

- For employees and former employees enrolled in the Citi High Deductible Health Plans (Basic and Premier)
- This notice, required by Medicare to be delivered to Medicare-eligible individuals[1], contains information about your current prescription drug coverage with Citigroup and prescription drug coverage available to people with Medicare.
- Keep this Notice. Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Citigroup and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. You may receive this notice at other times in the future, for example, before the next period in which you can enroll in Medicare prescription drug coverage and/or if your Citigroup prescription drug coverage changes such that the coverage becomes "creditable coverage." You may request another copy of this notice by calling ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative.

Prescription drug coverage and Medicare

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

"Non-Creditable Coverage."

- Citigroup has determined that the prescription drug coverage offered by the Basic and Premier High Deductible Health Plans are, on average for all plan participants, not expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Non-Creditable Coverage. This is important, because most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Citigroup high deductible health plans.

Understanding the basics

- You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join. Read this notice carefully - it explains your options.
- Consider joining a Medicare drug plan. You can keep your coverage from the Citigroup high deductible health plans. You can keep the coverage regardless of whether it is as good as Medicare drug plan. However, because your existing coverage is, on average, not at least as good as standard Medicare prescription drug coverage, you may pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

1. Citigroup is required by law to distribute this notice to both current and former employees who are enrolled in Citigroup coverage and who may be Medicare eligible. Generally, you become eligible for Medicare as a result of reaching age 65 or as a result of disability.

- You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. If you lose your prescription drug coverage under one of the Citigroup high deductible health plans, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) to enroll in a Medicare prescription drug plan because of your lost coverage. In addition, if you lose or decide to terminate your coverage under the Citigroup prescription drug plan; you will be eligible to join a Medicare prescription drug plan at that time under the SEP, as well.

You need to make a decision.

When you make your decision, you should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you decide to enroll in a Medicare prescription drug plan and you are an active employee or the family member of an active employee, you may also continue your Citigroup coverage. In this case, the Citigroup prescription drug program will continue to be the primary payer as it had before you enrolled in a Medicare prescription drug plan. This means that Medicare will pay for permitted coverage, as applicable, after Citigroup pays its benefit. If you waive or drop Citigroup prescription drug coverage, Medicare will be your only payer.

If you do decide to join a Medicare drug plan and drop your Citigroup prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with Citigroup and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about Medicare

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice

Call ConnectOne at 1-800-881-3938. From the main menu, choose the “health and welfare benefits” option and then follow the prompts for a Benefits Service Center representative.

For text telephone service: Call the National Relay Service at “711.” Then call ConnectOne at 1-800-881-3938 as instructed above.

NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Citigroup changes. You also may request a copy.

Your HIPAA rights

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

HIPAA restricts the ability of group health plans to exclude coverage for 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 Citi medical coverage, you must receive certification of your coverage from the medical plan in which you were enrolled. You may need this certification in the event you later become covered by a new plan under a different employer, or under an individual policy.

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

You should keep a copy of the coverage certification(s) you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if you obtain new employment and your new employer's plan has a 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 Citi medical coverage for yourself and/or your eligible dependents, including your spouse, because you and/or your family members have other health coverage, you may in the future be able to enroll yourself or your dependents in Citi coverage provided that you request enrollment within 31 days after the date your coverage ends because you or a family member loses eligibility under another plan or because COBRA coverage has ended. In addition, if you have a new dependent as a result of a marriage, birth, or adoption or placement for adoption of a child, you also may be able to enroll yourself and your eligible dependents provided you call within 31 days after the marriage, birth, or adoption.

If you miss the 31-day deadline, you 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, Citi reserves the right at any time to request written documentation of any dependent's eligibility for plan benefits and/or the effective date of the qualifying event.

Your right to privacy and information security

HIPAA requires employer health plans to maintain the privacy and security of your health information. HIPAA also requires the Plans to provide you with a notice of the Plans' legal duties and privacy practices with respect to your health information. The notice will describe how the Plans may use or disclose your health information and under what circumstances they may share your health information without your authorization (generally, to carry out treatment, payment or health care operations). In addition, the notice will describe your rights with respect to your health information. Please refer to the Plans' privacy notice for more information. You can obtain a copy of the notice by contacting the Benefits Service Center.

The Plan Sponsor shall use and disclose individually identifiable health information ("Protected Health Information") as defined in 45 C.F.R. Parts 160 and 164, and specifically 45 C.F.R. sec. 164.504(f) (the "HIPAA Privacy Rule"), only to perform administrative functions on behalf of the Plans. The Plan Sponsor shall not use or disclose such information for any purpose other than as permitted to administer the Plans or as permitted by applicable law.

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

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

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

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

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

Claims and appeals

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

Medical	
• For all plans other than HMOs	Use one of the following forms available on Citi.net to file a claim for a covered out-of-network expense: • 301 — Aetna Claim Form (for ChoicePlans 100 & 500, HDHP Basic & Premier participants). • 302 — CIGNA Claim Form (for ChoicePlans 100 & 500 participants). • 303 — UnitedHealthcare (for ChoicePlans 100, 500 and Hawaii Plan participants). • 322 — BlueCross BlueShield (for ChoicePlans 100 & 500 participants). • 323 — BlueCross BlueShield (Out-of-Area Plan). • Based on your business group you may obtain forms via the Web **www.Citi.net/human_resources/form.htm** or through the Forms and LifeTimes option of ConnectOne at 1-800-881-3938. • 310 — Express Scripts Retail Pharmacy–prescription drug program related to all non-HMO plans • 311 — Express Scripts Home Delivery–prescription drug program related to all non-HMO plans
• HMO participants	• Call your HMO for any claim-filing information.
Dental	
• MetLife Preferred Dentist Program (PDP)	• Use Form 304 — MetLife Dental Claim form available on **www.Citi.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 Citi.net to file an out-of-network expense.

Vision	• Call Davis Vision at 1-800-999-5431 or visit **www.davisvision.com**.
Employee Assistance Program	• Call Harris Rothenberg at 1-800-952-1245 or visit www.harrisrothenberg.com (Benefit Service Claims Only)
General Purpose Health Care Spending Account (HCSA) and Limited Purpose Health Care Spending Account (LPSA)	• If you do not use your Citi FlexDirect debit card, you can file a claim by using the HCSA/LPSA 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 Citi Flex Direct debit card. • Based on your business group you may obtain forms via the Web **www.Citi.net/human_resources/form.htm** or 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.
- Prescription drug claims must be filed within one year of the date of service.
- HCSA/LPSA claims must be filed by June 30 of the calendar year following the plan year in which the expense was incurred.

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

Claims and appeals for UnitedHealthcare medical plans

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

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
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 Claim 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 denial, contact Customer Service immediately.

UnitedHealthcare level one appeal

If you disagree with a claim determination after following the above steps, you can contact the Claim 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 Claim 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 Claim Administrator in considering the claim; and that demonstrates the Claim 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 Claim 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 Claim 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 Claim 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 Claim 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 Claim Administrator, you have the right to request a second level appeal from the Claim Administrator. Your second level appeal request must be submitted to the Claim 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 Claim 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 Claim 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, Citi has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claim Administrator's decisions are conclusive and binding. Please note that the Claim 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 Claim Administrator as soon as possible. The Claim Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, Citi has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claim Administrator's decisions are conclusive and binding.

Claims and appeals for Aetna medical plans

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

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

You will have two levels of appeal for both administrative and clinical appeals in accordance with the definitions below.

Administrative appeals are defined as appeals in response to denials based on contractual or benefit exclusion, limitation, or exhaustion not requiring clinical judgment. Administrative denials do not require a clinician to interpret the contractual limitation or apply clinical judgment to the limitation.

Clinical appeals are defined as appeals in response to denials based on clinical judgment for the determination and application the terms of the plan to the member's medical circumstances.

You will have 180 days following receipt of a claim denial to appeal the decision. You will be notified of the decision no later than 15 days (for 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 Claim 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 Claim Administrator.

For pre-service and post-service claim appeals, Citi has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claim Administrator's decisions are conclusive and binding. Please note that the Claim 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 Claim Administrator by telephone, fax, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received. If you are dissatisfied with the appeal decision, you may file a second level appeal within 60 days of receipt of the level one appeal decision. The appeal will be handled in the same timeframes as the first level appeal and a notice will be sent to you explaining the decision.

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

You must exhaust the applicable level one and level two processes of the appeal procedure before you contact the Department of Insurance to request an investigation of a complaint or appeal; or file a complaint of appeal with the Department of Insurance; or establish any litigation; or arbitration; or administrative proceeding; regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the appeals procedure.

External Review

An “External Review” is a review by 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 the following are satisfied:

- 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 appeal is made by the member or the member's authorized representative.
- 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 for which the member is financially responsible exceeds $500.

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

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

The External Review Organization will generally notify you of the decision within 30 calendar days of Aetna’s receipt of a properly completed External Review 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

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

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
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 Claim 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 Claim 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, Citi has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the plan. The Claim Administrator's decisions are conclusive and binding. Please note that the Claim 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 Empire BlueCross BlueShield medical plans

Timing of initial claim approval or denial

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

- **For claims involving urgent care**, you will be notified of the approval or denial no later than 72 hours after your claim is received. If your claim did not include enough information to determine whether it should be approved or denied, you will be notified within 24 hours after receiving your claim of the specific information that is necessary. You will have at least 48 hours to provide the specified information. You will be notified of the approval or denial no later than 48 hours after Empire BlueCross BlueShield receives the information or 48 hours after the deadline for providing the information, if earlier. For purposes of these claims procedures, urgent care means medical care or treatment that must be provided without delay to avoid seriously jeopardizing life, health or the ability to regain maximum function, or that must, in the opinion of a physician, be provided without delay to adequately manage severe pain.
- **For medical care requiring pre-certification approval (called a "pre-certification claim")**, you will be notified of the approval or denial of your claim no later than 15 calendar days after your claim is received. Empire BlueCross BlueShield may extend this 15-calendar day period to 30 calendar days if it needs more time to review your claim due to matters outside of its control. If a longer period of time is required, you will be notified within the initial 15-calendar day period of the reasons for the extension and the date by which a decision will be made. You will be notified if your claim did not include enough information to reach a decision. You will have at least 45 calendar days from receipt of the notice to provide the specified information.
- For care involving an ongoing course of treatment to be provided over a period of time or through a number of treatments (called "concurrent care decisions"), 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 calendar days after your claim is received. Empire BlueCross BlueShield may extend this 30-calendar day period to 45 calendar days if it needs more time to review your claim due to matters outside of its control. If a longer period of time is required, you will be notified within the initial 30-calendar day period of the reasons for the extension and the date by which a decision will be made. You will be notified if your claim did not include enough information to make a decision. You will have at least 45 calendar days from receipt of the notice to provide the specified information.

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

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

Appeal filing deadlines

Action	Expedited Appeal	Prospective Standard Appeal	Retrospective Appeal
You may appeal to Empire BlueCross BlueShield, in writing (for an urgent care claim: orally or in writing)	Within 180 calendar days after the date you were notified	Within 180 calendar days after the date you were notified	Within 180 calendar days after the date you were notified
Empire BlueCross BlueShield will notify you about the appeal decision	Within 72 hours after appeal is received	Within 15 calendar days after appeal is received	Within 30 calendar days after appeal is received
You can make a second appeal to Empire BlueCross BlueShield, in writing	N/A	Within 60 calendar days after appeal denial is received	Within 60 calendar days after appeal denial is received
Empire BlueCross BlueShield will notify you about the second appeal decision	N/A	Within 15 calendar days after appeal is received	Within 30 calendar days after appeal is received

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

Approval or denial of appeal. Empire BlueCross BlueShield will send you its decision within the following deadlines: 72 hours for urgent care claims; 15 calendar days for pre-certification claims; and 30 calendar 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 calendar days from receiving the appeal denial to send a second appeal to Empire BlueCross BlueShield. Your appeal must be in writing. Empire BlueCross BlueShield will send you its written decision within 15 calendar days for pre-certification claims and 30 calendar days for all other claims.

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

Authorized representative. If you appeal an adverse decision to Empire BlueCross BlueShield 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 Group Health Plan of St Louis HMO medical plans

Notice of Appeal: If You wish to submit an Appeal, You should contact Member Services in writing at the address shown on the ID card. If You prefer, You may also request information by contacting Member Services by telephone. (See the attached Schedule of Important Telephone Numbers and Addresses or the back of Your ID card.) However, a formal Appeal must be submitted in writing and must include the following information:

- Member name;
- Provider name;
- Date(s) of service;
- Member's and/or Member's Authorized Representative's mailing address;
- Clear indication of the remedy or corrective action being sought and an explanation of why the Plan should "reverse" the Adverse Benefit Determination;
- Copy of documentation to support the reversal of decision, e.g. Emergency details, date, time, symptoms, etc.; and
- In cases where the Member's Authorized Representative is appealing on behalf of the member, a completed Member Designated Release of Information form.

Requesting information by telephone does not constitute filing an Appeal.

First Level Pre-Service Appeal Review: A first level pre-service Appeal may be requested by You or Your Authorized Representative. The Plan shall acknowledge receipt of the Pre-Service Appeal within five (5) calendar days unless the Appeal has been resolved prior to that time.

Within five (5) working days after the investigation is completed or within fifteen (15) calendar days after the receipt of the Appeal, whichever is earliest, the Plan will notify You or Your Authorized Representative in writing of the Plan's decision regarding the Appeal and of Your right to file an Appeal for a second-level review.

Second Level Pre-Service Appeal Review: If You or Your Authorized Representative are not satisfied with the decision of the first level Appeal review, You may submit a request for a second-level review in writing to the Plan. You will be sent an acknowledgment letter within five (5) calendar days of receipt of Your request by the Plan. The Plan will submit the Appeal to an Appeal advisory panel consisting of:

1. other Member(s),
2. representative(s) of the Plan; and
3. in cases where the Appeal involves a medical necessity issue, the panel will consist of a majority of persons who are appropriate clinical peers in the same or similar specialties as those who would typically manage the case being reviewed.

Within five (5) working days after the investigation is completed or within fifteen (15) calendar days after the receipt of the Appeal, whichever is earliest, the Plan will notify You or Your Authorized Representative in writing of the Plan's decision regarding the Appeal.

First Level Post-Service Appeal Review: A first level Post-Service Appeal may be requested by You or Your Authorized Representative. The Plan shall acknowledge receipt of the Post-Service Appeal within five (5) calendar days unless the Appeal has been resolved prior to that time.

Within five (5) working days after the investigation is completed or within fifteen (15) calendar days after the receipt of the Appeal, whichever is earliest, the Plan will notify You or Your Authorized Representative in writing of the Plan's decision regarding the Appeal and of Your right to file an Appeal for a second-level review.

Second Level Post-Service Appeal Review: If You or Your Authorized Representative are not satisfied with the decision of the first-level Appeal review, You may submit a request for a second-level review in writing to the Plan. You will be sent an acknowledgment letter within five (5) calendar days of receipt by the Plan. The Plan will submit the Appeal to an Appeal advisory panel consisting of:

4. other Member(s),
5. representative(s) of the Plan; and
6. in cases where the Appeal involves a medical necessity issue, the panel will consist of a majority of persons who are appropriate clinical peers in the same or similar specialties as those who would typically manage the case being reviewed.

Within five (5) working days after the investigation is completed or within fifteen (15) calendar days after the receipt of the Appeal, whichever is earliest, the Plan will notify You or Your Authorized Representative in writing of the Plan's decision regarding the Appeal.

Urgent Care Appeal Review: An Urgent Care Appeal may be requested by You or Your Authorized Representative. For Appeals satisfying the definition of an Urgent Care Appeal you may request an expedited Appeal of a Plan decision verbally or in writing. Within a reasonable period of time not to exceed thirty-six (36) hours of receiving a valid request for an Urgent Care Appeal, the Plan will verbally notify You of its decision. The Plan will then send a written confirmation of its decision within the following three (3) working days.

Claims and appeals for Harvard Pilgrim HMO medical plans

Harvard Pilgrim Health Care has established policies, procedures, and standards for all steps in the process of receiving, investigating, and resolving member grievances. There are defined timeliness standards, and reporting and oversight processes to monitor actual performance against the standards – these processes are designed to ensure member satisfaction and comply with all state, NCQA, DOL and CMS regulations.

Harvard Pilgrim divides grievances into two types: “complaints” and “appeals.” A **complaint** is documentation of a member’s unmet expectation with the exception of issues that concern the denial of coverage for health services -- those issues are referred to as member **appeals**. Complaints are then further categorized as either being administrative, or clinical, in nature. Whether categorized as a complaint or an appeal, Harvard Pilgrim considers all member input valuable and will resolve the issue as soon as possible – for clinically urgent appeal matters, an expedited appeals process is available. Member feedback better enables the organization to evaluate plans and services and to make improvements.

To register a complaint or an appeal, members should contact the Harvard Pilgrim Member Services Department.

More complete information on the Appeals Process can be found in the Member Handbook.

Harvard Pilgrim Appeals Process

An appeal may be filed in person, by mail, by FAX or by telephone. An appeal may be filed whenever a Member is denied coverage by Harvard Pilgrim. Once an appeal is filed, Harvard Pilgrim will appoint an Appeal Coordinator who will be responsible for the appeal throughout Harvard Pilgrim's internal appeal process. This includes either the denial of a health service sought by a Member or the denial of payment for a health service that a Member has received.

Most appeals result from a misunderstanding with a provider or a claim processing error. These problems can be easy to resolve, so most appeals and complaints will first be considered in the informal inquiry process. However, the informal inquiry process will not be used to review a denial of coverage involving a medical necessity determination. Coverage decisions involving medical necessity determinations will be transferred directly to the formal appeal.

Documentation Process

The Appeals Coordinator documents the receipt of the appeal in Harvard Pilgrim's Member Appeals Tracking System which is a comprehensive reporting and documentation database. Each step of the process is recorded and tracked in order to manage, investigate and resolve the appeal. A chronological history is kept of each step taken towards resolution of the appeal.

Appeals Not Involving a Medical Necessity Determination/Benefits Appeal

The Appeal Coordinator will review and decide all appeals that do not involve a medical necessity determination. The Appeals Coordinator may seek information and advice from medical professionals concerning the appeal.

Appeals Involving a Medical Necessity Determination

Appeals that involve a medical necessity determination will be reviewed by a Harvard Pilgrim Medical Director.

Claims and appeals for UnitedHealthcare of the River Valley (formerly John Deere Health) HMO medical plans

Complaint, Appeal and Dispute Resolution Procedures

The following procedures provide a formal system for resolving Complaints or Appeals concerning coverage determinations, the provision of health care services or other matters concerning the operation of UnitedHealthcare of the River Valley.

Most Complaints can be resolved on an informal basis by consultation between You, UnitedHealthcare of the River Valley staff, and/or the health practitioner from whom You received services. If Your Complaint can not be resolved after informal consultation, You or Your Authorized Representative may request a formal Appeal. If You want to designate an Authorized Representative to assist You with this Appeals Process, this must be done in writing.

Your Authorized Representative may not file a formal Appeal without explicit, written designation by You.

You must exhaust the Appeals Process prior to pursuing additional dispute resolution remedies.

Expedited Appeal Procedure for Urgent Care Claims

For Urgent Care Claims, You or Your Authorized Representative may contact UnitedHealthcare of the River Valley, orally or in writing, to request expedited consideration of a formal Appeal. In determining whether a claim is for urgent care, UnitedHealthcare of the River Valley will apply the judgment of a

prudent layperson that possesses an average knowledge of health and medicine. If the request for expedited consideration is denied, the Appeal will automatically be reviewed according to the procedures described in the section entitled, Appeal Procedure for Pre-Service and Post-Service Claims That Are Not Urgent Care Claims. A request for expedited consideration will not be denied if a Physician with knowledge of Your medical condition determines that Your claim involves urgent care.

UnitedHealthcare of the River Valley will submit Your expedited appeal to an independent Physician reviewer. The independent Physician reviewer will be a Clinical Peer, who has no material, professional, familial or financial affiliation with UnitedHealthcare of the River Valley or You, or material, familial or financial connection to the case and/or outcome.

Within 72 hours after UnitedHealthcare of the River Valley receives a request for expedited handling which includes all necessary information, UnitedHealthcare of the River Valley will issue a decision based on the independent Physician reviewer's final determination to You or Your Authorized Representative by telephone or facsimile. Written confirmation of UnitedHealthcare of the River Valley 's final decision will be mailed to You or Your Authorized Representative within three calendar days after UnitedHealthcare of the River Valley provides the final decision by telephone or facsimile. If additional information is needed, You or Your Authorized Representative will be notified within 24 hours of the expedited Appeal request specifying what information is needed to make a decision.When the additional information is received, a final decision will be made within 48 hours of receipt of the specified information or at the end of the period given to provide the specified information, whichever is earlier.

If UnitedHealthcare of the River Valley 's final decision is adverse to You, You or Your Authorized Representative may request binding arbitration as described under the section entitled, Arbitration Procedure, or bring a civil action as described in the section entitled, Civil Actions Available Under ERISA.

Appeal Procedure For Pre-Service and Post-Service Claims That Are Not Urgent Care Claims

For Pre-Service and Post-Service Claims that are not Urgent Care Claims, You or Your Authorized Representative may request an Appeal by completing a written "Member Appeal Form," which will be provided to You or Your Authorized Representative upon written or oral request. The Member Appeal Form must be completed and filed to UnitedHealthcare of the River Valley within 180 calendar days from the date: (1) the Member received notification of a denial of coverage; or (2) the problem in question occurred. The Member Appeal Form must be completed and signed and the facts as alleged shall be binding on the Member. The Member Appeal Form must be filed by mail, facsimile, or hand-delivery to UnitedHealthcare of the River Valley, according to the instructions provided with the Member Appeal Form.

UnitedHealthcare of the River Valley will issue a final decision, in writing, to You or Your Authorized Representative within the following timeframes:

- Pre-Service Claim: 15 calendar days after receipt of the Member Appeal Form.
- Post-Service Claim: 30 calendar days after receipt of the Member Appeal Form.

If UnitedHealthcare of the River Valley 's decision on the Appeal is adverse to You, You have the right to further review. For Appeals related to determinations which require medical judgment, including determinations of medical necessity, You or Your Authorized Representative may request an Independent Physician Review (IPR) as described under the subsection entitled, Independent Physician Review Procedure. For all other Appeals, You or Your Authorized Representative may request a reconsideration of the Appeal decision as described under the subsection entitled, Member Reconsideration Procedure.

Independent Physician Review Procedure

You or Your Authorized Representative may request an "Independent Physician Review" (IPR) of an adverse decision resulting from an Appeal which denied You coverage on the basis that the service, procedure, or treatment in question was not medically necessary or medically appropriate. The provisions in this section shall not be construed to obligate UnitedHealthcare of the River Valley to make payment for any health care service, procedure, or treatment which is not covered under Your Plan.

At the time You or Your Authorized Representative is notified of the adverse Appeal decision described above, You shall also be advised of Your right to request an IPR. You or Your Authorized Representative must request an IPR within 30 calendar days of receiving UnitedHealthcare of the River Valley 's adverse Appeal decision.

The independent Physician reviewer will be a Clinical Peer, who has no material, professional, familial or financial affiliation with UnitedHealthcare of the River Valley or You, or material, familial or financial connection to the case and/or its outcome. UnitedHealthcare of the River Valley will not charge You any fees for an IPR filing or case review, or fees associated with diagnostic tests or other clinical services the External Independent Review Organization (EIRO) requests in order to complete the review.

However, UnitedHealthcare of the River Valley is not responsible for other costs such as those associated with You retaining an attorney.

After receiving a request for IPR, UnitedHealthcare of the River Valley will provide the following information to the EIRO:

- all relevant medical records and appropriate portions of the Appeal file;
- supporting documentation used to render the decision pertaining to Your case;
- a summary description of the applicable issues, including a statement of UnitedHealthcare of the River Valley 's decision;
- the relevant portions of UnitedHealthcare of the River Valley 's utilization management criteria, if applicable;
- any additional information or comments submitted by You or Your Authorized Representative to UnitedHealthcare of the River Valley regarding the Appeal; and
- any new information related to Your case that has become available since the initial Appeal decision.

UnitedHealthcare of the River Valley will issue a final written decision, based on the independent Physician reviewer's final determination, to You or Your Authorized Representative within the following timeframes:

- Pre-Service Claim: 15 calendar days after receipt of the request for independent Physician review.
- Post-Service Claim: 30 calendar days after receipt of the request for independent Physician review.

If UnitedHealthcare of the River Valley 's final decision is adverse to You, You or Your Authorized Representative may request binding arbitration as described under the section entitled, Arbitration Procedure, or bring a civil action as described in the section entitled, Civil Actions Available Under ERISA.

Member Reconsideration Procedure

A reconsideration of an adverse Appeal decision is available for any Pre-Service or Post-Service Claim which does not require a determination of medical necessity, or which does not require medical judgment. You have 30 calendar days from the date the Appeal decision was issued in which to file a request for reconsideration to the Member Reconsideration Committee of UnitedHealthcare of the River Valley .

The Committee meeting shall be held at the UnitedHealthcare of the River Valley home office in Moline, Illinois. You or Your Authorized Representative will be notified that the Member Reconsideration Procedure Committee will meet to hear Your case, and You or Your Authorized Representative will be provided the opportunity to submit additional information or comments in writing. The Reconsideration Committee shall resolve the Appeal by majority vote and will issue a final decision to You or Your Authorized Representative within the following timeframes:

- Pre-Service Claim: 15 calendar days after receipt of the request for reconsideration.
- Post-Service Claim: 30 calendar days after receipt of the request for reconsideration.

If UnitedHealthcare of the River Valley 's decision on the reconsideration is adverse to You, You or Your Authorized Representative may request binding arbitration as described under the section entitled, Arbitration Procedure, or bring a civil action as described in the section entitled, **Civil Actions Available Under ERISA**.

Civil Actions Available Under ERISA

If You remain dissatisfied after exhausting either:

7. the Expedited Appeal Procedure for Urgent Care Claims; or
8. the Appeal Procedure for Pre-Service and Post-Service Claim that are not Urgent Care Claims, and either
    a. the Independent Physician Review Procedure, or
    a. the Reconsideration Procedure, whichever is applicable,

then You have a right to bring a civil action under section 502(a) of ERISA, or to pursue arbitration as described under the section entitled, Arbitration Procedure.

Arbitration Procedure

Arbitration shall be conducted in accordance with the then current Employee Benefit Plans Claims Arbitration Rules of the American Arbitration Association (AAA). A request for arbitration must be filed with UnitedHealthcare of the River Valley and the American Arbitration Association in writing within six months of the date of the final Appeal decision being arbitrated. The question for the arbitrator will be whether the decision of UnitedHealthcare of the River Valley should be set aside because the decision was arbitrary and capricious. Judgment upon the decision by the arbitrator may be entered in any court having jurisdiction. Each party will bear its own costs and attorney fees. The expenses associated with the arbitration will be shared equally by both parties. Arbitration is final and binding on the parties. The parties waive their right to remedies in court, including their right to jury trial, except for the enforcement of the decision of the arbitrator. The Member and UnitedHealthcare of the River Valley agree that the arbitrator shall have no authority to award punitive damages and waive their right to such damages.

Resolution of Disputes Not Relating to Urgent Care, Pre-Service of Post-Service

All unresolved disputes which do not relate to Urgent Care Claims, Pre-Service Claims, or Post-Service Claims shall be resolved through mandatory, binding arbitration as described above.

Upon written request and free of charge, You or Your Authorized Representative may request copies of all documents relevant to Your Appeal and either the independent Physician review or reconsideration.

Claims and appeals for Optimum Choice, Inc. HMO medical plans

Resolving Member Grievances

Generally, problems can be resolved by contacting Optimum Choice, Inc. HMO's Customer Service Department regarding general concerns and inquiries. Inquiries and general concerns will be resolved within ten (10) business days of the receipt of your inquiry.

You are entitled to submit a formal statement of dissatisfaction to Optimum Choice, Inc. HMO on any matter that may be in dispute and request a first level review. In order to request a first level review, you must submit your written request to:

Customer Support Group
P.O. Box 933
Frederick, Maryland 21705

within sixty (60) calendar days of the incident in question. Optimum Choice, Inc. HMO will send you a written response within thirty (30) calendar days of receipt of your request. If the review cannot be completed within thirty (30) calendar days due to circumstances beyond Optimum Choice, Inc. HMO's control, Optimum Choice, Inc. HMO will extend the review period by an additional twelve (12) calendar days in order to issue a resolution.

If you are dissatisfied with the outcome of a first level review, you may request a second level review. To request a second level review, a written request must be sent to:

Customer Support Group
P.O. Box 933
Frederick, Maryland 21705

within thirty (30) business days of the first level review decision. Optimum Choice, Inc. HMO will send you a written response within thirty (30) calendar days of your request. If the review cannot be completed within thirty (30) calendar days due to circumstances beyond Optimum Choice, Inc. HMO's control, Optimum Choice, Inc. HMO will extend the review period by an additional twelve (12) calendar days in order to issue a resolution.

If you are still dissatisfied, you may also request a third level review. The third level review will be performed by a person not involved in either the first or second level review. To request a third level review, you must send a written request to:

Customer Support Group
P.O. Box 933
Frederick, Maryland 21705

within ten (10) business days of receipt of the second level review outcome. Optimum Choice, Inc. HMO will reach a final third level review decision within thirty (30) business days of receipt of your request. Optimum Choice, Inc. HMO will document the third level review decision and send a written explanation of the decision within five (5) business days of the decision.

Note: The three-level grievance procedure described above does not apply to an Adverse Decision.

Grievance Procedure for Adverse Decisions

Optimum Choice, Inc. HMO maintain a formal grievance procedure if you are not satisfied with an adverse decision.You or a Subscriber representative acting on your behalf may file a grievance regarding an adverse decision within thirty (30) business days of receipt of the adverse decision. The notice of adverse decision will state, among other things, the name and address of the medical director who made the adverse decision. The following is the address and telephone number of the medical director responsible for adverse decisions: Medical Director, OCI, 4 Taft Court, Rockville, Maryland 20850; Telephone: (301) 545-5763 or 1-800-962-2174.

You or your Member representative should call the Customer Service Department at the telephone number on your ID card for information on how to submit a grievance. Grievances for an adverse decision should be directed to:

Customer Support Group
P.O. Box 933
Frederick, Maryland 21705
Fax: (301) 360-8915.

All grievances regarding adverse decisions are formally recorded and acknowledged. Optimum Choice, Inc. HMO will reach a final decision within fourteen (14) business days after the date on which the grievance was received. Optimum Choice, Inc. HMO may communicate the grievance decision and send a written explanation of the decision, as well as the right to request a second level review of the grievance decision within five (5) business days of the grievance decision.

If you are not satisfied with a grievance decision, you or the Subscriber representative who filed a grievance on your behalf may request a second level review before a review committee. The request for a second level review must be received within thirty (30) business days for the grievance decision. Each request for a second level review will be formally acknowledged by us, in writing, to the Subscriber or Subscriber representative within ten (10) business days of receipt. Optimum Choice, Inc. HMO will reach a final second level grievance decision within thirty (30) business days from the date of receipt. Optimum Choice, Inc. HMO will document the second level Grievance decision and send a written explanation of the decision, as well as the right to request a formal external review of the second level grievance decision within five (5) business days of the decision. If Optimum Choice, Inc. HMO fails to comply with any deadline for completion of the second level review, the Subscriber or Subscriber representative will be relieved of the duty to exhaust the second level review process, and may proceed directly to the external review process.

Within thirty (30) business days of receipt of an adverse second level Grievance decision, the Subscriber or Subscriber representative may file a request for an external review with the Director of the Department of Health. Grievances regarding Medical Necessity decisions should be addressed to:

Director
Department of Health
Government of the District of Columbia
Attn: Grievance and Appeals Committee
825 North Capitol Street, N.E., Room 4119
Washington, D.C. 20002
Telephone: (202) 442-5979.

All other grievances should be addressed to:

Commissioner of Insurance
Government of the District of Columbia
810 First Street, N.E.
Washington, D.C. 20002

An expedited review process of a grievance is available for an urgent or Emergency medical condition. Optimum Choice, Inc. HMO will conclude its first level review within twenty-four (24) hours of receipt of the request for review from the Subscriber or Subscriber representative. The determination about the existence of an urgent or Emergency medical condition will be done on a case-by-case basis by the medical director based on the definition of Emergency medical condition defined herein. If you are dissatisfied with the first level decision, you or your Subscriber representative can request a second level review. Optimum Choice, Inc. HMO will complete a second level review of a grievance decision within twenty-four (24) hours of the receipt for request of a second level review. An expedited review decision may be communicated to you or your Subscriber representative orally. Within one (1) business day after a final decision has been rendered on an expedited review, Optimum Choice, Inc. HMO will send a written explanation of the grievance decision.

Claims and appeals for Oxford Health Plans medical plans

The amount of time Oxford Health Plans will take to make a decision on a claim will depend on the type of claim.

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
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 Claim 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 denial, contact Customer Service immediately.

Oxford Health Plans level one appeal

If you disagree with a claim determination after following the above steps, you can contact the Claim 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 Claim 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 Claim Administrator in considering the claim; and that demonstrates the Claim 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 Claim 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 Claim 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 Claim 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 Claim Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

Oxford Health Plans level two appeal

If you are not satisfied with the first level appeal decision of the Claim Administrator, you have the right to request a second level appeal from the Claim Administrator. Your second level appeal request must be submitted to the Claim 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 Claim 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 Claim 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, Citi has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claim Administrator’s decisions are conclusive and binding. Please note that the Claim Administrator’s decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Oxford Health Plans urgent claim appeals

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

For urgent claim appeals, Citi has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claim Administrator’s decisions are conclusive and binding.

Claims and appeals for Tufts Health Plan

Appeals and Grievances Department

If you need to call Tufts HP about a concern or appeal, contact a Member Services Coordinator at 1-800-462-0224.

To submit your appeal or grievance in writing, send your letter to:

Tufts Health Plan
Attn: Appeals and Grievances Department
705 Mt. Auburn Street
P.O. Box 9193
Watertown MA 02471-9193

For more information about Tufts Health Plan and to learn more about the self-service options that are available to you, please see the Tufts Health Plan Web site at **www.tuftshealthplan.com**.

Member Satisfaction Process

Tufts Health Plan has a multi-level Member Satisfaction Process including:

- Internal Inquiry;
- Member Grievance Process;
- Internal Member Appeals; and
- External Review by the Office of Patient Protection.

All grievances and appeals should be sent to Tufts HP at the following address:

Tufts Health Plan
Attn: Appeals and Grievances Department
705 Mt. Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193

All calls should be directed to Tufts HP's Member Services at 1-800-462-0224.

Internal Inquiry

Call a Tufts HP Member Services Coordinator to discuss concerns you may have regarding your health care. Every effort will be made to resolve your concerns within three (3) business days. If your concerns cannot be explained or resolved within three (3) business days or if you tell a Member Service Coordinator that you are not satisfied with the response you have received from Tufts HP, we will notify you of any options you may have, including the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

Tufts HP maintains records of each inquiry made by a Member or by that Member's authorized representative. The records of these inquiries and the response provided by Tufts HP are subject to inspection by the Commissioner of Insurance and the Department of Public Health.

Member Grievance Process

A grievance is a formal complaint about actions taken by Tufts HP or a Provider. There are two types of grievances: administrative grievances and clinical grievances. The two types of grievances are described below.

It is important that you contact Tufts HP as soon as possible to explain your concern. Call a Tufts HP Member Services Coordinator who will document your concern and forward it to a Grievance Analyst in the Appeals and Grievance Department. Grievances may be filed either verbally or in writing. To accurately reflect your concerns, you may want to put your grievance in writing and send it to the address provided at the beginning of this section. Your explanation should include:

- Your name and address;
- Your Tufts HP Member ID number;
- A detailed description of your concern (including relevant dates, any applicable medical information, and Provider names); and
- Any supporting documentation.

Important Note: The Member Grievance Process does not apply to requests for a review of a denial of coverage.

If you are seeking such a review, please see the "Internal Member Appeals" section below.

Administrative Grievances

An administrative grievance is a complaint about a Tufts HP employee, department, policy, or procedure, or about a billing issue.

To contact Member Services, call 1-800-462-0224, or see our Web site at **www.tuftshealthplan.com**.

Administrative Grievance Timeline

- If you file your grievance in writing, we will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Grievance Analyst coordinating the review of your grievance.
- If you file your grievance verbally, we will send you a written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.
- If your request for review was first addressed through the internal inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) business day Internal Inquiry process or earlier if you notify Tufts HP that you are not satisfied with the response you received during the Internal Inquiry process.
- Tufts HP will review your grievance and will send you a letter regarding the outcome, as allowed by law, within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual written agreement between you or your authorized representative and Tufts HP.

Clinical Grievances

A clinical grievance is a complaint about the quality of care or services that you have received. If you have concerns about your medical care, you should discuss them directly with your Provider. If you are not satisfied with your Provider's response or do not wish to address your concerns directly with your Provider, you may contact Member Services to file a clinical grievance.

If you file your grievance in writing, we will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Grievance Analyst coordinating the review of your grievance. If you file your grievance verbally, we will send you a written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.

Tufts HP will review your grievance and will notify you in writing regarding the outcome, as allowed by law, within thirty (30) calendar days of receipt. The review period may be extended up to an additional thirty (30) days if additional time is needed to complete the review of your concern. You will be notified in writing if the review timeframe is extended.

"Reconsideration"

If you are not satisfied with the result of the Clinical Grievance review process, you may request a "reconsideration". If you so choose, your concerns will be reviewed by a clinician who was not involved in the initial review process. Upon request for a reconsideration, your concerns will be reviewed within thirty (30) calendar days. You will be notified in writing of the results of the review.

Internal Member Appeals

An appeal is a request for a review of a denial of coverage for a service or supply that has been reviewed and denied by Tufts HP based on medical necessity (an adverse determination) or a denial of coverage for a specifically excluded service or supply.

It is important that you contact Tufts HP as soon as possible to explain your concern. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file an internal appeal. Appeals may be filed either verbally or in writing. If you would like to file a verbal appeal, call a Tufts HP Member Services Coordinator who will document your concern and forward it to a Member Appeals Analyst in the Appeals and Grievance Department. To accurately reflect your concerns, you may want to put your appeal in writing and send it to the address provided at the beginning of this section. Your explanation should include:

- Your name and address;
- Your Tufts HP Member ID number;
- A detailed description of your concern (including relevant dates, any applicable medical information, and Provider names); and
- Any supporting documentation.

To contact Member Services, call 1-800-462-0224, or see our Web site at **www.tuftshealthplan.com**.

Appeals Timeline

- If you file your appeal in writing, we will notify you in writing, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Member Appeals Analyst coordinating the review of your appeal.
- If you file your appeal verbally, we will send you a written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the Member Appeals Analyst coordinating the review of your appeal.
- If your request for review was first addressed through the internal inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day

following the end of the three (3) business day Internal Inquiry process or earlier if you notify Tufts HP that you are not satisfied with the response you received during the internal inquiry process.

- Tufts HP will review your appeal, make a decision, and send you a decision letter within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual verbal or written agreement between you or your authorized representative and Tufts HP. This extension may be necessary if we are waiting for medical records that are necessary for the review of your appeal and have not received them. The Appeals Analyst handling your case will notify you in advance if an extension may be needed. In addition, a letter will be sent to you confirming the extension.

When Medical Records are Necessary

If your appeal requires the review of medical records, you will receive a form that you will need to sign that authorizes your Providers to release to Tufts HP medical information relevant to your appeal. You must sign and return the form before Tufts HP can begin the review process. If you do not sign and return the form to Tufts HP within thirty (30) calendar days of the date you filed your appeal, Tufts HP may issue a response to your request without having reviewed the medical records. You will have access to any medical information and records relevant to your appeal that are in the possession and control of Tufts HP.

Who Reviews Appeals?

If the appeal involves a medical necessity determination, an actively practicing physician in the same or similar specialty as typically treats the medical condition, and who did not participate in any of the prior decisions on the case, will take part in the review. In addition, a committee made up of managers and clinicians from various Tufts HP departments will review your appeal. A committee within the Appeals and Grievances Department will review appeals involving non-covered services.

Appeal Response Letters

The letter you receive from Tufts HP will include identification of the specific information considered for your appeal and an explanation of the basis for the decision. A response letter regarding a final adverse determination (a decision based on medical necessity) will include: the specific information upon which the adverse determination was based; Tufts HP's understanding of your presenting symptoms or condition; diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria; alternative treatment options offered, if any; applicable clinical practice guidelines and review criteria; notification of the steps for requesting external review by the Office for Patient Protection; and the titles and credentials of the individuals who reviewed the case. Please note that requests for coverage of services that are specifically excluded in your Evidence of Coverage (EOC) are not eligible for external review.

An appeal not properly acted on by Tufts HP within the time limits of Massachusetts law and regulations, including any extensions made by mutual written agreement between you or your authorized representative and Tufts HP, shall be deemed resolved in your favor.

To contact Member Services, call 1-800-462-0224, or see our Web site at **www.tuftshealthplan.com**.

Expedited Appeals

Tufts HP recognizes that there are circumstances that require a quicker turnaround than the thirty (30) calendar days allotted for the standard Appeals Process. Tufts HP will expedite an appeal when there is an ongoing service about to terminate or a service to be delivered imminently whereby a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. Should you feel that your request meets the criteria cited above, you or your attending physician should

contact the Member Services Department. Under these circumstances, you will be notified of Tufts HP's decision within seventy-two (72) hours after the review is initiated. If your treating physician (the physician responsible for the treatment or proposed treatment) certifies that the service being requested is Medically Necessary; that a denial of coverage for such services would create a substantial risk of serious harm; and such risk of serious harm is so immediate that the provision of such services should not await the outcome of the normal grievance process, you will be notified of Tufts HP's decision within forty-eight (48) hours of the receipt of certification. If you are appealing coverage for Durable Medical Equipment (DME) that Tufts HP determined was not Medically Necessary, you will be notified of Tufts HP's decision within less than forty-eight (48) hours of the receipt of certification. If you are an Inpatient in a hospital, Tufts HP will notify you of the decision before you are discharged. If your appeal concerns the termination of ongoing coverage or treatment, the disputed coverage shall remain in effect at Tufts HP's expense through the completion of the Internal Appeals Process. Only those services which were originally authorized by Tufts Health Plan and which were not terminated pursuant to a specific time or episode-related exclusion will continue to be covered.

If you have a terminal illness, we will notify you of Tufts HP's decision within five (5) days of receiving your appeal. If Tufts HP's decision is to deny coverage, you may request a conference. We will schedule the conference within 10 days (or within 5 business days if your physician determines, after talking with a Tufts HP medical director, that based on standard medical practice the effectiveness of the proposed treatment or alternative covered treatment would be materially reduced if not provided at the earliest possible date). You may bring another person with you to the conference. At the conference, you and/or your authorized representative, if any, and a representative of Tufts HP who has authority to determine the disposition of the grievance, shall review the information provided.

If the appeal is denied, the decision will include the specific medical and scientific reasons for denying the coverage, and a description of any alternative treatment, services or supplies that would be covered.

Conference (Walk-in) Appeals

If the case involves an adverse determination (Medical Necessity determination), you or your representative may also appear in person or by conference call to present your appeal. This is an opportunity for you to present additional information to the Committee that may be better communicated in person. If you would like to present your appeal in person, you must request this option. A Member Appeals Analyst will contact you to schedule a date and time to appear. You will have approximately twenty (20) minutes to address the Committee. The Committee will not make a decision while you are present, and the Member Appeals Analyst will notify you of a decision after it has been made.

If You are Not Satisfied with the Appeals Decision

"Reconsideration"

In circumstances where relevant medical information (1) was received too late to review within the thirty (30) calendar day time limit; or (2) was not received but is expected to become available within a reasonable time period following the written resolution, you may choose to request a reconsideration. Tufts HP may allow the opportunity for reconsideration of a final adverse determination. If you request a reconsideration, you must agree in writing to a new time period for review. The time period will be no greater than thirty (30) calendar days from the agreement to reconsider the appeal.

To contact Member Services, call 1-800-462-0224, or see our Web site at **www.tuftshealthplan.com**.

External Review by the Office of Patient Protection

The Massachusetts Office of Patient Protection, which is not connected in any way with Tufts HP, administers an independent external review process for final coverage determinations based on medical

necessity (final adverse determination). Appeals for coverage of services specifically excluded in your EOC are not eligible for external review.

To request an external review by the Office of Patient Protection, you must file your request in writing with the Office of Patient Protection within forty-five (45) days of your receipt of written notice of the denial of your appeal by Tufts HP. The letter from Tufts Health Plan notifying you of the denial will contain the forms and other information that you will need to file an appeal with the Office of Patient Protection. You or your authorized representative may request to have your review processed as an expedited external review. Any request for an expedited external review must contain a certification, in writing, from a physician, that delay in providing or continuation of health care services that are the subject of a final adverse determination would pose a serious and immediate threat to your health. Upon a finding that a serious and immediate threat to your health exists, the Office of Patient Protection will qualify such request as eligible for an expedited external review. Your cost for an external review by the Office of Patient Protection is $25.00. This payment should be sent to the Office of Patient Protection, along with your written request for a review. The Office of Patient Protection may waive this fee if it determines that the payment of the fee would result in an extreme financial hardship to you. Tufts Health Plan will pay the remainder of the cost for an external review. Upon completion of the external review, the Office of Patient Protection shall bill Tufts HP the amount established pursuant to contract between the Massachusetts Department of Public Health and the assigned external review agency minus the $25 fee which is your responsibility. You, or your authorized representative, will have access to any medical information and records relating to your appeal in the possession of the Tufts HP or under its control. If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending.

The review panel may order the continuation of coverage where it determines that substantial harm to your health may result absent such continuation or for such other good cause, as the review panel shall determine. Any such continuation of coverage will be at Tufts HP's expense regardless of the final external review determination.

The decision of the review panel will be binding on Tufts HP. If the external review agency overturns a Tufts HP decision in whole or in part, Tufts HP will send you a written notice within five (5) business days of receipt of the written decision from the review agency. This notice will:

- include an acknowledgement of the decision of the review agency;
- advise you of any additional procedures that you need to take in order to obtain the requested coverage or services; advise you of the date by which the payment will be made or the authorization for services will be issued by Tufts HP; and
- include the name and phone number of the person at Tufts HP who will assist you with final resolution of the grievance.

Please note, if you are not satisfied with Tufts HP's Member Satisfaction Process, you have the right at any time to contact the Commonwealth of Massachusetts at either the Division of Insurance Bureau of Managed Care at 617-521-7777 or the Department of Public Health's Office of Patient Protection at:

Department of Public Health
Office of Patient Protection
250 Washington Street, 2nd Floor
Boston, MA 02108
Phone: 1-800-436-7757
Fax: 1-617-624-5046
Internet: **www.state.ma.us/dph/opp**

To contact Member Services, call 1-800-462-0224, or see our Web site at **www.tuftshealthplan.com**.

Claims and appeals for Express Scripts (the non-HMO/EPO prescription drug program)

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

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension due to matters beyond the control of the Claim 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 www.express-scripts.com. These forms tell you how and when to file a claim.

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

- The specific reasons for the denial;
- The specific references in the plan documentation on which the denial is based;
- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review;
- The procedure for further review of your claim; and

- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the plan's appeals procedure.

Express Scripts level one appeal

If you disagree with a claim determination after following the above steps, you can contact the Claim Administrator in writing to formally request an appeal. Your first appeal request must be submitted to the Claim 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 Claim Administrator in considering the claim; and that demonstrates the Claim 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 Claim 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 Claim 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 Claim 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 Claim 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 Claim Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Express Scripts level two appeal

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

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

Express Scripts urgent claim appeals

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

For urgent claim appeals, Citi has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claim Administrator's decisions are conclusive and binding.

Claims and appeals for MetLife PDP

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

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
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 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 180 days of receipt of the denial letter. As part of this review, you or your legal representative has the right to review all pertinent documents and submit issues and comments in writing to a committee selected by MetLife. The committee consists of senior representatives of MetLife Dental Claim Management and a Dental Consultant.

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

Claims and appeals for the CIGNA Dental Care DHMO

If you have a concern about your Dental Office or the CIGNA Dental Plan, you can call 1.800.CIGNA24 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.CIGNA24.

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 we need more information to make your level-one appeal decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

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

If you are not satisfied with the decision, you may request a level two appeal.

CIGNA Dental level two appeal

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review. The Level-Two Appeals process does not apply to resolutions made solely on the basis that the Dental Plan does not provide benefits for the service performed or requested.

The review will be completed within 30 calendar days. If we need more information to complete the appeal, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

CIGNA Dental expedited appeal

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

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

CIGNA Dental independent review

The independent review procedure is a voluntary program arranged by the Dental Plan and is not available in all areas. Contact CIGNA Dental at 1.800.CIGNA24 for more details.

Appeals to the state

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

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

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	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period.) Notice that more information is needed must be given within 30 days. You have 45 days to submit any additional information needed to process the claim.*
Pre-service claims (for services requiring precertification of services)	Not applicable. Delta Dental 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)	Usually not applicable. Urgent care claims do not ordinarily arise in the context of a fee-for-service plan involving dental care, such as Citi's dental plan. However, Delta Dental will comply with Department of Labor requirements for urgent care claims if any arise.
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 Dental 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 Dental **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 Dental 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 Dental will consult with a dentist who has appropriate training and experience in the pertinent field of dentistry who is neither the Delta Dental 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 Dental will not afford deference to the initial adverse benefit determination.

If after review, Delta Dental continues to deny the claim, Delta Dental 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 Dental 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 Dental in writing as soon as possible.

The matter will be immediately referred to Delta Dental's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta Dental'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 Dental 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 Benefit Plan

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	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
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 will have 180 days following receipt of a claim denial to appeal the decision. 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 the HCSA/LPSA

If you are denied a benefit under the HCSA/LPSA, 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; and
- a statement explaining your rights to bring civil action under Section 502(a) of ERISA after an adverse benefit determination upon review.

Step 3: If you disagree with the 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 Citi. If you still do not agree with the ADP's decision, you may file a written appeal with Citi 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 Citi denies your Appeal, you will receive notice within 30 days after the Citi receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Citigroup Inc.
Plans Administration Committee of Citigroup Inc.
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 Claim Administrator is required to give the participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination;
- You cannot file suit in federal court until you have exhausted these appeals procedures, however, you have the right to file suit under ERISA Section 502 following an adverse appeal decision;
- Each participant has the right to request and obtain documents, records and other information as it pertains to the Plans. Notwithstanding any provision of the Plan to the contrary, you must file any lawsuit with respect to your adverse benefit determination within 12 consecutive months after the date of receiving such a determination, or if earlier, within two years from the date on which you were aware, or should have been aware, of the claim at issue in the suit. The two year limitation shall be increased by any time a claim or appeal on the issue is under consideration by the appropriate fiduciary. If any different period to commence suit is specified in an insurance contract forming part of the Plan, that period will apply to suits against the insurer.

Wellness programs

Effective in 2007, The Plan Sponsor adopted several broad-based administrative programs intended to improve the health of Plan participants and reduce Plan Sponsor costs. These programs known together as Citi Live Well, are an element of your participation in the Plans. For details on the programs, see the 2008 Health and Welfare Summary Plan Description.

Administrative information

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

Future of the plans and plan amendments

Citi has the right to amend, modify, suspend, or terminate any Plan, in whole or in part, at any time for any reason without prior notice. Citi may make any such amendment, modification, suspension, or termination of the plans for any reason. Plan amendments shall be adopted and executed by the Senior Human Resources Officer of Citigroup Inc., a Committee of the Board of Directors of Citigroup Inc., or any officer of Citigroup Inc. authorized to adopt plan amendments or sign other documents on behalf of Citigroup Inc., and may include amendments to insurance contracts or administrative agreements. The Plans are subject to various legal requirements, which may require changes in the Plans.

In the event of the dissolution, merger, consolidation or reorganization of Citi, the Plans will terminate unless the Plans are continued by a successor to Citi.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Citi to the extent permitted under applicable law.

No right to employment

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

Plan administration

The Plan Administrator, the Plans Administrative Committee of Citigroup Inc., is responsible for the general administration of the Plans, and is the "named fiduciary" under ERISA for each of the Plans. The Plan Administrator will be the Plan fiduciary to the extent not delegated to a Claim Administrator pursuant to an agreement or other document or arrangement. The Plan Administrator and, where delegated, the Claim Administrators have the exclusive discretionary authority to construe and interpret the provisions of the Plans and make factual determinations regarding all aspects of the Plans and their benefits, including the power and discretion to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plans, and to remedy ambiguities, inconsistencies or omissions, and such determinations shall be binding on all parties.

The Plan Administrator 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 Plans including the processing and payment of claims under the Plans and the related recordkeeping, according to the terms of an administrative services or claims administration agreement;
- To prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plans; and

- To act as Claim Administrator and to review claims and claim denials under the Plans to the extent another insurer or administrator is not empowered with such responsibility.

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

Funding and payment policy

Benefits under the Health Benefit Plan and the Dental Benefit Plan may be funded from the general assets of Citi, a trust qualified under section 501(c)(9) of the Internal Revenue Code, or under insurance contracts. The Vision Benefit Plan is fully insured, and the Health Care Spending Account is funded from general assets of Citi. The costs of the Health Benefit Plan, the Dental Benefit Plan, and the Vision Benefit Plan are shared between Citi and the plan participants. The cost of the Health Care Spending Account is generally borne by the participants. The cost of the Citi Employee Assistance Program is borne by Citi. Any refund, rebate, dividend adjustment or other similar payment under any insurance contract entered into between Citi and any insurance provider shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse Citi for premiums it has paid or to reduce Plan expenses. All Plan assets shall be used to pay benefits under the Plans or pay the reasonable expenses of Plan administration. Payments under the Plans shall be made in accordance with Plan terms, insurance policies, or administrative agreements.

Compliance with law

The Plans shall be construed and administered in compliance with federal and state law mandates governing the Plans, including ERISA, COBRA, USERRA, HIPAA, the Code, the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act of 1996, as amended, and the Women's Health and Cancer Rights Ac of 1998.

Compliance with Section 125 of the Internal Revenue Code

About Your Health Care Benefits, the Citigroup Health Benefit Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan, and the Citigroup General Purpose Health Care Spending Account, and the Limited Purpose Health Care Spending Account and documents governing participant elections generally are, when read together, intended to comply with the requirements of Section 125 of the Internal Revenue Code of 1986, as amended, and constitute a cafeteria plan. All such documents are incorporated by reference to constitute a single plan, in accordance with applicable Treasury regulations.

As stated previously in this document, all participants are entitled to make their benefit elections under the foregoing Plans through salary reduction arrangements so that the participant's premium payments or health care spending account contributions can be made on a pre-tax basis. While the above-mentioned benefit Plans describe the benefits available, this About Your Health Care Benefits document authorizes employees to enter into salary reduction arrangements to pay their portion of the health care premiums on a pre-tax basis and authorizes employees to defer amounts under the health care spending accounts on a pre-tax basis with respect to subsequent expenses that will be incurred and later reimbursed. Changes in such elections are available only in limited circumstances set forth in the Plan document. The change in coverage must be consistent with the change in status. For example, if a dependent is added, the coverage should increase (not decrease). In addition to the foregoing, the Plans permit election changes based on the special enrollment rights under HIPAA.

Plan information

Employer Identification Number	52-1568099
Participating Employers	Citigroup Inc. and any of its [U.S.] subsidiaries in which at least an 80% interest is owned.
Plan Names and Numbers	
• Medical plans (self-funded ChoicePlans, High Deductible Health Plans (Basic and Premier), Hawaii Health Plan, Out-of-Area Plan, and HMOs) including prescription drugs	Citi Health Benefit Plan Plan number 508
• Dental plans	Citi Dental Benefit Plan Plan number 505
• Vision care plan	Citi Vision Benefit Plan Plan number 533
• General Purpose Health Care Spending Account/Limited Purpose Health Care Spending Account	Citi Flexible Benefits Plan Plan number 512
• Employee Assistance Program	Citi Employee Assistance Program Plan number 521
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

Claim Administrators

Each of the Claim Administrators has the discretion and authority to render benefit determinations in a manner consistent with the terms and conditions of the Plans— namely, those provisions of the Plan document that apply to the participant and administered by that particular Claim Administrator.

ChoicePlans and High Deductible Health Plans (Basic and Premier)	Aetna Citi 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 Citi HMO Administrator at 1-800-422-6106
For self-insured HMO/EPO plans	Aetna Citi Claims Division P.O. Box 981106 El Paso, TX 79998-1106 1-800-545-5862

For self-insured HMO/EPO plans (continued)	CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200 1-800-794-4953 or P.O. Box 182223 Chattanooga, TN 37422-7223 Group Health Plan of St. Louis P.O. Box 7121 London, KY 40742 1-800-775-3540 Harvard Pilgrim Health Care P.O. Box 699183 Quincy, Massachusetts 02269 1-888-333-4742 UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845 Empire BlueCross BlueShield P.O. Box 5072 Middletown, NY 10940 1-866-290-9098 United Healthcare P.O. Box 659752 San Antonio, TX 78265-9752 1-877-311-7845 UnitedHealthcare of the River Valley 2033 Meadowview Lane, Suite 300 Kingsport, TN 37660

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	Express Scripts Health Prescription Solutions, Inc. P.O. Box 2187 Lee's Summit, MO 64063-2187
• Express Scripts By Mail	Express Scripts, Inc. Home Delivery Services P.O. Box 510 Bensalem, PA 19020-0510
For Dental Plans	
• MetLife Preferred Dentist Program (PDP)	Metropolitan Life Insurance Company MetLife Dental Claims Unit P.O. Box 981282 El Paso, TX 79998-1282 1-888-832-2576 1-859-389-6505 Fax To submit an Appeal: Metropolitan Life Insusrance Company P.O. Box 14093 Lexington, KY 40512-4093
• CIGNA Dental Care DHMO	CIGNA Dental P.O. Box 189060 Plantation, FL 33318 1.800.CIGNA24
• Delta Dental	Delta Dental One Delta Drive Mechanicsburg, PA 17055 1-800-932-0783
For Vision Benefit 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 (for all Plans)	January 1 — December 31
Type of Administration	The Plans are administered by the Plans Administration Committee of Citigroup Inc. through agreements entered into with the Claim Administrators. However, final decision on the payment of claims rest with the Claim Administrators.

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, 2008

Citigroup Dental Benefit Plan

Introduction

This plan document sets forth the terms and conditions of your benefits under the Citigroup Dental Benefit Plan (the "Plan"), as amended and restated as of January 1, 2008. Citigroup Inc. ("Citi") has entered into an arrangement with MetLife, Delta Dental and CIGNA Dental to administer the Plan. This document should be read in combination with the "**About Your Health Care Benefits**" document, amended and restated as of January 1, 2008, which is also a component of the Citigroup Dental Benefit Plan document.

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

- MetLife Preferred Dentist Program (MetLife PDP);
- 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 (including the "About Your Health Care Benefits" component).

As explained in more detail in the About Your Health Care Benefits document, Citi reserves the right to amend or terminate the Plan at any time.

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 Citi and any individual.

MetLife Preferred Dentist Program

MetLife Preferred Dentist Program (MetLife PDP) 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 PDP.

The following is a summary of features covered under MetLife PDP. 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

** 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.*

*** Orthodontic benefits paid since January 1, 2004, under the MetLife and Delta Dental Citi sponsored Plan will count toward the lifetime orthodontia maximum across both Plans. SEE PAGE 47 of SPD.*

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 (through age 18), maximum of one application per calendar year;

- Space maintainers (through age 18);
- X-rays: one full mouth series per 36 months and up to 2 bitewing X-rays per year (up to 8 films per visit per calendar year);
- Sealants — permanent molars only (through 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) and composite “white” fillings;
- Extractions;
- Endodontic treatment;
- Oral surgery, unless covered under your medical plan or your HMO/EPO;
- Repair prosthetics, no limit;
- Repair or Recementing (crowns, inlays, onlays, bridgework or dentures), 1 relining or rebasing per 36 months;
- Periodontal maintenance treatments, up to 4 per calendar year, in combination with routine cleanings;
- Periodontal scaling and root planning, no limit (subject to medical necessity and consultant review);
- Addition of teeth to existing partial or full denture; and
- General anesthesia, when medically necessary, as determined by the Claim 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; replacement if at least 5 years old and unserviceable;
- 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 initial installation 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). Medical necessity, as determined by the Claim Administrator, is based upon the number and distribution of all missing, un-replaced teeth in the arch, as well as the overall periodontal condition of the remaining teeth.

Orthodontia services

The following is a list of covered orthodontia services:

- Orthodontic x-rays;
- Evaluation;
- Treatment plan and record;
- Services or supplies to prevent, diagnose, or correct a misalignment of teeth, bite, jaws or jaw joint relationship;
- Removable and/or fixed appliance(s) insertion for interreceptive treatment;
- Temporomandibular joint (TMJ) disorder appliances (for TMJ dysfunction that does not result from an accident); and
- Harmful habit appliances, includes fixed or removable appliances.

Oral cancer services

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

How the Plan works

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

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 (excluding orthodontia). A separate lifetime maximum of $3,000 per person applies to orthodontia treatments.

Covered charges

After you have met the deductible, MetLife PDP reimburses covered charges for out-of-network dentists at a percentage of reasonable and customary (R&C) charges. MetLife PDP 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.

Coverage for new orthodontic work

For example, if the orthodontic expense submitted is $5,000, the Plan will pay the 50% benefit, as follows:

Coverage for orthodontic appliance: MetLife will pay an initial appliance component (sometimes referred to as the "banding" fee), based on 20% of the submitted expense, at the 50% coinsurance level:

- $5,000 × 20% = $1,000 × 50% benefit = $500.
- First payment will be $500.

Coverage for monthly payments:

- $5,000 - $1,000 = $4,000.
- $4,000 ÷ 24 months = $167 × 50% benefit = $84.
- Monthly payment will be $84.

A monthly payment of $84 will be made over the course of treatment, paid each treatment quarter. The first payment will be based on 20% of the expense to cover the appliance fee. The remaining expense will be spread over the expected length of treatment, in this example, 24 months or 8 quarterly payments. Orthodontic benefits are subject to the calendar year deductible and the $3,000 lifetime orthodontic maximum. In this example, assuming the annual deductible has been met, the total amount paid will be $2,516.

Coverage for orthodontic work in progress

The MetLife PDP plan pays 50% co-insurance, after the annual deductible is met, up to a $3,000.00 lifetime orthodontia maximum.

Assume a 24-month orthodontia treatment began in January 2007, and Delta Dental has paid $1,250.00 for the orthodontia treatment during 2007, and the participant transfers to the MetLife PDP plan effective 01/01/2008. 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 (not counting the month when the appliance fee was paid).

As of January 2008, MetLife would deduct $1,000.00 for the appliance from the $5,000.00 submitted fee and the $167.00 monthly covered expense charges for the initial 11 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 2008 for the remaining 13 months of treatment or until the $3,000.00 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 $1,250.00 was previously paid by Delta Dental for service charges in 2007 in the example above, MetLife would pay for $84.00 per month for approximately 13 months of treatment or $1,092.00 to the $3,000.00 lifetime orthodontia maximum.

Treatment may continue with the 2007 provider (during the 2008 plan year) 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 Claim Administrator at the address on the form.

The Claim 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 that meets generally accepted standards of dental care. MetLife PDP 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 PDP 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. For example, cosmetic services such as tooth whitening are elective in nature and, therefore, not covered by the dental plan. Medical necessity is the treatment of dental diseases such as dental decay and periodontal (gum) diseases. Dental services must be performed by a dentist licensed to practice in the state or by a legally qualified physician. A dentist is a doctor of dental surgery or a doctor of medical dentistry.

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

- Any charges due to injuries sustained while committing a felony, assault, or during a riot or insurrection;
- Any charges for services and supplies furnished for you or your eligible dependent(s) prior to the effective date of coverage or subsequent to the termination date of coverage;
- 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 Citi: Delta Dental Premier and Delta Dental PPO.

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 Delta Dental Premier or Delta Dental PPO 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 Dental's participating providers agree to submit claims to Delta Dental and to accept Delta Dental's maximum plan allowances, or the dentist's actual charge, whichever is less (allowed amount) as payment in full. Participating dentists are paid directly by Delta Dental and, by agreement, can't bill you more than the applicable deductible or copayment for the service. By using a participating dentist, you limit your out-of-pocket costs. For services performed by non-participating dentists, Delta Dental sends the benefit payment directly to you. You're 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 Dental's allowance and services that aren't covered by the group dental service contract.*

*** Orthodontic benefits paid since January 1, 2004, under the MetLife and Delta Dental Citi sponsored Plan will count toward the lifetime orthodontia maximum across both Plans. SEE PAGE 47 of SPD.*

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 (any combination of routine or periodontal);
- Fluoride treatments (through age 17), maximum of one application per calendar year;
- Space maintainers (through age 17);
- X-rays: one full mouth series per 36 months and up to 2 bitewing X-rays per year (up to 8 films per visit per calendar year);
- Sealants — permanent molars only (through age 15), 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), Amalgam (“silver”) and Composites (“white” fillings); All other fillings will be benefited at the Amalgam amount;
- Extractions;
- Endodontic treatment;
- Oral surgery, unless covered under your medical plan or your HMO;
- Repair or recementing of crowns, inlays, onlays, bridgework or dentures – 1 denture relining or rebasing per 36 months;
- Periodontal treatment, maximum of three cleanings per calendar year (any combination of routine or periodontal);
- Injectable antibiotics; 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;
- 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 (must be at least five years old and not serviceable);
- 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 (must be at least five years old and not serviceable); and
- Dental implants - surgical placement of, prefabrication, superstructure and replacement (limited to once in a lifetime for the actual implant);
- Temporomandibular joint (TMJ) disorder related services — non-surgical 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, diagnose, or correct a misalignment of teeth or bite; and
- Harmful habit 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 Citi: Delta Dental Premier and Delta Dental PPO. Dentists in both networks agree to accept lower fees for services. The Delta Dental Premier network is larger, with more than 152,000 dental offices nationwide. You will receive a deeper discount in the smaller Delta Dental PPO network, with more than 78,000 offices.

Your total out-of-pocket payment is less if you use a Delta Dental PPO network dentist. You will pay more if you use a Delta Dental Premier 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 Dental 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. A separate lifetime maximum of $3,000 per person applies to orthodontia treatments.

Covered charges

After you have met the deductible, Delta Dental reimburses covered charges for out-of-network dentists at the Delta Dental Premier 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.

Coverage for new orthodontic work

After the deductible, 50% of the orthodontic benefit will be paid at the time of banding, with the remaining 50% of the orthodontic benefit 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.

For example, if the orthodontic expense submitted is $5,000, the Plan will pay the orthodontic benefit as follows:

- $5,000 (submitted amount is within the MPA) x 50% copayment= $2,500
- First half benefit paid at time of banding: $2,500 / 2 = $1,250.
- Second half benefit paid 12 months after date of banding: $2,500/2 = $1,250

Coverage for orthodontic work in progress

Delta Dental's liability will be calculated at 50% of Delta Dental's Allowance up to $3,000 per patient per lifetime. Benefits are based on the number of months remaining in treatment where applicable. Previous payments paid by MetLife or Delta Dental after January 1, 2004 will then be factored in to ensure that not more than the submitted fee is paid between the carriers. When present, coordination of benefits (COB) will be handled as Non-Duplication (See page 10 of Summary Plan Description for how COB works). Examples are as follows (Non-Duplication COB not being a factor), and annual deductible previously met:

- Step 1 - $5,000 (submitted amount is within the MPA) x 50% copayment = $2,500 with a 24 month treatment plan
- Step 2 - $2,500 minus the amount previously paid by MetLife or Delta Dental under the Citi Plan = Delta Dental's payment, made in one lump sum. ($2,500 - $1,424 {previous carrier payment} = $1,076)

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 Dental 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.

In order to determine the amount that Delta Dental will pay, we recommend pre-determination of your dental benefits. Ask your dentist to submit a pre-determination form to Delta.

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 Claim 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 Delta Dental and are **not** covered by the Plan:

- Prescription drugs, premedications, relative analgesia;
- Treatment, procedures, appliances or restorations primarily 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:
  - 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;
- Plaque control programs, including oral hygiene and dietary instruction, training or supplies used to educate people on the care of teeth;
- 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 for injuries sustained while committing a felony, assault, or during a riot or insurrection;
- Any charges for services and supplies furnished for you or your eligible dependent(s) prior to the effective date of coverage or subsequent to the termination date of coverage;
- 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.CIGNA24. You can also find a provider at the CIGNA Web site, **http://cigna.benefitnation.net/cigna/(ksmtg545tvtqiyezhahstk45)/docdir.aspx**.

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.CIGNA24 or at **www.cigna.com/dental** (if you are already a member).

Type of service	Coverage
Annual deductible	None
Annual maximum	None
Preventive and diagnostic services	Covered at 100%
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.** Except for Pediatric Dentistry and Endodontics, payment authorization is required for coverage of services performed by a Network Specialty Dentist.

- **Pediatric dentistry.** Coverage for treatment by a pediatric dentist ends on an enrolled child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your network general dentist shall provide care after the child's 7th birthday;
- **Oral surgery.** The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery; 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.CIGNA24 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 required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war;
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule;
- General anesthesia, sedation and nitrous oxide unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with covered services performed by an oral surgeon or periodontist. (For **Maryland** residents, general anesthesia is covered when medically necessary and authorized by your physician);
- Prescription drugs;
- Procedures, appliances or restorations if the main purpose is to change vertical dimension (degree of separation of the jaw when teeth are in contact); to diagnose or treat abnormal conditions of the temporomandibular joint ("TMJ") unless TMJ therapy is specifically listed on your Patient Charge Schedule; or to restore teeth damaged by attrition, erosion or abrasion and/or abfraction. (For **California** residents, the word "attrition" is modified as follows: except for medically necessary treatment where functionality of teeth has been impaired);
- The completion of crown and bridge, dentures or root canal treatment already in progress on the date you become covered by the Plan (For **Texas** residents, 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. 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.CIGNA24. 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 and will check your eligibility.

Broken appointments

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

If you or your enrolled dependent(s) breaks an appointment with 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 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.CIGNA24 or at www.mycigna.com (if you are already a member).

Emergencies

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

Examples of a dental emergency include:

- The loss of a large filling in a tooth or crown or a cracked tooth that resulted in significant acute pain and discomfort; or
- Swelling of the mouth that is a result of an infection, normally associated with an abscess.

Examples of non-dental emergencies include:

- A slight injury that did not result in significant bleeding, severe pain or acute infection;
- A sore spot under dentures that has created a small ulcer;
- A wisdom tooth that is erupting or painful but there is no swelling; or
- A chipped tooth that produced a sensitive spot that irritates the tongue.

Routine restorative or definitive treatment (Root Canal Therapy) is not considered emergency care and should be performed or referred by the Network General Dentist (NGD) or Network Pediatric Dentist (NPD).

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.

CIGNA Dental
P.O. Box 188045
Chattanooga, TN 37422-8045

After hours

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

Member Services

If you have any questions or concerns about the CIGNA Dental Care DHMO, call the Member Services Representatives. 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.CIGNA24. 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 through active benefits or your COBRA period has expired, 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 Citi. Call the CIGNA Dental Health Conversion Department at 1.800.CIGNA24 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 North Carolina, Inc., CIGNA Dental Health of Ohio, Inc., CIGNA Dental Health of Pennsylvania, Inc., CIGNA Dental Health of Texas, Inc., CIGNA Dental Health of Virginia, Inc. In other states, the CIGNA Dental Care plan is underwritten by Connecticut General Life Insurance Company or CIGNA HealthCare of Connecticut, Inc. and administered by CIGNA Dental Health, Inc.