Citi for you. HEALTH

Health and Welfare Summary Plan Description

For coverage effective January 1, 2008

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Important information about the contents of this document

This document describes health and welfare benefits for certain U.S. employees of Citigroup Inc. ("Citigroup") and its participating companies (collectively the "Company") as in effect January 1, 2008. The benefits described in this document are:

- Citigroup Medical Plan
  - Aetna ChoicePlan 100 and 500;
  - Aetna High Deductible Health Plan–Basic;
  - Aetna High Deductible Health Plan–Premier;
  - CIGNA ChoicePlan 100 and 500;
  - Empire BlueCross BlueShield ChoicePlan 100 and 500;
  - UnitedHealthcare ChoicePlan 100 and 500;
  - UnitedHealthcare Hawaii Health Plan;
  - Empire BlueCross BlueShield Out-of-Area Health Plan;
  - Health maintenance organization ("HMO") and exclusive provider organization ("EPO") Plans; and
  - Citigroup Prescription Drug Program administered by Express Scripts.
- Citigroup Dental Plan
  - CIGNA Dental Care;
  - Delta Dental; and
  - MetLife Preferred Dentist Program (PDP).
- Citigroup Vision Care Plan
- Citigroup Employee Assistance Program
- Citigroup Disability Plan
- Spending Accounts
  - Health Care Spending Account (HCSA);
  - Limited Purpose Health Care Spending Account (LPSA) also known as the Limited Purpose Spending Account;
  - Dependent Care Spending Account (DCSA); and
  - Transportation Reimbursement Incentive Program (TRIP).
- Life Insurance
  - Citigroup Basic Life and Accidental Death and Dismemberment (AD&D) Insurance;
  - Optional Group Universal Life (GUL) and Supplemental AD&D Insurance; and
  - Citigroup Business Travel Accident Insurance.
- Citigroup Long-Term Care Insurance Plan.

If you and/or your dependents are enrolled in Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. See page 77 for details.

This summary has been written, to the extent possible, in non-technical language to help you understand the basic terms and conditions of the health and welfare benefit plans described above (the "Citigroup Health and Welfare Plans" or collectively the "Plans" and individually a "Plan"). This document is intended to be only a summary of the major highlights of the Plans. Details can be found in the Plan documents, which are available on the Benefits Book Online Web site at **www.benefitsbookonline.com**.

If you do not have access to this Web site, you can request a copy of the Plan documents at no cost to you by speaking with a Benefits Service Center representative. Call ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and then follow the prompts for the Benefits Service Center.

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

No general explanation can adequately give you all the details of the Plans. This general explanation does not change, expand, or otherwise interpret the terms of the Plans. If there is any conflict between this SPD, or any written or oral communication by an individual representing the Plans, and the Plan documents (including any related insurance contracts), the terms of the Plan documents — including any related insurance contracts as interpreted in the sole discretion of the Plan Administrator — will be followed in determining your rights and benefits under the Plans.

Citigroup may change or discontinue the Plans or any part thereof at any time for any reason without notice.

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

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

An introduction to your summary plan description

Citigroup offers a variety of health and welfare benefits to meet your needs. The following information describes the health and welfare benefits available effective January 1, 2008. For a copy of the Plan documents, visit **www.benefitsbookonline.com**. If you do not have access to this Web site, you can request a copy of the Plan documents at no cost to you by speaking with a Benefits Service Center representative. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts for the Benefits Service Center. If you are hearing impaired using a TDD (telecommunications device for the deaf), call the Telecommunications Relay Services at 711 and then call ConnectOne as instructed above.

The 2008 provisions, described here, are expected to be available in the online Plan documents in early 2008.

You are responsible for keeping this book until such time as a subsequent version is made available to you.

This book is divided into three sections:

Section 1-General information includes:

- Benefits overview;
- When you must enroll;
- Eligibility and the definition of eligible dependents;
- Domestic partner benefits;
- Coordination of benefits;
- Coverage categories;
- Qualified changes in status;
- How to file a claim; and
- Glossary.

Section 2-Plan provisions include details of the following Plans:

- Medical Plan: ChoicePlan 100 and 500, High Deductible Health Plan (Basic and Premier), Hawaii Health Plan, and the Out-of-Area Health Plan;
- Citigroup Prescription Drug Program;
- HMOs/EPOs;
- Dental;
- Vision care;
- Employee Assistance Program;
- Disability;
- Life/AD&D insurance;
- Business Travel Accident insurance;
- Long-Term Care insurance; and
- Spending accounts.

Section 3-Legal and administrative information includes:

- When coverage ends;
- Notice of HIPAA Privacy Practices;
- Important notices about Medicare and your prescription drug coverage;
- COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended;
- Recovery provisions;
- Claims and appeals; and
- ERISA information.

Contents

Section 3-Legal and administrative information

Contact directory

Telephone

- To call ConnectOne: 1-800-881-3938
- From outside the United States: 1-469-220-9600
- If you are hearing-impaired using a TDD: Call the Telecommunications Relay Services at 711. Then call ConnectOne at 1-800-881-3938.

Web

If you have intranet or Internet access, you can review many of your benefits and obtain benefits information and enroll through the Total Comp at Citi Web site at **www.totalcomponline.com**. From the "quick links" page, you can link to some of the Citigroup benefits providers without an additional login.

For information about these topics or Plans or to visit the Web site for these Plans	Contact	At
• **Basic Life/Accidental Death and Dismemberment (AD&D) insurance** • **Business Travel Accident insurance**	Benefits Service Center	Call ConnectOne. From the ConnectOne main menu, choose the "health and welfare benefits" option (option 4).
Beneficiary designations	Citigroup Retirement Services	Call ConnectOne. From the ConnectOne main menu, choose the "pension" option (option 2). Visit the Total Comp at Citi Web site at **www.totalcomponline.com**. From the "quick links" page, click on the link for Your Benefits Resources. Go directly to **http://resources.hewitt.com/citigroup**.
Benefits Service Center	CitiStreet	Call ConnectOne. From the ConnectOne main menu, choose the "health and welfare benefits" option (option 4).
COBRA coverage (Consolidated Omnibus Budget Reconciliation Act)	ADP	1-800-422-7608 **www.benedirect.adp.com**
Dental	CIGNA Dental Care Delta Dental MetLife Preferred Dentist Program (PDP)	1-800-244-6224 **www.mycigna.com** (participants only) 1-877-248-4764 **www.deltadentalpa.org/citigroup** 1-888-832-2576 **www.metlife.com/dental**
Citigroup Benefits Web Site To enroll, obtain plan information, and update dependent information	Not applicable	Visit the Total Comp at Citi Web site at **www.totalcomponline.com**. From the "quick links" page, click on the link for the Citigroup Benefits Web Site. Go directly to **https://mybenefits.csplans.com**.
Dependent Care Spending Account	ADP	1-800-378-1823 Visit the Total Comp at Citigroup Web site at **www.totalcomponline.com**. From the "quick links" page, click on the link for the Citigroup Spending Accounts Service Center. Go directly to **www.flexdirect.adp.com/citigroup**.

For information about these topics or Plans or to visit the Web site for these Plans	Contact	At
Disability To report a disability and for information about the Short-Term Disability (STD) and Long-Term Disability (LTD) Plans and the Family and Medical Leave Act (FMLA) You also can report a disability by calling MetLife directly.	MetLife	Call ConnectOne. From the ConnectOne main menu choose the "managed disability" option (option 3). 1-888-830-7380
Eligibility, enrollment, general information about the health and welfare benefits plans, status changes, and continuing coverage after a termination of employment	Benefits Service Center	Call ConnectOne. From the ConnectOne main menu, choose the "health and welfare benefits" option (option 4). Visit the Total Comp at Citi Web site at **www.totalcomponline.com**. From the "quick links" page, click on the link for the Citigroup Benefits Web Site.
Employee Assistance Program (EAP)	Harris Rothenberg	1-800-952-1245 1-800-256-1604 (TDD) Outside the United States, 212-422-8847 (call collect) **https://www.harrisrothenberg.com/login.html** User ID: umbrella Password: group
Health Care Spending Account	ADP	1-800-378-1823 Visit the Total Comp at Citigroup Web site at **www.totalcomponline.com**. From the "quick links" page, click on the link for the Citigroup Spending Accounts Service Center. Go directly to **www.flexdirect.adp.com/citigroup**.
Health Savings Account	Citi GTS	1-877-472-6771 **www.hsa.citibank.com**
HMOs (health maintenance organizations) For general information about HMOs/EPOs For details, call the telephone number on your HMO/EPO information sheet. Once enrolled in an HMO/EPO, call the number on your ID card.	Citigroup HMO Information Line	1-800-422-6106
Limited Purpose Health Care Spending Account	ADP	1-800-378-1823 Visit the Total Comp at Citigroup Web site at **www.totalcomponline.com**. From the "quick links" page, click on the link for the Citigroup Spending Accounts Service Center. Go directly to **www.flexdirect.adp.com/citigroup**.
Long-Term Care insurance	John Hancock Life Insurance Co.	1-800-222-6814 **http://groupltc.jhancock.com** Username: groupltc Password: mybenefit

For information about these topics or Plans or to visit the Web site for these Plans	Contact	At
Medical (non-HMO/EPO plans)	Aetna (ChoicePlan, High Deductible Health Plans)	1-800-545-5862 1-800-628-3323 (TDD) **www.aetna.com**
	CIGNA (ChoicePlan)	1-800-794-4953 **www.cigna.com** **www.mycigna.com** (participants only)
	Empire BlueCross BlueShield (ChoicePlan, Out-of-Area Health Plan)	1-866-290-9098 **www.empireblue.com/citi**
	UnitedHealthcare (ChoicePlan, Hawaii Health Plan)	1-877-311-7845 1-800-842-0090 (TDD) **www.provider.uhc.com/citi** (public site for Citigroup employees) **www.myuhc.com/groups/citi** (participants only)
Optional Group Universal Life (GUL)/Supplemental AD&D insurance	MetLife (Optional GUL)	1-800-523-2894
	CIGNA (AD&D)	1-800-238-2125
Plan documents For the health and welfare plans, Citigroup Pension Plan, and Citigroup 401(k) Plan	Not applicable	**www.benefitsbookonline.com** If you do not have access to this Web site, you can request a copy of the Plan documents at no cost to you by speaking with a Benefits Service Center representative. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option (option 4) and then follow the prompts for the Benefits Service Center. If you are hearing impaired using a TDD, call 711 and then call ConnectOne as instructed above.
Prescription Drug Program (non-HMO plans) To refill an Express Scripts Home Delivery prescription using the automated system; for instructions on how your doctor can fax your prescription to the Express Scripts Pharmacy; to arrange credit card payment for all your home delivery pharmacy service orders	Express Scripts	1-800-227-8338 1-800-899-2114 (TDD) **https://member.express-scripts.com/preview/citigroup2008** (public site for Citigroup employees) **www.express-scripts.com** (participants only)
Prior authorization		1-800-224-5498
Transportation Reimbursement Incentive Program (TRIP)	ADP	1-800-378-1823 Visit the Total Comp at Citigroup Web site at **www.totalcomponline.com**. From the "quick links" page, click on the link for the Citigroup Spending Accounts Service Center. Go directly to **www.flexdirect.adp.com/citigroup**.
Total Compensation Web site Link to benefits information and to enroll in health and welfare benefits.	Not applicable	**www.totalcomponline.com**
Vision Care For Plan information and laser vision correction providers/ arrangements	Davis Vision	1-877-923-2847 Enter code 2227 **www.davisvision.com**
Workers' Compensation	Constitution State Services Co.	1-800-243-2490

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Section 1
General Information

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Benefits overview

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

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

- **Basic Life and Accidental Death and Dismemberment (AD&D) insurance,** each equal to your total compensation, up to $200,000, on your date of eligibility; Basic Life insurance is administered by MetLife, while AD&D is administered by CIGNA;
- **Business Travel Accident insurance,** administered by AIG, of up to five times your total compensation to a maximum benefit of $2 million;
- **Employee Assistance Program (EAP),** administered by Harris Rothenberg International LLC, a confidential, professional counseling service designed to help you and your family resolve issues that affect your personal lives or interfere with job performance;
- **Short-Term Disability (STD) coverage,** administered by MetLife, to replace up to 100% of your annual base salary for an approved disability leave of up to 13 weeks; the number of weeks at 100% pay will depend on your length of service with Citigroup; see page 53 for the STD schedule of benefits that applies to you; and
- **Long-Term Disability (LTD) coverage,** administered by MetLife, equal to 60% of your total compensation if your total compensation is less than or equal to $50,000.99.

Additional benefits to consider that require active enrollment:

- Benefits paid with pretax dollars:
  - Medical;
  - Dental;
  - Vision care;
  - Health Care Spending Account (HCSA);
  - Limited Purpose Health Care Spending Account (LPSA);
  - Dependent Care Spending Account (DCSA); and
  - Transportation Reimbursement Incentive Program (TRIP). See the box below for information about TRIP enrollment and the effective date of coverage.
- Benefits paid with after-tax dollars:
  - LTD, if your total compensation is $50,001 and above; if your Total Compensation is below this amount, LTD is a core benefit provided at no cost to you;
  - Optional Group Universal Life (GUL) and Supplemental AD&D insurance; and
  - Long-Term Care insurance.

Enrolling in TRIP

The Transportation Reimbursement Incentive Program (TRIP) allows you to set aside pretax dollars from your pay to reimburse yourself for eligible transportation expenses incurred traveling to and from work. You can enroll in TRIP at any time, and your TRIP election will be effective the first of the month after you enroll, if administratively possible; otherwise, your coverage and payroll deductions will begin the first of the following month. *TRIP elections are not part of annual enrollment.*

When you must enroll

Enrolling in Citigroup health and welfare benefits is not mandatory. If you do not enroll, you will have the core coverage described at left. If your total compensation increases above $50,000.99 in any year, the following year you must enroll if you want LTD coverage. (Evidence of good health will *not* be required.) Company-paid LTD coverage is available only to employees whose total compensation is less than or equal to $50,000.99.

If you want Citigroup medical, dental, and/or vision coverage, you *must* enroll during your initial enrollment period. Once enrolled in medical, dental, and/or vision coverage, if you do not enroll during a subsequent annual enrollment period you will be assigned the same coverage, or, if that coverage is no longer available, to comparable medical, dental, and/or vision coverage.

If you do *not* enroll for medical, dental, and/or vision coverage during your initial enrollment period and later decide you want coverage, you can enroll during a subsequent annual enrollment period or as the result of a qualified change in status. See page 12.

To have coverage in the Health Care Spending Account/ Limited Purpose Health Care Spending Account and/or the Dependent Care Spending Account, you must enroll each year.

After you enroll or 'default'

Confirmation of enrollment

If you enroll by telephone: A confirmation statement will be mailed to your home between one and three weeks after you enroll. Your confirmation statement will list your benefits elections and their costs. Review this confirmation statement carefully for accuracy, and retain it as proof of your enrollment. If you find an error, call the Benefits Service Center immediately. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, select the "health and welfare benefits" option and follow the prompts to speak with a Benefits Service Center representative.

If you enroll online: A confirmation statement will appear after you enroll and before you log out. Print and retain a copy as proof of your enrollment. If you enroll online during annual enrollment, a confirmation statement will be mailed to your home after the enrollment period. If you find an error, call the Benefits Service Center immediately. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, select the "health and welfare benefits" option and follow the prompts to speak with a Benefits Service Center representative.

Confirmation of default

If you do not enroll, you will have the "default" coverage shown on your Personal Enrollment Worksheet and on the Citigroup Benefits Web Site available through Total Comp at Citi at **www.totalcomponline.com** or by going directly to **https://mybenefits.csplans.com**.

You will receive a default statement by mail within several weeks after your enrollment deadline. The default statement will list your default coverage.

Health Plan ID cards

If you enroll in the following Plan for the first time:	An ID card will be mailed to you within several weeks from:
An HMO/EPO	The HMO/EPO
ChoicePlan 100 or 500, High Deductible Health Plan (Basic and Premier), the Hawaii Health Plan, or the Out-of-Area Health Plan	Medical: Your Plan Prescription drug coverage: Express Scripts
CIGNA Dental Care, Delta Dental	Your Plan
Davis Vision	Davis Vision

For Delta Dental and Davis Vision: If you enroll in these plans you will receive a card for reference only. You do not need to present your card to obtain services.

For MetLife Dental: A reference card can be printed from the Citigroup intranet, but it is not required to obtain services.

Eligibility for Citigroup coverage

Eligibility at a glance

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

- You work in the United States for the Global Consumer Group, Global Wealth Management, Citi Markets & Banking, Citigroup Corporate Center, and their participating businesses, including employees paid by Citigroup and working for CitiStreet LLC; and
- You are an active[1]:
  - Full-time employee (regularly scheduled to work 40 hours or more a week) **or**
  - Part-time employee (regularly scheduled to work at least 20 or more hours a week); and
- You receive regular semimonthly or monthly pay.

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

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

When you are not eligible to enroll

You are not eligible to enroll in the Plans if:

- Your compensation is not reported on a Form W-2 Wage and Tax Statement issued by a participating business;
- You are employed by a Citigroup subsidiary or affiliate that is not a participating business;
- You are engaged under an agreement that states you are not eligible to participate in the applicable Plan or program;
- You are a non-resident alien performing services outside the United States; or
- You are classified by Citigroup as an independent contractor or consultant.

If you are a U.S. citizen or legal resident employed outside the United States or if you are otherwise unsure whether you are eligible to participate in the Plans, call the Benefits Service Center as instructed on page 4 or contact your local Human Resources department for more information.

No pre-existing condition limitations

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

Definition of eligible dependents

Upon request, you must provide proof of your dependent's eligibility for coverage. Your eligible dependents must be U.S. citizens or legal residents and generally are:

- Your lawfully married spouse, or your common-law spouse if you live in a state that recognizes common-law marriages; if you are legally separated or divorced, your spouse is not an eligible dependent unless mandated by state law;
- Your domestic partner; see "Domestic partner benefits" beginning on page 13 for details;
- Your domestic partner's eligible dependents; see "Domestic partner benefits" beginning on page 13 for details;
- Your unmarried children who rely on you for a majority of their financial support and who you claim as dependents on your federal tax return and are:
  - Your biological children;
  - Your legally adopted children;
  - Your stepchildren who live with you full time in a regular parent-child relationship; or
  - Any other child permanently living with you for whom you are the legal guardian in accordance with the laws of the state in which you reside.

You can cover your unmarried children if they:

- Are under the age of 19[2] as of December 31 of the plan year that precedes the enrollment year; or
- Are under the age of 25[2] as of December 31 of the plan year that precedes the enrollment year and are full-time students at an accredited school or college; (during enrollment each year you will be prompted to certify that your eligible child is a student; upon request, you must provide proof of student status in writing); or
- Were covered under the Plans before age 19, or age 25 as full-time students, and became incapable of self-sustaining employment due to a disability, in which case the eligible dependent may be eligible for coverage beyond such age; or
- Are disabled adults when you began employment with Citigroup and you enrolled the child when you were first eligible to do so.

No dependent can be covered under these Plans as both an employee and as an eligible dependent or as an eligible dependent of more than one employee. If your dependent child accepts a job at Citigroup and is benefits-eligible, you must drop your child from your coverage and your child must enroll in his or her own employee coverage.

Coordination of benefits

Coordination of benefits prevents duplication of payments when a covered employee or a covered dependent has health coverage under a Citigroup Plan and one or more other plans, such as a spouse's or other employer's plan.

The Citigroup Medical Plan (which includes prescription drug coverage), the Citigroup Dental Plan, and the Citigroup Vision Care Plan contain a coordination of benefits provision that

[2] For information on when coverage ends, see "When coverage ends" on page 75.

may reduce or eliminate the benefits otherwise payable under the applicable Plan when benefits are payable under another plan. Certain provisions are summarized below, and additional terms and conditions may apply under the terms of the Plan documents.

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

How coordination of benefits works

- **When the Citigroup Plan is primary:** The Citigroup Plan considers benefits as if a secondary plan does not exist, and it will pay benefits first.
- **When the Citigroup Plan is secondary:** The Citigroup Plan will pay the difference, if any, between what you would have received from Citigroup if it were the only coverage and what you are eligible to receive from the other plan. *Total benefits will never equal more than what the Citigroup Plan would have paid alone*. When the Citigroup Plan is secondary and the patient is covered under an HMO/EPO, benefits under the Citigroup Plan will be limited to the copayment, if any, for which you would have been responsible under the HMO/EPO, whether or not the services provided are rendered by the HMO/EPO. If a service is not covered or coverage is denied, you will be responsible for payment.

The Citigroup Plan will be the primary plan for claims:

- For you, if you are not covered as an employee by another plan;
- For your spouse, if your spouse is not covered as an employee by another plan; and
- For your dependent children.

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

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

In case of divorce or separation

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

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

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

Total Compensation and your benefits

Total compensation is used to determine:

- Medical contributions;
- LTD benefits and, where applicable, LTD contributions;
- Basic Life/AD&D insurance benefits;
- Optional GUL/Supplemental AD&D insurance and costs;
- Eligibility for the DCSA subsidy;
- STD for Financial Advisors, Financial Advisor Associates, and Investment Associates in Global Wealth Management and Account Executives in Citi Markets & Banking; and
- Business Travel Accident insurance benefits.

Definition of total compensation

If you are enrolling in benefits as a new hire or newly eligible employee: Your total compensation at the time you are hired is equal to your annual salary. If you are to be paid commissions only, your total compensation is calculated differently, either based on a default amount or an amount established as appropriate for your position. Ask your HR representative for details.

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

If you are enrolling during the annual enrollment period for coverage effective January 1, 2008: Your Total Compensation for purposes of benefits enrollment is made up of the following:

1. Annual base pay as of July 1, 2007;
2. Commissions paid from January 1–December 31 in the year prior to enrollment to capture an entire year of commissions paid; commissions paid from January 1–December 31, 2006, will be used for the 2008 annual enrollment calculations;
3. Cash bonus (other than the cash portion of any annual discretionary award package) paid in the period January–December 31 in the year prior to enrollment; cash bonuses paid in the period January 1–December 31, 2006, excluding the cash portion of the annual discretionary award package dated January 2006, will be used for the 2008 annual enrollment calculations;
4. Annual discretionary award package dated in the year of enrollment (includes the following, if applicable: cash bonus, Capital Accumulation Program [CAP] Basic Award, and, for employees with discretionary award packages valued at $500,000 and above, Supplemental CAP award); annual discretionary award packages dated January 2007 will be used for 2008 annual enrollment calculations; and
5. Short-Term Disability benefits paid from January 1–December 31, 2006, for employees paid commissions only.

For new hires: Any guaranteed bonus will be considered in the calculation of your Total Compensation for benefits purposes.

Note: If you are a former AAMG employee who became eligible to participate in Citigroup benefits effective July 1, 2007, your Total Compensation, for purposes of determining benefits during the 2008 plan year will be the greater of:

- Your annual base salary as of July 1, 2007 or
- Your pay reported on your 2006 Form W-2 Wage and Tax Statement.

For Global Wealth Management Financial Advisors

In your first year of employment, your total 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. *Providing a copy of your previous year's Form W-2 is optional.*

If you provide a copy of your Form W-2, your Basic Life insurance amount will be set at the higher amount (up to $200,000) based on your W-2 earnings. **Note:** 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 your Form W-2 amount is irrevocable and applies only in your first year of employment.

Coverage categories

Citigroup offers four coverage categories from which you may choose to enroll for medical and dental coverage:

- Employee only: coverage for you only;
- Employee plus spouse/domestic partner: coverage for you and your spouse/domestic partner only;
- Employee plus children: coverage for you and your eligible children including the eligible children of your domestic partner; and
- Employee plus family: coverage for you, your spouse/domestic partner, your eligible children, and your domestic partner's eligible children.

You can change your coverage category during the annual enrollment period and within 31 days of a qualified change in status.

Qualified changes in status

You must report to Citigroup any change of status that affects your benefits within 31 days of the qualified event by following the process described under "How to report a qualified change in status event" at right. *Do not report qualified changes in status to your medical Plan*. Your medical Plan must receive status change information from Citigroup, not from you.

Depending on the event, you can:

- Enroll in or cancel your medical, dental, vision care, HCSA/LPSA, or DCSA coverage;
- Increase or decrease the amount of your HCSA/LPSA or DCSA coverage;
- Enroll in or increase Optional GUL insurance/Supplemental AD&D insurance and/or Long-Term Disability coverage without having to provide proof of good health. (For Optional GUL, you may increase your existing coverage if the first, second, third, or sixth bullets below apply. Initial election of spouse/domestic partner or child coverage under this program is available if the first, second, or third bullets below apply.)

Examples of qualified changes in status are:

1. Your marriage, legal separation, or divorce;
2. Meeting the eligibility to qualify as a domestic partner;
3. The birth or adoption of a child;
4. The loss of coverage eligibility for a dependent child who becomes ineligible due to age, gets married, obtains a full-time job, or recovers from a disability;
5. The loss of coverage under your spouse's/domestic partner's or other employer's plan;
6. The death of a spouse/domestic partner or dependent child;
7. The issuance of a Qualified Medical Child Support Order (QMCSO);
8. Relocation outside your medical and/or CIGNA Dental Plan's network area; and
9. The start of a military leave of absence.

How to report a qualified change in status event

You will have 31 days from the date of the event to report a qualified change in status event and, if applicable, make changes to your and/or your dependent's coverage. To add a newborn child to your coverage, you must do so within 31 days of the child's birth.

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

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

When reporting a new dependent whom you wish to enroll in Citigroup coverage, you may have to change your coverage category. For example: You are enrolled in medical coverage under the "employee only" category and then you get married. If you want to cover your new spouse, you must report information about your new spouse *and* change from the "employee only" to the "employee plus spouse" coverage category.

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

- Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option. From the Benefits Service Center main menu, choose the option to change your coverage for the current year. You can report most changes by following the prompts. However, you must speak with a representative to report a divorce or the death of a dependent.
- Visit Total Comp at Citi at **www.totalcomponline.com**. From the "quick links" page, click on the link for the Citigroup Benefits Web Site.

Change in Status Worksheet

You can review the Change in Status Worksheet (Form 308B), which lists status events and the corresponding changes you can make to your benefits coverage for each event. To obtain a Change in Status Worksheet, visit the "Forms" section of

the You @ Citigroup site on Citigroup.net at **www.citigroup.net/human_resources/form.htm**. Instructions for the Change in Status Worksheet are on Form 308A.

Deadline to report qualified changes in status

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

Plan changes you can make at any time

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

- LTD: You can enroll at any time but you must provide evidence of good health except when enrolling as a new hire, when your total compensation increases above $50,000.99 (so that you must pay if you want to continue LTD coverage), or as a result of certain qualified changes in status. However, unless you were enrolled in a prior employer's group plan three months prior to your hire date at Citigroup, the disability Plan will not cover any total disability caused by, contributed to, or resulting from a pre-existing condition until you have been enrolled in the Plan for 12 consecutive months. A pre-existing condition is an injury, sickness, or pregnancy for which — in the three months prior to the effective date of coverage — you received medical treatment, consultation, care, or services; took prescription medications or had medications prescribed; or had symptoms that would cause a reasonably prudent person to seek diagnosis, care, or treatment.
- Optional GUL/AD&D: For the GUL portion of the benefit, MetLife will require evidence of good health if you want to:
  - Enroll for the first time (other than during your initial enrollment period as a new hire or newly eligible for Citigroup benefits) or
  - Increase your coverage amount.

Note: CIGNA administers the AD&D portion of the benefit and does not require evidence of good health.

- Long-Term Care insurance: You can enroll at any time; John Hancock will require evidence of good health before coverage will be approved.
- TRIP: You can enroll or change your contribution at any time. Changes are effective the first of the following month or as soon as administratively possible.

Domestic partner benefits

Citigroup offers benefits coverage to your certified unmarried domestic partner of the same or opposite sex. You may cover your domestic partner and his or her eligible children under the following Plans:

- Medical, though some HMOs/EPOs do not cover domestic partners or their children; see below for HMOs/EPOs that will not cover domestic partners in 2008;
- Dental;
- Vision care;
- Health Care Spending Account, provided your domestic partner and his or her eligible children are considered tax dependents under Section 152 of the Code;
- Limited Purpose Health Care Spending Account, provided your domestic partner and his or her eligible children are considered tax dependents under Section 152 of the Code;
- Optional GUL/Supplemental AD&D insurance for domestic partners and life insurance for children;
- Long-Term Care insurance.

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

The following HMO/EPO will not cover domestic partners in 2008: Arise Health Plan, formerly Prevea Health Plan (WI).

All other HMOs/EPOs cover domestic partners. For more information about HMO/EPO coverage for domestic partners, call the HMO/EPO at the telephone number on the HMO/EPO information sheet in your enrollment kit.

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

When you can enroll your domestic partner in Citigroup coverage

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

- Upon completing a Domestic Partner Coverage Application (Form 324) and Affidavit of Domestic Partnership (Form 325), available on the "Forms" section of the Citigroup intranet at **http://www.citigroup.net/human_resources/form.htm#benefits** and through the Benefits Service Center; call the Benefits Service Center as instructed on page 4;
- The birth or adoption of a child; and
- Your domestic partner's loss of benefits coverage in another employer's plan.

Eligibility

You are eligible to enroll your domestic partner in Citigroup coverage if you are a U.S. employee who is active or on an approved leave of absence. If you are not actively at work, you cannot enroll your domestic partner in Optional GUL or Long-Term Care insurance.

To be eligible for coverage, you and your partner may be of the same or opposite sex and both of you must meet the following criteria:

- You currently share a principal residence and intend to do so permanently;
- You have lived together for at least six consecutive months prior to enrollment;
- You are financially interdependent, or your partner is dependent on you for financial support;
- Neither you nor your domestic partner is legally married to another person;
- Both of you are at least 18 years old and mentally competent to consent to contract;
- You are not related by blood to a degree of closeness that would prohibit marriage were you of the opposite sex;
- Neither you nor your domestic partner is in a domestic partnership with anyone else;
- You have mutually agreed to be responsible for each other's common welfare; and
- You are in a relationship intended to be both permanent and one in which each is the sole domestic partner of the other.

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

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

To cover a domestic partner, you must first complete an Affidavit of Domestic Partnership, (see left column for location of forms). If your domestic partnership ends, you must complete an Affidavit of Termination of Domestic Partnership (Form 327). You must wait six months from the time you file the Termination of Domestic Partnership Form to add a new domestic partner.

The children of your domestic partner are eligible for coverage if they:

- Are the biological or adopted children of your domestic partner, children for whom your domestic partner has legal guardianship in accordance with the laws of the state in which you reside, or children who have been placed in your home for adoption; and
- Are living with you and your domestic partner on a full-time basis or living away at school; and

- Are under the age of 19[3] as of December 31 of the plan year that precedes the enrollment year; or
- Are under the age of 25[3] as of December 31 of the plan year that precedes the enrollment year and are full-time students at an accredited school or college; (during enrollment each year, you will be prompted to certify that your domestic partner's eligible child is a student; you also must provide proof of student status in writing upon request);
- Were covered under the Plans before age 19, or age 25 as full-time students, and became incapable of self-sustaining employment due to a disability, in which case the eligible dependent may be eligible for coverage beyond such age; or
- Are disabled adults when you began your employment with Citigroup and you enrolled the child when you were first eligible to do so.

Cost of domestic partner benefits

If your domestic partner and his or her children:

- **Qualify** as your dependents under Section 152 of the Code, your contributions for domestic partner medical, dental, and/or vision care coverage will be deducted from your pay before taxes are withheld.
- **Do not qualify** as dependents under Section 152 of the Code, you will pay for their medical, dental, and/or vision care coverage with after-tax dollars.

Tax implications

According to federal tax law, your taxes may be affected when you enroll your domestic partner in Citigroup coverage. This book does not address state and local tax treatment. For information on how applicable tax law may apply to your personal situation, consult your tax adviser.

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

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

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

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

Example:

Total Citigroup cost for employee only coverage is $350 per month. Total Citigroup cost for employee + spouse/domestic partner coverage is $700;

The $350 cost for partner coverage will be treated as taxable income to you. This amount is known as imputed income.

If you terminate domestic partner coverage

If you complete a Termination of Domestic Partnership Form, the taxes paid on the imputed income are not refunded.

If you and your domestic partner marry

Imputed income paid on domestic partner benefits will continue until you report your qualified change in status to the Benefits Service Center and request that the imputed income be stopped.

If your domestic partner qualifies as a tax dependent

If your domestic partner and his or her children qualify as dependents under Section 152 of the Code, your contributions for their medical, dental, and/or vision care coverage will be deducted from your pay before taxes are withheld, and there are no tax implications for you. Since the requirements are complex, consult your tax adviser for information on how domestic partnership benefits will affect your taxes.

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

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

[3]Coverage will remain in effect through December 31 of the year in which the child becomes ineligible or turns 25.

Beneficiary forms

Your beneficiary information should be on file with Citigroup. If you have never designated a beneficiary, visit the Your Benefits Resources™ Web site through Total Comp at Citi at **www.totalcomponline.com**. This site is available from the Citigroup intranet and the Internet. From the "quick links" page, click on the link for Your Benefits Resources™. You also can go directly to Your Benefits Resources™ at **http://resources.hewitt.com/citigroup/**.

You also can call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "pension" option. From the "pension" option, follow the prompts for "pension beneficiary information" to name a beneficiary for the Basic Life (including AD&D) insurance, Citigroup 401(k) Plan, and/or Citigroup Pension Plan.

If you enroll in Optional GUL insurance, you must complete a MetLife Beneficiary Designation (Form 201) available on the Citigroup intranet at **www.citigroup.net/human_resources/form.htm** and return it to MetLife at the address on the form. Your beneficiary for Optional GUL insurance also is your beneficiary for Supplemental AD&D coverage.

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

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

Wellness benefits: the Citi Live Well Program

The Citi Live Well Program is designed to help you improve your health. Live Well gives you and your family the tools and resources to both manage your health care and achieve your health goals. Here are the components of the Live Well Program.

Live Well tools and resources	Description	Who participates	How to access
Health Advocate	A free, personal support service to help you manage your health care needs, from working through difficult health claims to choosing a doctor to making choices regarding a serious illness.	Active employees (full-time and part-time), their spouses/domestic partners, dependents, parents, and parents-in-law. You don't need to be enrolled in a medical plan offered by Citi to use Health Advocate.	1-866-449-9933 From 8 a.m. to 9 p.m. ET on weekdays; after hours and on weekends, please leave a message and a representative will return your call the next business day.
Health Risk Assessment on the Citi Live Well Portal	A secure, online health questionnaire that's a part of your Personal Health Record. By completing it, you can learn more about your health.	Active, benefits-eligible employees can participate and do not need to be enrolled in a medical plan offered by Citi. However, spouses/domestic partners must be enrolled in a medical plan offered by Citi to participate.	Citi Live Well Portal via Total Comp at Citi at **www.totalcomponline.com**; your spouse/domestic partner can go to **www.activehealthportal.net/citi**.
Personal Health Record on the Citi Live Well Portal	A secure, online health record to keep track of important health information in one place.	Active, benefits-eligible employees, their spouses/domestic partners, and dependents (including those under the age of 18). You do not need to be enrolled in a medical plan offered by Citi to access the Personal Health Record.	Citi Live Well Portal via Total Comp at Citi at **www.totalcomponline.com**; your spouse/domestic partner and dependents 18 and over can go to **www.activehealthportal.net/citi**.
Live Well Health Management Program	Programs to help you improve and manage your health.	Active employees, their spouses/domestic partners, and dependents who are enrolled in one of the following medical plans offered by Citi and are invited to participate: Aetna, Empire BlueCross BlueShield, CIGNA, UnitedHealthcare (including John Deere, Oxford, and Optimum Choice), Group Health Plan of St. Louis, Harvard Pilgrim, or Tufts Health Plan.	1-866-449-9933
24-Hour Nurseline	Access to nurses who can respond around the clock to immediate health issues.	Active, benefits-eligible employees, their spouses/domestic partners, and dependents. You do not need to be enrolled in a medical plan offered by Citi to call the 24-Hour Nurseline.	1-866-494-7879; available 24/7

Health Advocate

Health Advocate is a free program available to you *and* your family, including your parents and parents in-law, regardless of your health coverage. You and your family do not need to be enrolled or eligible to participate in a medical Plan offered by Citigroup to use Health Advocate.

Health Advocate helps you take control of your health care issues. You and your family can call Health Advocate to speak with a staff of medical professionals and health-related specialists to help you:

- Resolve insurance claims and billing issues;
- Identify and make appointments with a hard-to-reach specialist;
- Obtain additional information about a medical condition;
- Address medical issues and health care needs of your family members; and
- Understand issues related to prescription drugs, such as comparisons between generic and brand-name medications.

Health Risk Assessment

The Health Risk Assessment is a brief, online questionnaire that provides a snapshot of your current health status and may recommend ways to make healthy changes. It can help you build your Personal Health Record.

The Health Risk Assessment is available to active, benefits-eligible employees. You do not need to be enrolled in a medical plan offered by Citigroup to participate. Spouses/domestic partners also may complete the Health Risk Assessment but only if they are enrolled in a medical plan offered by Citigroup.

The Health Risk Assessment is a simple, secure, online questionnaire that takes about 15 minutes to complete. It immediately generates a personalized report summarizing your health. You can use the report to discuss concerns with your doctor, as a checklist of questions to ask, or to update your doctor on your health status, for example, if any signs or symptoms are worsening. It is linked automatically to your Personal Health Record, described below.

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

Personal Health Record

The Personal Health Record gives you a place to store all of your medical information. Depending on the medical plan in which you are enrolled, it can provide:

- A health summary of your conditions, allergies, prescribed medications, and recent testing, based on the claims submitted by your providers to your medical plan;
- Ways to help you track your hospital visits and insurance claims information;
- Personalized alerts that notify you of health risks, such as for high blood pressure, or health reminders to get an annual screening; and
- Online health information resources, including a medical dictionary, to put information at your fingertips whenever you need it.

The Personal Health Record is a key to taking charge of your health. Even if you are not enrolled in one of the following plans — Aetna, Empire BlueCross BlueShield, CIGNA, UnitedHealthcare (including John Deere, Oxford, and Optimum Choice), Group Health Plan of St. Louis, Harvard Pilgrim, or Tufts Health Plan — the Personal Health Record can still help you track and manage your health. You can keep your Personal Health Record up to date by entering recent doctor's visits, immunizations, medications, and other information.

If you, your spouse/domestic partner, and dependents are enrolled in plans administered by Aetna, Empire BlueCross BlueShield, CIGNA, UnitedHealthcare (including John Deere, Oxford, and Optimum Choice), Group Health Plan of St. Louis, Harvard Pilgrim, or Tufts Health Plan, your Personal Health Record and that of your family will be populated automatically with the pertinent data from your health care provider. To opt out of the Personal Health Record, you must call 1-800-490-3054 to terminate your access to the database.

Live Well Health Management Program

If you are enrolled in one of these medical plans — Aetna, Empire BlueCross BlueShield, CIGNA, UnitedHealthcare (including John Deere, Oxford, and Optimum Choice), Group Health Plan of St. Louis, Harvard Pilgrim, or Tufts Health Plan — and your Health Risk Assessment results or Personal Health Record indicates that you have one of a number of conditions, or that you could benefit from making a lifestyle change (such as losing weight or quitting smoking), you may be invited to participate in the Live Well Health Management Program.

This program includes personal support for managing conditions ranging from asthma to osteoporosis. If you are identified for participation, a Nurse Care Manager may contact you to provide support.

If you receive an invitation and decide to participate in the program, you will work one-on-one with your own Nurse Care Manager to set and achieve your health goals. You also will receive educational materials and suggested issues to discuss with your doctor.

The Live Well Health Management Program does not take the place of your doctor. Rather, it is designed to enhance your care and enable you and your doctor to make more informed decisions about your health.

If you are invited to join the program but do not want to participate, alert a Nurse Care Manager by calling **1-800-490-3054** and you will be removed from the program. You can rejoin the program at any time by calling the same number.

If you currently participate in a similar program through your medical plan, you may receive notification that these services will be provided through the Live Well Health Management Program going forward.

24-Hour Nurseline

The 24-Hour Nurseline is available to active, benefits-eligible employees and their spouses/domestic partners and dependents. You can call the 24-Hour Nurseline at any time to speak with a nurse who can answer questions about an immediate health issue.

The 24-Hour Nurseline can help when you or your family members experience medical symptoms or have a health question, such as:

- "My child is running a fever";
- "I think I have poison ivy"; or
- "I have a pain in my arm."

Important Information about the Citi Live Well Program

Citi Live Well has been designed to provide for your privacy and to comply with all federal and state privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Personal health information is maintained by a third-party vendor (ActiveHealth, a subsidiary of Aetna) and is not maintained on Citigroup data systems.

All information provided through the Citi Live Well Program is available for review by you, your doctors, and other health care professionals. Safeguards have been implemented to prevent your personal information from being seen by or shared by other persons. No Citigroup employee should see your health information on the Citi Live Well Portal or the Personal Health Record Web site. Citigroup will receive aggregate reports to review the performance of the program.

By enrolling in the Citigroup Medical Plans, you consent to the terms and conditions of Citi Live Well, as they may be amended from time to time. If you are enrolled through Citigroup in Aetna, Empire BlueCross BlueShield, CIGNA, UnitedHealthcare (including John Deere, Oxford, and Optimum Choice), Group Health Plan of St. Louis, Harvard Pilgrim, or Tufts Health Plan, your claims information, including prescription drug information, will be transmitted to ActiveHealth as part of your participation in the Citigroup Medical Plans.

Please be aware that the Personal Health Record may not contain all the information about your health, unless you supply such information, and that alerts or care considerations may be mailed to your home address if opportunities to improve your health are indicated.

Maternity benefits

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

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

Reminder: To cover a newborn under your Citigroup medical, dental, or vision coverage, you must report dependent information to the Benefits Service Center within 31 days of the child's birth. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and follow the prompts for the Benefits Service Center. You also can visit the Citigroup Benefits Web Site through Total Comp at Citi at **www.totalcomponline.com** or by going directly to **https://mybenefits.csplans.com**. See "How to report a qualified change in status event" on page 12.

While you may want to call your medical Plan to report the birth of a child, your child will not be covered unless you call the Benefits Service Center within 31 days.

Women's Health and Cancer Rights Act notice

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

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

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

Qualified Medical Child Support Orders (QMCSOs)

As required by the federal Omnibus Budget Reconciliation Act of 1993, any child of a participant under a Citigroup Medical, Dental, or Vision Plan or the Health Care Spending Accounts who is an alternate recipient under a QMCSO will be considered as having a right to dependent coverage under the Medical, Dental, or Vision Plan, or the Health Care Spending Accounts.

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

To receive, at no cost, a detailed description of the procedures for a QMCSO, or if you have a question about filing a QMCSO, call the Benefits Service Center as instructed on page 4. You can file your QMCSO by mailing it to:

Citigroup QMCSO Administration
P.O. Box 56757
Jacksonville, FL 32241-6757.
1-904-791-2755

How to file a claim

Most medical and dental benefits are paid directly to the providers. Listed below are the forms needed to claim benefits that are not paid directly. If you do not receive benefits to which you believe you are entitled, see the "Claims and appeals" section beginning on page 91.

NAME OF PLAN	Name/form number and when to use the form	How to obtain a form
Aetna	Aetna Medical Benefits Request (Form 301) Use to file a claim for covered out-of-network expenses.	Visit the "Forms" section of the Citigroup intranet at **www.citigroup.net/human_resources/**. Visit the "health and welfare" section of the Citigroup Benefits Web Site. Visit Total Comp at Citi at **www.totalcomponline.com**. From the "quick links" page, click on the link for the Citigroup Benefits Web Site. You also can go directly to **https://mybenefits.csplans.com**.
CIGNA	CIGNA Medical Claim Form (Form 302) Use the form to file a claim for covered out-of-network expenses.	
Empire BlueCross BlueShield	Health Insurance Claim Form for the ChoicePlan (Form 322) Health Insurance Claim Form for the Out-of-Area Health Plan (Form 323) Use the forms to file a claim for covered out-of-network expenses.	
UnitedHealthcare	Citigroup Health Claim Transmittal (Form 303) Use the form to file a claim for covered out-of-network expenses.	
Delta Dental	Delta Dental Claim Form (Form 307) Use the form to file a claim for covered out-of-network expenses.	
MetLife Dental	MetLife Dental Claim Form (Form 304) Use the form to file a claim for covered dental expenses.	
Health Care Spending Account (HSCA)	If you do not use your Health Care Spending Account Reimbursement Card, you can file a claim using the HCSA Reimbursement Request Form (Form 316). Use the form to submit eligible health care claims for reimbursement.	
Limited Purpose Health Care Spending Account (LPSA)	LPSA Reimbursement Request Form (Form 315) Use the form to submit eligible vision, dental, or preventive care health care claims for reimbursement.	
Dependent Care Spending Account (DCSA)	DCSA Reimbursement Request Form (Form 317) Use the form to submit eligible dependent care claims for reimbursement.	
Express Scripts	Express Scripts Prescription Drug Claim (Form 310) Use the form to file a claim for covered out-of-network expenses.	In addition to the above, call Express Scripts at 1-800-227-8338 or visit **www.express-scripts.com**.
Transportation Reimbursement Incentive Program (TRIP)	Transportation Reimbursement Incentive Program Claim Form (Form 306) Use the form to submit eligible transit and/or parking expenses for reimbursement if you do not purchase your transit and/or parking pass on the Citigroup Spending Account Web Service Center.	In addition to instructions under "Visit the 'Forms' section," above, call the TRIP Information Line at 1-800-378-1823.
HMO/EPO	Forms available from the HMO/EPO if needed.	Contact your HMO/EPO directly.

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

- Medical, dental, and vision claims must be filed within two years of the date of service. However, some HMOs/EPOs have shorter claim-filing deadlines. Contact your HMO/EPO for details.
- Prescription drug claims must be filed within one year of the date of service.
- HCSA claims must be filed by June 30 following the year in which the expense was incurred.
- LPSA claims must be filed by June 30 following the year in which the expense was incurred.
- DCSA claims must be filed by June 30 following the year in which the expense was incurred.
- TRIP claims must be filed within 12 months of the date on which the expense was incurred.

Glossary

Coinsurance: The portion of a covered expense that you pay after you have satisfied the deductible. For example, if a plan pays 90% of certain covered expenses, your coinsurance for these expenses is 10%.

Covered expenses: Medical and related costs, incurred by participants, that qualify for reimbursement under the terms of the insurance contract.

Deductible: The amount of eligible expenses you and each covered dependent must pay each calendar year before a plan begins to pay benefits.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A U.S. law mandating that anyone belonging to a group health insurance plan must be allowed to purchase health insurance within an interval of time beginning when the previous coverage is lost.

The law protects employees — especially those with long-term health conditions who may be reluctant to leave jobs because they are afraid that pre-existing condition clauses will limit coverage of any such conditions under a new insurance plan — from losing health insurance due to a change in employment status. See "Notice of HIPAA Privacy Practices" beginning on page 81.

Medically necessary: A service or supply is considered medically necessary if it is a generally accepted health care practice and is required to treat your condition, as determined by the Claims Administrator.

Non-occupational disease: A non-occupational disease is a disease that does not:

- Arise out of (or in the course of) any work for pay or profit or
- Result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of the cause if proof is furnished that the person:

- Is covered under any type of Workers' Compensation law and
- Is not covered for that disease under such law.

Non-occupational injury: A non-occupational injury is an accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury that does.

Notification: A requirement that a participant calls his or her health plan to coordinate any inpatient surgery, hospitalization, and certain outpatient diagnostic/surgical procedures. Notification helps ensure that you obtain the most appropriate care for your condition in the most appropriate setting. Call your Plan for more information.

Out-of-pocket maximum: Total payments (deductibles and coinsurance) toward eligible expenses that a covered person pays for himself or herself and/or dependents as defined by the contract.

Once the maximum out-of-pocket amount has been met, the Plan will pay 100% of reasonable and customary (R&C) charges. If the expenses incurred are higher than the R&C amount, the individual receiving the service is responsible for paying the difference even if the out-of-pocket maximum has been reached.

Precertification: A requirement that a participant calls his or her health Plan before seeking certain treatment. The Plan will:

1. Help the participant and his/her health care provider determine the best course of treatment based on the diagnosis and acceptable medical practice, and
2. Determine whether certain covered services and supplies are medically necessary.

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

Pre-existing condition: An injury, sickness, or pregnancy for which — in the three months before the effective date of coverage — you received medical treatment, consultation, care, or services; took prescription medications or had medications prescribed; or had symptoms that would cause a reasonably prudent person to seek diagnosis, care, or treatment.

Preventive care: Routine care examinations based on guidelines from the American Medical Association and doctor recommendations. Covered expenses include routine physical exams (including well-woman and well-child exams), routine cancer screenings, and immunizations. See "Preventive care" on page 28.

Reasonable and customary (R&C) charge: Any charge that, for services rendered by or on behalf of a non-network physician, does not exceed the amount determined by the Claims Administrator in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Claims Administrator by comparing the actual charge for the service or supply with the prevailing charges made for it. The Claims Administrator determines the prevailing charge by taking into account all pertinent factors including:

- The complexity of the service;
- The range of services provided; and
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

Wellness services: Charges for routine care examinations based on the guidelines from the American Medical Association and doctor recommendations. Covered expenses include, but are not limited to, routine physical exams (including well-woman and well-child exams), cancer screenings, and immunizations.

Citi for you. HEALTH

Section 2
Plan Provisions

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Medical

The following information applies to all Citigroup medical options except HMOs/EPOs. If you are interested in HMO/EPO coverage, see the HMO/EPO information sheets posted on the Citigroup Benefits Web Site or that accompany your Personal Enrollment Worksheet.

Citigroup offers HMOs/EPOs and the following non-HMO/EPO Plans:

- ChoicePlan 100;
- ChoicePlan 500;
- High Deductible Health Plan–Basic;
- High Deductible Health Plan–Premier;
- Hawaii Health Plan; and
- Out-of-Area Health Plan (available only if you live in an area where a ChoicePlan is not available).

The Citigroup Benefits Web Site and Personal Enrollment Worksheet list the medical options available to you based on your home zip code.

ChoicePlan administrators

The ChoicePlan is administered by Aetna, CIGNA, Empire BlueCross BlueShield, and UnitedHealthcare. The administrators available to you depend on your location.

In some states, you will have a choice between administrators. In other states, Citigroup has designated only one administrator. The ChoicePlan design is essentially the same no matter which company administers the Plan. Exceptions are noted.

A summary of all the non-HMO/EPO Plans follows.

Citigroup medical options at a glance

For HMO/EPO information, see the information sheets at **www.benefitsbookonline.com** or in your enrollment kit.

	CHOICEPLAN 100 CHOICEPLAN 500 For administrator(s), see your Personal Enrollment Worksheet		HIGH DEDUCTIBLE HEALTH PLAN Administered by Aetna			
			Basic		Premier	
	Network	Out of network	Network	Out of network	Network	Out of network
Annual deductible (in and out of network combined)						
• Individual	Plan 100: $100 Plan 500: $500	Plan 100: $500 Plan 500: $1,500	$2,100	$3,100	$1,200	$2,400
• Maximum per family	Plan 100: $200 Plan 500: $1,000	Plan 100: $1,000 Plan 500: $3,000	$4,200 Includes prescription drug expenses	$6,200 Includes prescription drug expenses	$2,400 Includes prescription drug expenses	$4,800 Includes prescription drug expenses
Out-of-pocket maximum (includes deductible; in and out of network combined)						
• Individual	Plan 100: $2,000 Plan 500: $3,000	Plan 100: $4,000 Plan 500: $6,000	$5,000	$7,500	$2,500	$5,000
• Maximum per family	Plan 100: $4,000 Plan 500: $6,000	Plan 100: $8,000 Plan 500: $12,000	$10,000 Includes prescription drug expenses	$15,000 Includes prescription drug expenses	$5,000 Includes prescription drug expenses	$10,000 Includes prescription drug expenses
• Lifetime maximum	None	None	None	None	None	None
Professional care (in office)						
• Doctor/primary care physician (PCP) visits	90% after deductible	70% after deductible	80% after deductible	70% after deductible	90% after deductible	70% after deductible
• Specialist visits	90% after deductible	70% after deductible	80% after deductible	70% after deductible	90% after deductible	70% after deductible
Preventive care, subject to frequency limits						
• Well adult and immunizations	100%	100% no deductible up to $250 maximum, then covered at 70%; immunizations covered at 70%, no deductible	100%	100% of reasonable and customary charges	100%	100% of reasonable and customary charges
• Well child and immunizations	100%	100% no deductible up to $250 maximum, then covered at 70%; immunizations covered at 70%, no deductible	100%	100% of reasonable and customary charges	100%	100% of reasonable and customary charges
• Cancer screenings (PAP test, mammogram, sigmoidoscopy, colonoscopy, PSA screening)	100%	100% no deductible up to $250 maximum, then covered at 70%	100%	100% of reasonable and customary charges	100%	100% of reasonable and customary charges
Hospital emergency room						
No coverage in any medical option if not a true emergency	$50 copayment waived if admitted within 24 hours of emergency room use		80% after deductible		90% after deductible	
Urgent care center						
	90% after deductible	90% after deductible; 70% after deductible for Empire BlueCross BlueShield participants	80% after deductible	70% after deductible	90% after deductible	70% after deductible

HAWAII HEALTH PLAN Administered by UnitedHealthcare	OUT-OF-AREA HEALTH PLAN Administered by Empire BlueCross BlueShield (available only in an area where a ChoicePlan is not available)
Annual deductible (in and out of network combined)	
$200 $600	$300 $600
Out-of-pocket maximum (includes deductible; in and out of network combined)	
$1,000 $2,000 $3 million	$1,000 $2,000 None
Professional care (in office)	
90% after deductible when using network providers; 80% after deductible when using out-of-network providers	80% after deductible 80% after deductible
Preventive care, subject to frequency limits	
80%	100% of reasonable and customary charges
80%	100% of reasonable and customary charges
80%	100% of reasonable and customary charges
Hospital emergency room	
90% after deductible for doctor; 80% after deductible for hospital	80% after deductible
Urgent care center	
90% after deductible when using network providers; 80% of reasonable and customary charges after deductible when using out-of-network providers	80% after deductible

Citigroup medical options at a glance

For HMO/EPO information, see the information sheets at **www.benefitsbookonline.com** or in your enrollment kit.

	CHOICEPLAN 100 CHOICEPLAN 500 For administrator(s), see your Personal Enrollment Worksheet		HIGH DEDUCTIBLE HEALTH PLAN Administered by Aetna			
			Basic		Premier	
	Network	Out of network	Network	Out of network	Network	Out of network
Hospital inpatient and outpatient						
Semiprivate room and board, doctor's charges, lab, and X-ray	90% after deductible; notification required for hospitalization and certain outpatient procedures	70% after deductible; precertification required for hospitalization and certain outpatient procedures	80% after deductible; notification required for hospitalization and certain outpatient procedures	70% after deductible; precertification required for hospitalization and certain outpatient procedures	90% after deductible; notification required for hospitalization and certain outpatient procedures	70% after deductible; precertification required for hospitalization and certain outpatient procedures
Infertility						
Expenses are covered in and out of network combined; deductible and coinsurance apply to all covered services.	Up to a $24,000 family lifetime medical maximum and a $7,500 family lifetime prescription drug maximum. (See plan document at **www.benefitsbookonline.com** for specifics of covered and non-covered services.) For Hawaii Health Plan participants only: Infertility coverage is not subject to your deductible.					
Mental health and substance abuse						
• Inpatient Maximum of 30 days a calendar year in and out of network combined You may be eligible for additional visits with Plan approval after a medical necessity review. Coinsurance does not apply to out-of-pocket maximum.	90% after deductible if you call your Plan and use network providers or facilities; 70% after deductible for approved visits over Plan limits	70% after deductible, precertification required; 50% after deductible for approved visits over Plan limits	80% after deductible if you call your Plan and use network providers or facilities; 70% after deductible for approved visits over Plan limits	70% after deductible, precertification required; 50% after deductible for approved visits over Plan limits	90% after deductible if you call your Plan and use network providers or facilities; 70% after deductible for approved visits over Plan limits	70% after deductible, precertification required; 50% after deductible for approved visits over Plan limits
• Outpatient Maximum of 52 visits a calendar year, except for Hawaii Health Plan (50 visits a year) in and out of network combined. You may be eligible for additional visits with Plan approval after a medical necessity review. Coinsurance does not apply to out-of-pocket maximum.	90% after deductible if you call your Plan and use network providers or facilities; 70% after deductible for approved visits over Plan limits	50% after deductible; 50% after deductible for approved visits over Plan limits	80% after deductible if you call your Plan and use network providers or facilities; 70% after deductible for approved visits over Plan limits	50% after deductible; 50% after deductible for approved visits over Plan limits	90% after deductible if you call your Plan and use network providers or facilities; 70% after deductible for approved visits over Plan limits	50% after deductible; 50% after deductible for approved visits over Plan limits
Therapies						
Physical/speech/occupational therapy (all therapies combined): Limited to 60 visits a year in and out of network combined. You may be eligible for additional visits with Plan approval after a medical necessity review.	90% after deductible; 70% after deductible for approved visits over Plan limits	70% after deductible; 50% after deductible for approved visits over Plan limits	80% after deductible; 70% after deductible for approved visits over Plan limits	70% after deductible; 50% after deductible for approved visits over Plan limits	90% after deductible; 70% after deductible for approved visits over Plan limits	70% after deductible; 50% after deductible for approved visits over Plan limits
Chiropractic therapy: limited to 20 visits a year in and out of network combined.	90% after deductible	70% after deductible	80% after deductible	70% after deductible	90% after deductible	70% after deductible

HAWAII HEALTH PLAN Administered by UnitedHealthcare	OUT-OF-AREA HEALTH PLAN Administered by Empire BlueCross BlueShield (available only in an area where a ChoicePlan is not available)
Hospital inpatient and outpatient	
90% after deductible when using network doctors; 80% after deductible when using out-of-network doctors; 80% after deductible when using network hospitals; 80% after $100 confinement deductible and calendar-year deductible when using out-of-network hospitals; notification required for hospitalization and certain outpatient procedures	80% after deductible; notification required for hospitalization, facility admissions, and certain outpatient procedures
Infertility	
Up to a $24,000 family lifetime medical maximum and a $7,500 family lifetime prescription drug maximum. (See plan document at **www.benefitsbookonline.com** for specifics of covered and non-covered services.) For Hawaii Health Plan participants only: Infertility coverage is not subject to your deductible.	
Mental health and substance abuse	
80% after deductible when using network providers; precertification required; 50% after deductible plus additional $100 confinement deductible when using out-of-network providers; precertification required; 70% network after deductible/50% out of network after deductible for approved visits over Plan limits	80% after deductible; precertification required; 70% for approved visits over Plan limits
80% after deductible in and out of network combined; precertification required; failure to precertify will result in coverage at 50% after deductible up to $80 a visit; 70% network after deductible/50% out of network after deductible for approved visits over Plan limits	50% after deductible; precertification required; 50% after deductible for approved visits over Plan limits
Therapies	
Limited to 20 visits a year for each type of therapy in and out of network benefits combined 90% network after deductible; 80% out of network after deductible; 70% network after deductible/50% out of network after deductible for approved visits over Plan limits	80% after deductible; 70% for approved visits over Plan limits
Limited to 20 visits a year per type of therapy in and out of network combined 90% network after deductible; 80% out of network after deductible	80% after deductible

Quick tip:

Use the Health Care Spending Account (HCSA)/Limited Purpose Health Care Spending Account (LPSA) to save money on your out-of-pocket health care expenses. Since you forfeit any money remaining in the account that you do not use, estimate conservatively. See the HCSA section on page 64 and the LPSA section on page 67 for details.

Preventive care

Preventive care services are available in all non-HMO/EPO plans.

Routine exams and well-child immunizations

ChoicePlans and Out-of-Area Health Plan

Routine periodic exams for both adults and children are covered as follows:

- When performed by network providers:
  - Exams: 100% with no deductible to meet;
  - Immunizations: 100% with no deductible to meet
- When performed by out-of-network providers:
  - Exams: 100% up to $250 with no deductible to meet, then covered at 70% of reasonable and customary charges; 100% of reasonable and customary charges in the Out-of-Area Health Plan;
  - Immunizations: 70% of reasonable and customary charges with no deductible to meet; 100% of reasonable and customary charges with no deductible to meet in the Out-of-Area Health Plan.

High Deductible Health Plans

- When performed by network providers:
  - Exams: 100% with no deductible to meet;
  - Immunizations: 100% with no deductible to meet
- When performed by out-of-network providers:
  - Exams: 100% of reasonable and customary charges;
  - Immunizations: 100% of reasonable and customary charges

Hawaii Health Plan

Routine physical exams and well-woman exams are covered at 80% with no deductible to meet. Well-child exams and immunizations are covered at 80% with no deductible to meet.

Preventive care services include but are not limited to:

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

Contact the plan for details.

Cancer screenings

In all Plans except the Hawaii Health Plan and the High Deductible Health Plans, cancer-screening tests are covered as follows:

- When performed by network providers: 100% with no deductible to meet;
- When performed by out-of-network providers: 100% up to $250 with no deductible to meet, then covered at 70% of reasonable and customary charges; 100% of reasonable and customary charges with no deductible to meet in the Out-of-Area Health Plan.

Cancer screening tests are:

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

Verify network provider participation

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

ChoicePlan

In a ChoicePlan, you choose whether to use network or out-of-network providers each time you need treatment. You must meet a deductible both in and out of the network before the Plan will pay benefits. Precertification is required before any inpatient hospital stay and certain outpatient procedures.

ChoicePlan network features

- When you visit a network provider, you do not have any claim forms to complete.
- The ChoicePlan has no lifetime maximum benefit other than for infertility coverage.
- You will pay a network deductible for all services — with the exception of preventive care — before the Plan will pay benefits. Once you meet your network deductible, the Plan will pay 90% of covered charges while you will pay 10% of covered charges up to your annual out-of-pocket maximum. Any amounts that count toward the network deductible also count toward the out-of-network deductible.
- Preventive care: Routine periodic exams (well adult and well child), well-child immunizations, and cancer screenings are covered at 100% (no deductible to meet).
- Allergy injections: Allergy injections for which you are not charged for an office visit will be covered at 100%, and the deductible and coinsurance will be waived.
- Prescription drugs are covered under the Citigroup Prescription Drug Program administered by Express Scripts. You must meet a separate deductible for drugs purchased at a retail network pharmacy before the plan will pay benefits. You do not need to meet a deductible to order prescription drugs through the Express Scripts Home Delivery program or CuraScript. See prescription drug information beginning on page 37.

Paying your bill at your network doctor's office

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

Choosing network providers

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

- Aetna: Open Access Plans; Aetna Choice POS II;
- CIGNA: Open Access Plus network;
- Empire BlueCross BlueShield: PPO/EPO; or
- UHC: Choice Plus Plan.

ChoicePlan out-of-network features

- You must file a claim to be reimbursed for covered expenses. See "How to file a claim" on page 20.
- The Plan has no lifetime maximum benefit other than for infertility coverage.
- Routine periodic exams (well adult and well child) are covered at 100% up to $250 with no deductible to meet and then covered at 70% of reasonable and customary charges; immunizations for children are covered at 70% of reasonable and customary charges with no deductible to meet.
- Other than for preventive care services, you must meet an annual deductible before the ChoicePlan will pay benefits. The network deductible also counts toward the out-of-network deductible.
- Most covered expenses are reimbursed at 70% of reasonable and customary charges after the annual deductible is met.
- You must notify your Plan before undergoing certain procedures and services, according to your Plan's rules, or you may pay a penalty. In the ChoicePlan administered by Aetna, Empire BlueCross BlueShield, and CIGNA, the process is known as "precertification." In the ChoicePlan administered by UHC, the process is called "care coordination." See "Precertification" on page 35 or "Care coordination program" on page 37.

Multiple surgical procedure guidelines

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

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

- First procedure: The Plan will allow 100% of the negotiated or reasonable and customary fee.
- Second procedure: The Plan will allow 50% of the negotiated or reasonable and customary fee.
- Third and additional procedures: The Plan will allow 50% of the negotiated or reasonable and customary fee for each additional procedure.

- Bilateral and separate operative areas: The Plan will allow 100% of the negotiated or reasonable and customary fee for the primary procedure and 50% of the secondary procedure and 50% of the negotiated or reasonable and customary fee for tertiary/additional procedures.

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

High Deductible Health Plan (Basic and Premier)

Administered by Aetna

The High Deductible Health Plan (HDHP) covers the same services as the ChoicePlan and Out-of-Area Health Plan. However, there are certain major differences between them.

- HDHPs provide what is referred to as "catastrophic" medical coverage. They are *not* intended for individuals who want to be reimbursed for almost all their health care expenses from their first medical expense in the calendar year.
- HDHPs are designed to be used in conjunction with a Health Savings Account (HSA) in which you and/or your employer contributes pretax dollars to pay for your deductible and other eligible out-of-pocket expenses. HDHP participants are permitted to enroll in the Limited Purpose Health Care Spending Account (LPSA). However, participants cannot enroll in the Health Care Spending Account (HCSA). Enrollment in an HCSA disqualifies participants from making HSA contributions.
- If enrolled in any coverage category other than that for an individual, you must meet the entire family deductible before the plan will pay benefits. The entire out-of-pocket maximum also applies to all covered participants and not to any individual.
- Prescription drugs count toward the individual/family deductible and out-of-pocket maximum. You do not need to meet a separate prescription drug deductible.

	HIGH DEDUCTIBLE HEALTH PLAN-Premier		HIGH DEDUCTIBLE HEALTH PLAN-Basic	
Company contribution to your HSA	$500 individual/ $1,000 all other coverage categories		$500 individual/ $1,000 all other coverage categories	
	Network	**Out of network**	**Network**	**Out of network**
Deductible	$1,200/$2,400	$2,400/$4,800	$2,100/$4,200	$3,100/$6,200
Out-of pocket maximum (including deductible)	$2,500/$5,000	$5,000/$10,000	$5,000/$10,000	$7,500/$15,000
Coinsurance	90%	70%	80%	70%
Prescription drug coverage for generic, preferred, and non-preferred medications				
Retail	$5/$30/50% up to a $50 minimum/$150 maximum after the annual deductible	Covered at 50% after the annual deductible	$5/$30/50% up to a $50 minimum/$150 maximum after the annual deductible	Covered at 50% after the annual deductible
Mail order	$12.50/$75/50% up to a $125 minimum/$375 maximum after the annual deductible	Not applicable	$12.50/$75/50% up to a $125 minimum/$375 maximum after the annual deductible	Not applicable

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

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

High Deductible Health Plan features

- Most covered network expenses are reimbursed at 80% (Basic) and 90% (Premier) of negotiated charges after the annual deductible has been met. Claims submitted by an out-of-network provider generally are reimbursed at 70% of reasonable and customary charges after the deductible has been met.
- Routine physical exams for adults and children and well-woman exams are covered at 100% when using network providers and 100% of reasonable and customary charges when using out-of-network providers with no deductible to meet.
- Prescription drugs are covered by the Citigroup Prescription Drug Program administered by Express Scripts. To purchase prescription drugs at a retail network pharmacy and through the Express Scripts Home Delivery program and CuraScript for a copayment or coinsurance, you first must meet your combined medical and prescription drug deductible.
- However, you can purchase certain preventive-care medications for a copayment or coinsurance *before* the deductible is met. Copayments/coinsurance count toward your out-of-pocket maximum.
- The Plan has no lifetime maximum benefit other than for infertility coverage.

Citigroup has determined that the HDHPs are not "creditable coverage" under Medicare. If you enroll in the HDHP and become eligible for Medicare in the next 12 months, you may pay more for Medicare Part D prescription drug coverage if you later elect it. For information about creditable coverage, see the Non-Creditable Coverage Disclosure Notice on page 79.

Health Savings Accounts (HSAs)

An HSA must be used in conjunction with a qualified High Deductible Health Plan (HDHP), such as the Basic and Premier Plans.

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

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

To establish an HSA, you must be covered by an HSA-compliant plan, such as the HDHP, and you cannot be enrolled in "impermissible medical care coverage," such as a Health Care Spending Account.

If you enroll in the High Deductible Health Plan (Basic or Premier) for 2008 and you establish an HSA at Citibank, N.A., Citigroup will contribute to your account. The contribution amounts are up to $500 for employee only coverage and up to $1,000 for any of the other coverage categories. "Establish" an account means you apply for an account and are approved because you meet certain credit and "know your customer" requirements. If your account is not established, you cannot receive the employer contribution.

If you do not enroll in an HDHP, by law you cannot establish a Health Savings Account.

Account features

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

Note: HSAs, whether administered by Citibank or another administrator, are not part of the Citigroup Medical Plans or any other employee benefit plan sponsored by Citigroup.

HSAs and the LPSA

If you enroll in an HDHP and make tax-free contributions to an HSA you can no longer participate in the Health Care Spending Account (HCSA). *HCSA enrollment disqualifies your contributions to the HSA.*

According to Internal Revenue Service (IRS) regulations, if you establish an HSA you can enroll in Citigroup's Limited Purpose Health Care Spending Account (LPSA) to reimburse yourself for eligible expenses such as those for vision, dental, and preventive medical care. An LPSA works like the HCSA, except only certain types of expenses are eligible for reimbursement. See page 67 for more information.

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

Hawaii Health Plan

Administered by UnitedHealthcare.

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

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

Hawaii Health Plan features

- You must meet an annual $200 individual deductible ($600 family) before the Plan will pay benefits.
- Your annual individual out-of-pocket maximum, including the deductible, is $1,000 ($2,000 family).
- Most covered network expenses are reimbursed at 90% after the annual deductible has been met. Claims submitted by an out-of-network provider are reimbursed at 80% of reasonable and customary charges.
- Routine physical exams for adults and children and well-woman exams are covered at 80% with no deductible to meet.
- Immunizations for children are covered at 80% with no deductible to meet.
- Prescription drugs are covered under the Hawaii Prescription Plan of the Citigroup Prescription Drug Program administered by Express Scripts. You must meet a separate deductible for drugs purchased at a retail network pharmacy before the plan will pay benefits. You do not have to meet a deductible to order prescription drugs through the Express Scripts Home Delivery program and CuraScript. See prescription drug information beginning on page 37.
- The Plan has a $3 million lifetime maximum benefit.

Filing a claim

See "How to file a claim" on page 20.

Out-of-Area Health Plan

Administered by Empire BlueCross BlueShield; available only in areas where no ChoicePlan is offered.

You can save money by using network providers who agree to charge discounted fees to members. When you use a network provider, most covered expenses are paid at 80% of the negotiated fee after the annual deductible has been met. See pages 24-27.

For the names of network providers, visit Empire BlueCross BlueShield at **www.empireblue.com/citi** or call 1-866-290-9098. When prompted to choose a network, enter "Traditional/Indemnity."

Out-of-Area Health Plan features

- Preventive care is covered at 100% of reasonable and customary charges without having to meet the deductible.
- Other than for preventive care benefits, you must meet an annual $300 individual deductible ($600 family) before the Plan will pay benefits.
- Your annual individual out-of-pocket maximum, including the deductible, is $1,000 ($2,000 family).
- Most eligible expenses are reimbursed at 80% of what Empire BlueCross BlueShield considers the reasonable and customary fee after the annual deductible has been met.
- Prescription drugs are covered under the Citigroup Prescription Drug Program administered by Express Scripts. You must meet a separate deductible for drugs purchased at a retail network pharmacy before the plan will pay benefits. You do not have to meet a deductible to order prescription drugs through the Express Scripts Home Delivery program and CuraScript. See prescription drug information beginning on page 37.
- The Plan has no lifetime maximum benefit.

Filing a claim

See "How to file a claim" on page 20.

Additional medical Plan information

These features apply to ChoicePlan 100 and 500, the High Deductible Health Plans (Basic and Premier), the Hawaii Health Plan, and the Out-of-Area Health Plan, as noted.

Infertility

All non-HMO/EPO medical options cover the medical and prescription drug expenses associated with infertility treatment. All non-HMO/EPO Plans cover the medical infertility treatment including in-vitro fertilization, artificial insemination, GIFT, ZIFT, and other non-experimental/investigational treatments. Infertility treatment is also covered for any condition or treatment of a condition that would destroy the function for the ovaries or testes.

If both you and your spouse/domestic partner are enrolled in Citigroup coverage, both of you together are eligible for the lifetime maximum benefits under the infertility provision (medical and prescription drug as listed in the bullets below). *Each of you is not eligible for the lifetime maximum benefit.*

The infertility benefit covers:

- Prescription drug expenses (managed by Express Scripts) associated with infertility treatment up to a $7,500 lifetime infertility prescription drug maximum for participants and
- Medical expenses up to a $24,000 lifetime infertility medical maximum across all non-HMO/EPO Plans in and out of network combined.

For the donor, the Plan covers the cost of physical lab work including genetic testing, psychological evaluations, and medications to synchronize the cycle of the donor with the cycle of the recipient and to stimulate the ovarian function of the donor; all office visits; ultrasound; lab work normally done on the Plan participant; and the harvesting of her eggs.

The lifetime maximum per family can be spent in one year or over a number of years. If you change non-HMO/EPO medical options, the Claims Administrators will keep track of the amount you have remaining toward this benefit. *Expenses for your donor are counted toward your lifetime family maximum.*

Call your Plan if you have questions about specific procedures or treatments.

For Hawaii Health Plan participants only: Infertility coverage is not subject to your deductible.

For HMO/EPO participants: HMOs/EPOs may offer different infertility coverage; check your HMO/EPO information sheet for details.

Programs available to Aetna participants

National Medical Excellence Program® (NME)

Available to participants enrolled in any medical option administered by Aetna including Aetna HMOs/EPOs.

The NME can arrange for care when appropriate care is not available in your local service area. Specifically, NME may coordinate the care for participants who need:

- Bone marrow or organ transplantation;
- "Investigational" or new technology (when standard care is not available);
- Preauthorized care that is not available within 100 miles of a participant's home; or
- Emergency care while temporarily traveling outside the United States.

If your case is referred to NME, a case manager will work with your PCP or specialist to identify the best possible resources for care. Covered medical expenses will be paid according to your Plan.

In addition, the program will cover the cost of transportation and lodging for you and a companion if the facility to which you are directed is more than 100 miles from your home. The lodging expense maximum is $50 per night, and the travel and lodging maximum is $10,000. For details, contact the Member Services number on your medical plan ID card.

National Advantage Program (NAP)

Available to Aetna participants using out-of-network services.

By using NAP, you have access to discounted rates for many hospital and doctor claims that would otherwise be paid as billed or for emergency/medically necessary services that are not provided in the Aetna network. For more information, call Aetna at 1-800-545-5862.

Aetna tools

Aetna offers the following tools to help you manage your health care expenses. For a preview of these tools, visit the Aetna Web site for participants, Aetna Navigator, at **www.aetna.com**. If you are not a participant, you can tour the Aetna Web site at **www.aetna.com/members/tour/index.html**.

Aetna Navigator Hospital Comparison Tool

The Hospital Comparison Tool provides a report that compares hospitals in your area for more than 160 diagnoses and procedures. This information can help you decide where to obtain care.

Estimate the cost of care

This tool allows you to compare the estimated average costs for 200 different health care services in your area. You can see the potential for savings by choosing a doctor who participates in the Aetna network.

Cost and quality transparency

This tool is designed to help you make informed health care decisions based on the actual costs of care and the clinical quality of physicians in select areas.

In the cost-only markets (Charlotte, NC; Detroit and East Midland, MI; Las Vegas, NV; Massachusetts; Milwaukee, WI; Utah) doctor-specific charges for health care services are displayed.

In the cost and quality transparency markets (Arizona; Atlanta, GA; Cincinnati, Cleveland, and Columbus, OH; Central Valley, Los Angeles, Northern, and San Diego, CA; Colorado; Delaware; Connecticut; metropolitan Washington, DC; Jacksonville, Tampa, Orlando, and South FL; Austin, Dallas, Houston, and San Antonio, TX; Maine; Metro New York; Seattle, WA; Chicago, IL; Indianapolis, IN; Pittsburgh, PA; Kansas City, MO and KS; Richmond, VA; Oklahoma City and Tulsa, OK), information is taken from Aetna's Aexcel evaluation process, which is used to evaluate a specific panel of specialists based on defined measures of clinical performance and cost-efficiency.

Program available to Empire BlueCross BlueShield participants

Blue Distinction Centers for Transplant (BDCT) Program

Available to participants enrolled in any medical option administered by Empire BlueCross BlueShield including Empire BlueCrossBlueShield HMOs/EPOs.

The Blue Distinction Centers for Transplant (BDCT) is a center of excellence bone marrow and organ transplant program offered through participating Blue Cross Blue Shield Plans. All institutions selected as BDCT centers of excellence must meet stringent criteria. BDCT includes seven individual networks for covered transplants: heart; lung; heart/lung; liver; simultaneous kidney-pancreas; and pancreas and bone marrow (autologous and allogeneic).

The program offers a $25,000 lifetime maximum for charges associated with the search for a viable organ or tissue donor.

In addition, travel and lodging benefits are available to participants approved for transplant services. Benefits include the cost of airline, bus, rail, or taxi fare necessary for the patient and one companion (two companions if the patient is under age 19). There is a $125 per day maximum for charges related to meals and lodging and a $10,000 lifetime maximum for all travel and lodging services combined.

For additional information about these benefits, call Member Services at the telephone number on the back of your ID card.

Programs available to UnitedHealthcare participants

Cancer Resource Services

Available to participants enrolled in any UHC medical option, including UHC HMOs, by calling Cancer Resource Services at 1-866-936-6002 from 8 a.m. to 8 p.m. Eastern time on weekdays, excluding holidays.

To use Cancer Resource Services, you must enroll before receiving any treatment. If you are receiving treatment at the time you are hired or newly eligible for benefits, call Cancer Resource Services immediately to enroll.

Cancer Resource Services can assist when you or a covered dependent is diagnosed with cancer and must make difficult and important decisions such as what kind of treatment to get and where to get treatment.

In addition to helping you answer these questions, the Cancer Resource Services unit also can arrange for and coordinate access to a full range of comprehensive cancer treatment services provided by UHC's network of cancer "centers of excellence." Centers of excellence cancer centers provide:

- Comprehensive, highly specialized teams of experts with extensive experience in cancer diagnosis and treatment, including rare cancers;

- Second-opinion services if you are unsure about your diagnosis or what treatment is right for you;
- Experience in performing a large number of cancer surgeries and other complex procedures; and
- Access to new experimental treatments that may be an option for some patients.

To learn more about Cancer Resource Services or to enroll, call 1-866-936-6002 or visit the Cancer Resource Services Web site at **www.urncrs.com**. You are not charged for this service, and you have no obligation to use a Cancer Resource Services center.

Shared Savings Program

Available to UHC participants enrolled in non-HMO/EPO Plans.

By using an out-of-network provider, your out-of-pocket costs generally will be higher than when you use a network provider.

However, by using a provider available through UHC's Shared Savings Program, your claim will still be paid at the out-of-network level, but a discounted rate will be used to determine the amount of your out-of-pocket cost. In addition, Shared Savings providers will not collect the portion of billed charges that exceeds the discounted rate.

Once enrolled in a Plan administered by UHC, visit **www.myuhc.com/groups/citi** for information about the Shared Savings Program and for the names of participating providers.

Mental health and substance abuse benefits

The non-HMO/EPO Plans provide confidential mental health and substance abuse services through a network of counselors and specialized practitioners.

When you call your medical Plan at the toll-free number on your medical ID card, you will speak with an intake coordinator who will help find the right care provider for you. In an emergency, the intake coordinator also will provide immediate assistance and, if necessary, arrange for treatment at an appropriate facility.

You must call your Plan before seeking treatment for mental health or chemical dependency treatment. Call your Plan for the names of network providers.

Benefits are limited to 30 days of inpatient treatment and 52 outpatient visits per calendar year for network and out-of-network care combined. Your Plan may approve additional visits, at a reduced level of coverage, based on medical necessity.

Precertification

Precertification helps ensure that you obtain the most appropriate care for your condition. Requirements vary, so if you are enrolled in a ChoicePlan administered by Aetna, CIGNA, or Empire BlueCross BlueShield, review your Plan's precertification requirements below. UHC ChoicePlan participants should refer to the "Care Coordination program" section on page 37.

Precertification requirements for the ChoicePlan administered by Aetna and CIGNA

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

For CIGNA participants only

- You must call CIGNA at 1-800-794-4953 for precertification of any inpatient confinement (network and out of network).

- You must call CIGNA for precertification of any out-of-network service described here; otherwise you will pay a penalty.

CIGNA encourages you to call for precertification of all outpatient services listed here.

You are encouraged to call before:

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

For outpatient services and diagnostic testing

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

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

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

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

Precertification for the ChoicePlans administered by Empire BlueCross BlueShield

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

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

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

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

You are required to obtain precertification for the following services:

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

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

Care Coordination Program

For non-HMO/EPO Plans administered by UHC

UHC's Care Coordination Program is designed to encourage the identification and follow-up of your covered health care needs. Care Coordination activities are not a substitute for the medical judgment of your doctor, and the ultimate decision of what medical care you or your covered dependents actually receive is left to you and your doctor.

No benefits are payable unless the services and supplies are covered under the Plan.

Care Coordination is composed of these activities:

- **Notification:** Notification serves as the "gate" to other Care Coordination Program activities. You must call the UHC Care Coordination Program at 1-877-311-7845 if you require any of the following services:
  - Inpatient facility admissions, including emergency admissions;
  - Home health care services, including private-duty nursing;
  - Reconstructive procedures;
  - Hospice care;
  - Maternity (for notification purposes); you must call within the first trimester;
  - Maternity admissions exceeding 48 hours for normal delivery/96 hours for cesarean section;
  - Dental services (accident only);
  - Durable medical equipment with a retail cost of more than $1,000 whether for purchase or rental; and
  - Transplant services.
- **Admission Counseling:** A telephone process during which members will receive education about their upcoming admission.
- **Inpatient Care Advocacy:** A process to facilitate access to care for hospitalized participants. Care advocates will work with the doctor and hospital staff to assess the participant's medical condition and plan of care to determine whether there are potential delays in service or whether another level of care may be more appropriate.
- **Welcome Home:** A program for participants who have a specific diagnosis following their discharge from the hospital. This program is designed to support a successful transition from the inpatient setting to the home.
- **Impact:** An outpatient program to identify members at risk for declining health status. The program focuses on stabilizing outpatient care needs to prevent an avoidable readmission or gaps in the delivery of health care.

Citigroup Prescription Drug Program

Express Scripts manages the Citigroup Prescription Drug Program for participants in ChoicePlan 100 and 500, the High Deductible Health Plans (Basic and Premier), the Hawaii Health Plan, and the Out-of-Area Health Plan.

Express Scripts covers FDA (Food and Drug Administration)-approved (federal legend) medications that require a prescription from your doctor. The plan does not cover over-the-counter (OTC) products such as aspirin, vitamins, supplements, or other products that do not require a prescription.

Express Scripts offers two ways to purchase prescription drugs:

1. A network of retail pharmacies nationwide where you can obtain prescription drugs for your immediate short-term needs, such as an antibiotic to treat an infection.
2. Express Scripts Home Delivery through which you may save money by having your maintenance and preventive drugs delivered by mail.

You will pay a deductible, as shown on page 38, for drugs purchased at a retail pharmacy before the Plan will pay benefits. *You will never pay more than the cost of the drug.*

PRESCRIPTION DRUG PROGRAM AT A GLANCE

	ChoicePlan 100 and 500, Out-of-Area Health Plan	High Deductible Health Plan-Basic and Premier[4]	Hawaii Health Plan
Deductible **Applies to drugs purchased at a retail pharmacy**	$100 per person/$200 family maximum (prescription drug deductible)	**Basic:** individual $2,100 network/ $3,100 out of network; family $4,200 network/ $6,200 out of network **Premier:** individual/$1,200 network/$2,400 out of network; family $2,400 network/ $4,800 out of network	$50 per person/$100 family maximum
Copayment for up to a 34-day supply at a network pharmacy after you meet your deductible			
• Generic drug[5]	$5		$10
• Preferred or formulary drug	$30		$20
• Non-preferred or non-formulary drug[3]	50% of the cost of the drug with a minimum payment of $50 to a maximum of $150 after deductible		50% of the cost of the drug with a minimum payment of $40 to a maximum of $100 after $50/$100 deductible
You may have the same prescription filled up to three times at a retail pharmacy. On the fourth fill, you will pay 100% of the cost of the medication.			
Copayment for a 90-day supply through the Express Scripts Home Delivery program (no deductible to meet)[6]			
• Generic drug	$12.50		$25
• Preferred or formulary drug	$75		$50
• Non-preferred or non-formulary drug	50% of the cost of the drug with a minimum payment of $125 to a maximum of $375		50% of the cost of the drug with a minimum payment of $100 to a maximum of $250
Benefits at an out-of-network pharmacy	50% of your cost after you meet the deductible; you must file a claim for reimbursement.		
Copayment for a 30-day supply of specialty medication through the CuraScript Specialty Pharmacy or at a retail network pharmacy (no deductible to meet if purchased through CuraScript)[6]			
• Generic drug	$5		$10
• Preferred or formulary drug	$30		$20
• Non-preferred or non-formulary drug	50% of the cost of the drug with a minimum payment of $50 to a maximum of $150 after deductible		50% of the cost of the drug with a minimum payment of $40 to a maximum of $100 after $50/$100 deductible

[4]In the High Deductible Health Plan, you must meet your combined medical/prescription drug deductible before the Plan will pay benefits except for certain preventive drugs. For a list of these preventive medications, call Express Scripts at 1-800-227-8338 or visit **http://www.express-scripts.com**. Your cost for these preventive medications is the applicable copayment or coinsurance, which will count toward your out-of-pocket maximum. See medical chart on page 24 for the out-of-pocket maximums.

[5]The use of generic equivalents whenever possible (through both the retail and Express Scripts Home Delivery programs) is more cost-effective. Ask your medical professional about this distinction.

[6]Citigroup does not determine formulary drugs. Rather, Express Scripts brings together an independent group of practicing doctors and pharmacists who meet quarterly to review the formulary list and make determinations based on current clinical information. Call Express Scripts at 1-800-227-8338 for a copy of its Preferred Formulary or visit **http://www.express-scripts.com**.

Retail network pharmacies

When you need a prescription filled the same day, for example, an antibiotic to treat an infection, you can go to one of the thousands of pharmacies nationwide that participate in the Express Scripts network and obtain up to a 34-day supply for your copayment (once you meet your deductible).

If you expect to have the prescription filled more than three times, use the Express Scripts Home Delivery program described at right.

To find out whether a pharmacy participates in the Express Scripts network:

- Ask your pharmacist;
- Visit **www.express-scripts.com**, and use the online pharmacy locator; or
- Call Express Scripts at 1-800-227-8338, and follow the prompts for the retail pharmacy locator.

A network pharmacy will accept your prescription and prescription drug ID card, and, once you have met your deductible, charge you the appropriate copayment/coinsurance for a covered drug. Your copayment/coinsurance will be based on whether your prescription is for a generic drug, a preferred brand-name drug on Express Scripts Preferred Formulary, or a non-preferred brand-name drug.

Using your prescription drug ID card

You must use your prescription drug ID card when purchasing drugs at a retail pharmacy.

You will have a 45-day grace period from the effective date of your enrollment during which, if you do not present your prescription drug ID card at the time of service, you will be reimbursed for 100% of the cost of any covered drugs, less the network copayment, after meeting the annual deductible.

If you do not use your card at network pharmacies after your first 45 days of participation, you will be reimbursed for only 50% of the cost of the prescription drug after you have met the annual deductible.

In either case, you must pay the entire cost of the prescription drug and then submit a claim form for reimbursement.

Meeting your deductible

When you buy a prescription drug at a retail pharmacy, you must meet the applicable deductible (individual or family) before the Plan will pay benefits.

For answers to your questions about the applicable deductibles, call Express Scripts at 1-800-227-8338.

Express Scripts Home Delivery

For prescriptions for maintenance medication that you have filled more than three times, you must use the Express Scripts Home Delivery program to avoid paying 100% of the cost of the drug.

Through Express Scripts Home Delivery you can buy up to a 90-day supply at one time. You will make one copayment for each prescription drug or refill, and your cost will be less than what you would pay to purchase the same amount at a retail network pharmacy.

When you use Express Scripts Home Delivery:

- Your medications are dispensed by one of Express Scripts Home Delivery pharmacies and delivered to your home.
- Medications are shipped by standard delivery at no cost to you. You will pay for express shipping.
- You can order and track your refills online at **www.express-scripts.com**, or you can call Express Scripts at 1-800-227-8338 to order your refill by telephone.
- Registered pharmacists are available 24/7 for consultations.

If you need refills of your medication

The first three times you purchase a maintenance medication at a retail network pharmacy or out-of-network pharmacy after you meet the applicable deductible, you will pay the applicable copayment. You will receive a notice from Express Scripts advising you of the benefits of the Express Scripts Home Delivery program. If, after the prescription is filled three times, you still want to purchase this maintenance medication at a retail pharmacy instead of through Express Scripts Home Delivery, you will pay 100% of the cost using either the current prescription or a new prescription for the same medication and strength. If you need to know if your prescription drug is considered a maintenance medication, call Express Scripts at 1-800-227-8338.

If you use specialty medication

CuraScript – Express Scripts' specialty pharmacy – dispenses oral and injectable specialty medications for the treatment of complex chronic diseases, such as, but not limited to, multiple sclerosis, hemophilia, cancer, and rheumatoid arthritis. Prescriptions sent to Express Scripts Home Delivery that should be filled by CuraScript will be forwarded.

CuraScript offers the following:

- Once you are using the CuraScript program, CuraScript will call your doctor to obtain a prescription and then call you to schedule delivery.
- Prescription drugs can be delivered via overnight delivery to your home, work, or doctor's office within 48 hours of ordering.
- You are not charged for needles, syringes, bandages, sharps containers, or any supplies needed for your injection program.
- A CuraScript team of representatives is available to take your calls, and you can consult 24 hours a day with a pharmacist or nurse experienced in injectable medications.
- CuraScript will send you monthly refill reminders.

You can purchase a 30-day supply of specialty medication through CuraScript. To learn more about CuraScript's services, including the cost of your prescription drugs, call CuraScript at 1-866-413-4135.

Controlled substances

Upon request, Express Scripts will fill prescriptions for controlled substances for up to a 90-day supply, subject to state law.

Because special requirements for shipping controlled substances may apply, Express Scripts uses only certain Home Delivery pharmacies to dispense these medications. If you submit a prescription for a controlled substance along with other prescriptions, it may need to be filled through a different pharmacy from your other prescriptions. As a result, you may receive your order in more than one package.

For more information about controlled substances and for the laws in your state, call Express Scripts at 1-800-227-8338.

Note: Kentucky and Hawaii state laws require you to provide your Social Security number to the pharmacy or Express Scripts before it can dispense your medication(s).

'Generics Preferred'

The Generics Preferred program was designed to encourage the use of generic drugs instead of brand-name drugs. Typically, brand-name medications are 50% to 75% more expensive than generics.

If you choose the brand-name drug, where a generic exists, you must pay the difference between the brand and generic in addition to your copayment. *Express Scripts will always dispense an available generic medication unless otherwise indicated by the prescriber or the member.*

Prior authorization

To purchase certain medications or to receive more than an allowable quantity of some medications, your pharmacist must receive "prior authorization" from Express Scripts before these drugs will be covered under the Citigroup Prescription Drug Program.

- Examples of medications requiring "prior authorization" are Retin-A cream, growth hormones, anti-obesity medications, rheumatoid arthritis medications, and Botox.
- Examples of medications whose quantity will be limited are smoking cessation products, migraine medications, and erectile dysfunction medications.

Other medications, such as certain non-steroidal anti-inflammatories, will be covered only in situations where a lower-cost alternative medication is not appropriate.

To determine if your medication requires a prior authorization or is subject to a quantity limit, call Express Scripts at 1-800-227-8338 or visit the Express Scripts Web site at **www.express-scripts.com**. Your pharmacist also can determine if a prior authorization is required or a quantity limit will be exceeded at the time your prescription is dispensed.

If a review is required, you or your pharmacist can ask your doctor to initiate a review by calling 1-800-224-5498. After your doctor provides the required information, Express Scripts will review your case, which typically takes one to two business days. Once the review is completed, Express Scripts will notify you and your doctor of its decision.

If your medication or the requested quantity is not approved for coverage under the Citigroup Prescription Drug Program, you can purchase the drug at its full cost.

Medical necessity review (for non-formulary drugs)

Under certain circumstances, you and your doctor may request that Express Scripts perform a medical review of your medications. For additional information and instructions on how your doctor can request a review, call Express Scripts at 1-800-227-8338.

High Deductible Health Plan information

The High Deductible Health Plan covers the cost of certain preventive drugs without having to meet a deductible. You will pay the applicable copayment or coinsurance, which will count toward your out-of-pocket maximum.

For a list of these preventive medications, call Express Scripts at 1-800-227-8338. You also can visit **www.express-scripts.com**. From the Benefit Overview menu, select "Coverage & Copayments."

If, for 2007, you are enrolled in an HMO/EPO medical option or are not enrolled in Citigroup coverage and you are considering enrolling in the High Deductible Health Plan for 2008, visit **https://member.express-scripts.com/preview/citigroup2008** to view the 2007 list of preventive medications. On the home page scroll to "High Deductible Health Plan Preventive Drug List" for a link to the list.

For all other covered drugs, you must meet your combined medical/prescription drug deductible before the Plan will pay benefits.

HMOs and EPOs

Health maintenance organizations (HMOS) and exclusive provider organizations (EPOs)[7] encourage preventive care and provide services through the use of their networks.

The following features apply to most HMOs/EPOs:

- You will make a copayment for each doctor's office visit and for other services.
- You will pay $500 for each inpatient stay in a hospital.
- You will pay $200 for each treatment in an outpatient facility, such as outpatient surgery.
- Each HMO/EPO covers prescription drugs based on its own formulary list and benefit schedule.

If you are eligible to enroll in an HMO/EPO, you will find the name of the HMO/EPO and your cost on the Citigroup Benefits Web Site and on your Personal Enrollment Worksheet. Review the HMO/EPO information sheets for details of coverage. HMO/EPO information sheets accompany your Personal Enrollment Worksheet and are available on the Citigroup Benefits Web Site.

For information about a specific HMO/EPO or a list of providers, contact the HMO/EPO using the Web address or telephone number on the HMO/EPO information sheet.

Out-of-network benefits

Some HMOs/EPOs offer minimal out-of-network benefits. See the HMO/EPO information sheets for information on any out-of-network benefits offered.

The following HMOs/EPOs will offer out-of-network benefits for 2008:

- Oxford Health Plans (CT, NJ, NY);
- HIP Health Plan of New York; and
- Independent Health (NY).

Lifetime maximum benefit

The following HMOs/EPOs limit the benefit payable per lifetime per individual as follows:

- Arise Health Plan (formerly Prevea Health Plan), $2 million;
- Sanford Health Plan (formerly Sioux Valley Health Plan), $2 million; and
- SelectHealth (formerly IHC Health Plans), $2.5 million.

Choosing a PCP

When you enroll in an HMO/EPO for the first time, you must select a primary care physician (PCP) for yourself and each family member you enroll; otherwise, a network PCP will be assigned to you based on your home zip code.

In some HMOs/EPOs, you will receive an ID card showing *no* PCP election. You must call your HMO/EPO to choose a PCP before you can use its services. **Note:** Empire BlueCross BlueShield does not require a PCP designation.

Aetna's Aexcel Network

For participants in an Aetna HMO/EPO in AZ, CT, DE, FL, GA, NJ, NY, OH, and TX (Dallas, Houston, and San Antonio).

Aetna's Aexcel specialist program offers access to designated specialty care. To receive the highest level of benefits, HMO/EPO participants in the above locations must use Aexcel specialists in the following 12 specialties:

- Cardiology: heart and circulatory health;
- Cardiothoracic surgery: heart surgery, including coronary artery bypass and valve procedures;
- Gastroenterology: diseases of the digestive system and liver, including ulcers, colitis, intestinal irritation and inflammation, Crohn's disease, and colorectal cancer;
- General surgery: procedures such as appendectomies, hernia repairs, breast surgeries, and colorectal surgeries;
- Neurology: disorders of the nervous system such as pain syndromes, movement disorders, multiple sclerosis, and seizures;

[7]An HMO is a health maintenance organization. An EPO is an exclusive provider organization that provides network coverage through a select list of providers. Both types of plans cover services only when performed at a network facility or by a network doctor.

- Neurosurgery: surgery performed on the brain, spinal cord, and nerves;
- Obstetrics and gynecology: childbirth and women's health;
- Orthopedics: disorders of muscles, bones, and joints;
- Otolaryngology/ENT: ailments related to ears, nose, and throat;
- Plastic surgery: surgery to restore form and function to injured or diseased body parts;
- Urology: health of the male and female urinary tracts and the male reproductive organs; and
- Vascular surgery: surgery to correct problems in arteries and veins.

Aetna physicians in these specialty categories who rated highest overall in measures of clinical performance and cost efficiency were designated for inclusion in the Aexcel network. To locate an Aexcel specialist, visit the DocFind section of the Aetna Web site at **www.aetna.com**.

Review your HMO/EPO information sheet for details on the level of benefits provided.

Self-insured HMOs and EPOs

The HMOs/EPOs[8] administered by Aetna, CIGNA HealthCare, Empire BlueCross BlueShield, Group Health Plan of St. Louis (MO), Harvard Pilgrim Health Care (MA), John Deere Health HMO (IA and TN), Optimum Choice, Inc. (DC, DE, and MD), Oxford Health Plans (NY, NJ, and CT), Tufts Health Plan (MA), and UnitedHealthcare (collectively the "Health Plans") are self-insured (they are *not* subject to state laws).

See the HMO/EPO information sheets for the features of the HMOs/EPOs.

For a list of providers, visit each Plan's Web site or call the numbers below:

- **Aetna:**
  Visit the Aetna Navigator Web site at **www.aetna.com**, or call Aetna member services at 1-800-545-5862.
- **CIGNA:**
  Visit **www.cigna.com** and click on the Network option, or call CIGNA member services at 1-800-794-4953.
- **Group Health Plan of St. Louis:** Visit **www.ghp.com**, or call Group Health Plan of St. Louis member services at 1-800-755-3901.
- **Harvard Pilgrim Health Care:** Visit **www.harvardpilgrim.org**, or call Harvard Pilgrim Health Care member services at 1-888-333-4742.
- **Empire BlueCross BlueShield EPO:** Visit **www.empireblue.com/citi** for a directory of network providers. Click on the PPO/EPO network. You also can call Empire BlueCross BlueShield at 1-866-290-9098.
- **John Deere Health HMO (IA):** Visit **www.uhcrivervalley.com**, or call John Deere member services at 1-800-747-1446.
- **John Deere Health HMO (TN)**: Visit **www.uhcrivervalley.com**, or call John Deere member services at 1-800-224-6602.
- **Optimum Choice, Inc.:** Visit **www.unitedhealthcare.com**, or call Optimum Choice member services at 1-800-815-8958.
- **Oxford Health Plans:** Visit **www.oxhp.com**, or call Oxford member services at 1-800-760-4566.
- **Tufts Health Plan:** Visit **www.tuftshealthplan.com**, or call Tufts member services at 1-800-462-0224.
- **UnitedHealthcare:** Visit **www.myuhc.com/groups/citi**, or call UHC at 1-877-311-7845.

Empire BlueCross BlueShield EPO

The EPO plan administered by Empire BlueCross BlueShield uses the same network of quality physicians and providers as the previously described ChoicePlan PPO plans. However, the EPO does not offer out-of-network coverage. You must receive services from a BlueCard® PPO Program network provider to receive benefits.

Present your ID card to your participating BlueCard® PPO Program provider at the time of service. He/she will recognize your plan network by the PPO in a suitcase icon on the front of the card and charge the plan-required copayment at the time of service.

You may use any BlueCard® PPO Program provider without having to obtain a referral for services or choose a specific primary care physician (PCP). However, if you use a provider outside the PPO network, you will not be covered by the plan or be reimbursed for that visit or service unless it is an emergency.

[8]An HMO is a health maintenance organization. An EPO is an exclusive provider organization that provides network coverage through a select list of providers. Both types of plans cover services only when performed at a network facility or by a network doctor.

Dental

Citigroup offers three dental options:

- Delta Dental;
- MetLife Preferred Dentist Program (PDP); and
- CIGNA Dental Care.

You can enroll in Citigroup dental coverage even if you do not enroll in Citigroup medical coverage. You can enroll in any of the same four coverage categories available for medical coverage: employee only: employee plus spouse/domestic partner: employee plus children: or employee plus family. See "Coverage categories" on page 11.

Both Delta Dental and MetLife PDP allow you to visit any dentist. However, when you visit a dentist in the Plan's network, you will pay a discounted fee. See the Citigroup Benefits Web Site or your Personal Enrollment Worksheet for the cost of the options available to you.

Quick tip: dental differences

CIGNA Dental Care costs less from your pay than the other two options, but you must use a CIGNA Dental provider to receive a benefit, except in very limited circumstances. See "CIGNA Dental Care" beginning on page 49.

DENTAL OPTIONS AT A GLANCE

	Delta Dental	MetLife Preferred Dentist Program (PDP)	CIGNA Dental Care[9]
Annual deductible			
- Individual	$50	$50	None
- Family maximum	$150	$150	None
Preventive and diagnostic services	100% paid, no deductible to meet[10]	100% paid, no deductible to meet[11]	100% paid when you use your network dentist
Basic services Such as fillings, amalgams ("silver") and composite ("white"), root canals, periodontal services, extractions, oral surgery	80% after deductible[10]	80% after deductible[11]	You pay a copayment when you use your network dentist
Major restorative services Such as crowns, inlays/onlays, bridges, dentures	50% after deductible[10]	50% after deductible[11]	You pay a copayment when you use your network dentist
Orthodontia	50% after deductible[12]	50% after deductible[12]	You pay a copayment when you use your network dentist
Lifetime orthodontia limit for children and adults	$3,000 per person[12]	$3,000 per person[12]	Coverage limited to 24 months of treatment
TMJ (temporomandibular joint) treatment excluding surgery[13]	50% after deductible[10]	50% after deductible if not the result of an accident (covered under orthodontia)	Not covered
Implants	50% after deductible[10]	Subject to "dental necessity"	Not covered
Annual maximum	$3,000 per person	$3,000 per person	None

[9]You can obtain a schedule of charges and a list of providers by calling CIGNA Dental Care at 1-800-244-6224. Once enrolled, you can obtain a schedule of charges at **www.mycigna.com**. You are entitled to see specialists, as needed, with the approval of your network dentist.

[10]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, cannot 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 are responsible for paying the non-participating dentist's total fee, which may include amounts, such as deductibles and copayments, in addition to your share of Delta Dental's allowance and services that are not covered by the group dental service contract.

[11]MetLife PDP providers charge negotiated fees for services. For services other than those for preventive care, you must meet the annual deductible before the plan will pay a percentage of eligible costs. Benefit amounts for out-of-network dentists are based on reasonable and customary charges for your geographic area.

[12]Orthodontic benefits paid since January 1, 2004, under the MetLife and Delta Dental Plans will count toward the lifetime orthodontia maximum across both Plans.

[13]Call your medical Plan for information on any TMJ treatment it may cover.

Quick tip: The Health Care Spending Account (HCSA) and Limited Purpose Health Care Spending Account (LPSA) can save you money on your out-of-pocket dental expenses. Since you forfeit any money remaining in the account that you do not use, estimate conservatively.

See the HCSA section on page 64 and the LPSA section on page 67 for details.

Delta Dental

Delta Dental offers:

- The freedom to choose any dentist;
- The largest network of dental providers in the United States;
- Access to Delta Dental PPO and Delta Dental Premier participating dentists;
- Dentists who accept agreed-upon fees;
- No claims to file when using a network dentist; and
- Lower out-of-pocket costs when using a network dentist.

Dental benefits may be based on the least costly treatment that conforms to generally accepted dental practice.

Preventive/diagnostic services

Preventive services are covered at 100% of Delta Dental's allowed amount with no deductible to meet. Oral cancer services are included with no frequency limit up to a $3,000 lifetime maximum.

Preventive/diagnostic services are:

- Routine oral exam: up to two exams per calendar year;
- Routine cleanings: up to three cleanings per calendar year (any combination of routine or periodontal);
- Fluoride treatments: one application per calendar year through age 17;
- Space maintainers through age 17;
- X-rays: two bitewing X-rays per calendar year and one full mouth series per 36 months;
- Sealants through age 15 (permanent molars only/one application every 36 months); and
- Palliative treatment: emergency treatment only.

Basic services

Basic services are covered at 80% of Delta Dental's allowed amount after meeting an annual deductible of $50 for an individual ($150 family).

Basic services are:

- Fillings: amalgam ("silver") and anterior composites ("white");
- Extractions;
- Endodontic treatment (root canals);
- Oral surgery; unless covered under your medical plan or your HMO/EPO;
- Repair or recementing of crowns, inlays, onlays, bridgework, or dentures; one relining or rebasing per 36 months;
- Periodontal treatment; up to three cleanings per calendar year (any combination of routine or periodontal);
- Periodontal surgery; limited to once in any five-year period/quadrant; the five-year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this contract, under any prior dental contract, or by you;
- Injectable antibiotics; and
- General anesthesia, when medically necessary.

Major services

Major services are covered at 50% of Delta's allowed amount after meeting an annual deductible of $50 for an individual ($150 family).

Major services are:

- Inlays, onlays, and crowns;
- Removable dentures: initial installation and any adjustments during the first six months; replacement of existing removable dentures or fixed bridgework with a new denture or the addition of teeth to a partial removable denture; to qualify for replacement, dentures must be at least five years old and unserviceable;
- Fixed bridgework: initial installation; replacement of existing removable dentures or fixed bridgework with new fixed bridgework or the addition of teeth to the existing fixed bridgework; to qualify for replacement, bridgework must be at least five years old and unserviceable;
- Dental implants: surgical placement of, prefabrication, superstructure, and replacement limited to once in a lifetime of the actual implant; and
- 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.

Orthodontia services

Orthodontia is covered for children and adults at 50% of Delta Dental's allowance up to a lifetime maximum of $3,000 per covered person. For treatments scheduled to last more than 12 months, benefits are paid in two annual installments.

Orthodontic services are:

- Orthodontic X-rays;
- Harmful habit appliances; and
- Services or supplies to prevent, diagnose, or correct a misalignment of teeth or bite.

Procedures and services that are not covered

The following services and supplies are not covered:

- Prescription drugs, premedications, relative analgesia;
- Charges for hospitalization, including hospital visits;
- Nitrous oxide;
- Plaque control programs, including oral hygiene and dietary instruction;
- Procedures to correct congenital or developmental malformations except for children eligible at birth;
- Procedures, appliances, or restorations primarily for cosmetic purposes;
- Increasing vertical dimension;
- Replacing tooth structure lost by attrition;
- Periodontal splinting;
- Gnathological recordings;
- Equilibration;
- Charges for dental practice and administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry, such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment;
- Services provided or supplies furnished or devices started prior to the effective eligibility date of a patient;
- Myofunctional therapy;
- Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration;
- Treatment or supplies for which the patient would have no legal obligation to pay in the absence of this or any other similar coverage; and
- Experimental procedures.

Delta Dental reserves the right to limit reimbursement levels based on alternative methods of treatment.

Delta Dental's networks

Delta Dental gives you access to two dentist networks. You can choose a dentist from the larger Delta Dental Premier network (176,000 dental offices nationwide) or the Delta Dental PPO network (100,000 offices nationwide). You also can choose any dentist outside the Delta Dental network.

Your savings are greatest with PPO participating dentists; your savings can be considerable with Premier participating dentists; and your savings likely will be the least with non-participating dentists because these dentists do not contract with Delta Dental to limit the fees they charge. You can locate dentists by PPO or Premier network on the Delta Dental Web site. If your dentist participates in both the PPO and Premier networks, Delta Dental pays the lower PPO allowances to the dentist, and you get the PPO network savings.

EXAMPLE ASSUMING DEDUCTIBLE HAS BEEN MET	Delta Dental PPO participating provider	Delta Dental Premier participating provider	Out-of-network dentist
Dentist's charge for a crown	$1,000	$1,000	$1,000
Delta's allowance	$640	$800	$800
Plan pays	$320	$400	$400
Copayment amount (the amount you pay)	50% of $640 = $320	50% of $800 = $400	50% of $800 = $400 + $200, balance of bill = $600
Maximum amount dentist receives	$640	$800	$1,000
You save	**$360**	**$200**	**$0**
Note: These numbers are for illustration only.			

For the names of participating providers:

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

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 also are eligible for coverage under another plan.

Dental necessity

When used in connection with non-emergency treatment, Delta Dental will determine dental necessity in terms of generally accepted dental standards. The fact that a dentist has prescribed, ordered, recommended, or approved a service or supply does not, in itself, make it a dental necessity.

When used in connection with emergency treatment, dental necessity means the treatment is necessary to relieve pain or prevent the immediate and substantial worsening of the condition.

Filing a claim

See "How to file a claim" on page 20.

MetLife Preferred Dentist Program (PDP)

MetLife PDP offers:

- Total freedom of choice; you can visit any dentist at any time;
- A nationwide network of more than 99,000 dentists, including 23,000 specialists, who charge negotiated fees that are typically lower than the provider's normal fee; this reduces your out-of-pocket cost;
- Stringent credentialing requirements for providers;
- Personalized provider directories that you can view online or order by telephone and have faxed or mailed to you; and
- MetLife Dental Reference Card available on the "Forms" section of You @ Citigroup at **www.citigroup.net/human_resources/form.htm (intranet only)**.

Preferred Dentist Program (PDP)

You can take advantage of the PDP feature, which consists of a network of dentists who accept fees that are typically 10% to 30% less than community average charges. When visiting a participating PDP dentist, you are responsible only for the difference between the Plan's benefit payment amount and the PDP fee.

To find out if your dentist is in the PDP network:

- Visit the MetLife Web site at **www.metlife.com/dental**, or
- Call 1-888-832-2576 for a provider directory.

Preventive/diagnostic services

- Routine oral exams, maximum of two exams per calendar year;
- Routine cleanings, maximum of two cleanings per calendar year;
- Fluoride treatments through age 18, maximum of one application per calendar year;
- Space maintainers through age 18;
- Full mouth series and panoramic X-rays, once every 36 months;
- Bitewing X-rays, up to two bitewing X-rays per calendar year (up to eight films per visit);
- Sealants, permanent molars only through age 16, one application every 36 months; and
- Palliative treatments: emergency treatment only; not paid as a separate benefit from other services on the same day.

Basic services

- Fillings (except gold fillings): includes amalgam ("silver") and composite ("white") fillings to restore injured or decayed teeth;
- Extractions;
- Endodontic treatment;
- Oral surgery, unless covered under your medical plan or your HMO/EPO;
- Repair prosthetics: no limit;
- Recementing (crowns, inlays, onlays, bridgework, or dentures): no limit;
- Addition of teeth to existing partial or full denture;
- Denture relining and rebasing: once every 36 months;
- Periodontal maintenance treatments, up to four per calendar year, in combination with routine periodontal or prophylaxes cleanings;
- Periodontal scaling and root planing: no limit (subject to consultant review);
- Bruxism appliance; and
- General anesthesia, when medically necessary, as determined by the Claims Administrator and administered in connection with a covered service.

Major services

- Inlays, onlays, and crowns (including precision attachments for dentures; must be at least five years old and unserviceable); limited to one per tooth every five years;
- Removable dentures, initial installation, and any adjustments made within the first six months;
- Removable dentures (replacement of an existing removable denture or fixed bridgework with new denture; dentures must be at least five years old and unserviceable); limited to once every five years;
- Fixed bridgework, including inlays, onlays, and crowns used to secure a bridge (initial installation);
- Fixed bridgework, including inlays, onlays, and crowns used to secure a bridge (replacement of an existing removable denture or fixed bridgework with new fixed bridgework or addition of teeth to existing fixed bridgework; bridgework must be at least five years old and unserviceable); limited to once every five years; and
- Dental implants (subject to medical necessity and consultant review); medical necessity, as determined by the Claims Administrator, is based on the number and distribution of all missing, unreplaced teeth in the arch, as well as the overall periodontal condition of the remaining normal teeth.

Orthodontia services

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

Procedures and services that are not covered

The following exclusions apply to the 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:
  - 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;
- Charges incurred for services or supplies not recommended by a licensed dentist;
- Charges incurred due to sickness or injury 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;
- 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;
- Charges that, in the absence of this coverage, you would not be legally required to pay;
- Charges incurred that result directly or indirectly from war (whether declared or undeclared);
- Charges resulting from injury sustained while committing an assault or felony;
- 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;
- Charges for services or supplies that are not generally accepted in the United States as being necessary and appropriate for the treatment of dental conditions including experimental care;
- 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;
- Charges for services rendered to sound and natural teeth injured in an accident;
- Care and treatment in excess of the reasonable and customary charge; and
- Services that, to any extent, are payable under any medical benefits, including HMOs/EPOs.

Alternate benefit provision

Before deciding how much the Plan will pay for covered procedures, MetLife will consider any less-costly alternatives that will produce a satisfactory result based on generally accepted dental standards of care. You and your dentist may choose the more costly procedure, but you will be responsible for the difference in cost between the benefit amount and the dentist's charge.

Predetermination of benefits

MetLife recommends that you obtain a predetermination of benefits before undergoing any procedure that will cost more than $300. By requesting a predetermination of benefits, you will know in advance how much you will be responsible for paying. Then, you can choose whether to continue with the more expensive treatment or the alternate procedure.

If you do not request a predetermination of benefits, you may find that the Plan will pay less than you anticipated or nothing at all, depending on the procedure and treatment provided.

Medical necessity

Medical necessity is the treatment of dental diseases such as dental decay and periodontal (gum) diseases. Dental services must be performed by a dentist licensed to practice in the state or by a legally qualified physician. A dentist is a doctor of dental surgery or a doctor of medical dentistry.

The Plan Administrator, acting through the Claims Administrator, reserves the right to determine whether, in its judgment, a service or supply is medically necessary or payable under this Plan. The fact that a dentist has prescribed, ordered, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Filing a claim

See "How to file a claim" on page 20.

CIGNA Dental Care

CIGNA Dental Care operates like a health maintenance organization: Once enrolled, you must receive all services from the CIGNA Dental Care provider you selected. Except for emergency treatment for pain, you will not be covered for any dental services you receive outside the CIGNA Dental network.

If you do not choose a primary dentist when you enroll, CIGNA Dental will assign a dentist to you based on your home zip code.

CIGNA Dental confirms that each dentist in its network is properly licensed, certified, and insured and complies with government health standards.

Plan features

- A nationwide network of approximately 34,000 dentists;
- No deductibles to meet;
- No annual or lifetime dollar maximums;
- No charge for exams, X-rays, or routine cleanings;
- Reduced prices on covered procedures when there is a charge;
- Specialist care with an approved referral at the same fees you would pay a general dentist;
- Automated Dental Office Locator for 24-hour information by telephone or fax to help you find the right dentist;
- Automatic participation in the CIGNA Healthy Rewards® program, which offers discounts on various health-related services and products; for more information, visit **www.cigna.com**;
- Orthodontia for children and adults limited to 24 months of treatment; additional treatment is available at a prorated cost of the initial treatment;
- Coverage for general anesthesia and IV sedation when *medically necessary and performed by a network oral surgeon or periodontist for covered procedures;* general anesthesia does not include nitrous oxide; and
- One routine cleaning every six months at no charge for normal healthy teeth and gums; you may pay for additional cleanings; charges are listed on the Patient Charge Schedule.

Referrals for children

You are not required to obtain a referral from a network general dentist for a CIGNA Dental member under age 7 to be treated by a network pediatric dentist. Exceptions for coverage at the network pediatric dentist for children ages 7 and older are considered for clinical and/or medical reasons.

Limitations on covered services

- Frequency: See the Patient Charge Schedule for limitations on frequency of covered services, such as cleaning.
- Specialty care: You must obtain payment authorization from CIGNA Dental for coverage of services by a network specialist.
- Pediatric dentistry: Coverage for referral to a pediatric dentist ends on a covered child's seventh birthday. CIGNA Dental may consider exceptions for medical reasons on an individual basis. The network general dentist will provide care after the child's seventh birthday.
- Oral surgery: The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is for orthodontic reasons only.

Procedures and services that are not covered

The services or expenses listed below are not covered under the Plan. You are responsible for these charges at the dentist's usual fees.

- Services that are not listed on the Patient Charge Schedule;
- Services provided by a non-network dentist without CIGNA Dental's prior approval (except emergencies);
- Services related to an injury or illness paid under Workers' Compensation, occupational disease, or similar laws; (NC residents: Services or supplies for the treatment of an occupational injury or sickness that are paid under the NC Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer, or Workers' Compensation insurance carrier according to a final adjudication under the NC Workers' Compensation Act or an order of the NC Industrial Commission approving a settlement agreement under the NC Workers' Compensation Act);

- 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);
- 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 (MD 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); diagnose or treat abnormal conditions of the temporomandibular joint (TMJ), unless TMJ therapy is specifically listed on your Patient Charge Schedule; or restore teeth that have been damaged by attrition, abrasion, erosion, and/or abfraction;
- The completion of crown and bridge, dentures, or root canal treatment in progress on the effective date of your CIGNA Dental coverage (TX residents: Pre-existing conditions, including the completion of crown and bridge, dentures, or root canal treatment 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 or orthodontic 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 to be unnecessary or experimental in nature (CA residents: This exclusion should read "Services considered to be unnecessary in accordance with professionally recognized standards of dental practice"; MD residents: This exclusion should read "Services considered to be unnecessary"; PA residents: This exclusion should read "Services considered experimental in nature");
- 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 (TX residents: Benefits are available for network dentist charges for covered services performed at a hospital; other associated charges are not covered and should be submitted to your medical plan for benefit determination);
- Services to the extent you, or your dependent, is compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy (AZ, MD, NC, and PA residents: This exclusion does not apply; KY residents: Services compensated under no-fault or insured motorist policies are not excluded);
- Crowns and bridges used solely for splinting; and
- Resin-bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge schedule.

Visit the CIGNA Web site at **www.cigna.com**, or call 1-800-244-6224 for more information.

You may have the right to convert your CIGNA Dental Care coverage into an individual policy after you terminate employment with Citigroup. For more information, see the Plan document at **www.benefitsbookonline.com**. If you do not have access to this Web site, you can request a copy at no cost to you by speaking with a Benefits Service Center representative. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts for the Benefits Service Center.

Vision Care

The Vision Care Plan, administered by Davis Vision, offers a variety of routine vision care services and supplies. You do not have to be enrolled in the Plan to cover a dependent.

Both network and out-of-network benefits are available. You can split your benefit by going to both network and out-of-network providers. For example, you can obtain an annual eye examination from a Davis Vision provider while purchasing your frames and lenses out of network. However, before taking a prescription from one vendor to be filled at another vendor, you should confirm that the prescription will be honored.

Network benefits

Network benefits include:

- Examination: one eye examination, including dilation, when professionally indicated, each calendar year covered at 100%;
- Frame and spectacle lenses: one pair of eyeglasses each calendar year from the Davis Vision "Collection" covered at 100%; or
- A $61 wholesale allowance toward the cost of any network provider's frame or an equivalent retail allowance at a retail chain, for example, a $150 allowance at a Wal-Mart location; spectacle lenses will be covered at 100%; or
- Contact lenses in lieu of eyeglasses: plan formulary contact lenses; one pair of soft standard daily-wear or four boxes of disposable or two boxes of planned replacement contact lenses, fitting and follow-up care each calendar year covered at 100% or, if you choose contact lenses that are not covered under the Plan formulary, you will receive a maximum credit of $130 toward other lenses plus 15% off the amount above $130 (additional discount not applicable at Wal-Mart locations);
  - The $130 credit is applied toward non-plan contacts, fitting, and follow-up.
- 20% discount on additional pairs of glasses at most network providers.

The following lenses are covered at 100%: glass or plastic lenses (single, bifocal, or trifocal); all prescription ranges, including post-cataract lenses; tinting of plastic lenses; standard and premium progressive addition multifocals; polycarbonate lenses; oversize lenses; ultraviolet coating; blended segment lenses; PGX (sun-sensitive) glass lenses; scratch-resistant coating; intermediate-vision lenses; anti-reflective coatings; hi-index lenses; polarized lenses; and plastic photosensitive lenses.

Out-of-network benefits

If you receive services outside the Davis Vision provider network, the Plan will provide reimbursements of up to the following:

- Annual exam: $30;
- Lenses: single vision, $25; bifocal, $35; trifocal, $45; lenticular, $60;
- Frame only: $50;
- Contact lenses: $75 elective; $225 medically necessary (with prior approval from Davis Vision).

Definition of medical necessity

Davis Vision may determine your contact lenses to be medically necessary and appropriate in the treatment of certain conditions. In general, contact lenses may be medically necessary and appropriate when their use, in lieu of eyeglasses, will result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression.

Contact lenses may be determined to be medically necessary in the treatment of keratoconus, anisometropia corneal disorders, pathological myopia, aniseikonia post-traumatic disorders, aphakia, aniridia, and irregular astigmatism. Davis Vision must review and approve any coverage for medically necessary contact lenses.

Low vision

Low vision is defined as a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low-vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the usable vision that remains.

With prior approval by Davis Vision, covered low-vision services will include:

- Low-vision evaluation: One comprehensive exam every five years is covered with a maximum charge of $300; sometimes called a functional vision assessment, this exam can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye hand coordination, problems perceiving contrast, and lighting requirements for optimum vision.
- Maximum low-vision aid: Aids such as high-power spectacles, magnifiers, and telescopes are covered at a maximum of $600 per aid with a lifetime maximum of $1,200. These devices are used to improve the levels of sight, reduce problems of glare, or increase contrast perception based on the individual's visual goals.
- Follow-up care: The Plan covers four visits in any five-year period with a maximum charge of $100 per visit.

Laser vision correction

Laser vision correction is not covered under the Plan. However, a discount is available if you use a provider in the Davis Vision laser vision correction network. You are eligible for up to a 25% discount off the provider's reasonable and customary fees or a 5% discount off any advertised fee for laser vision correction surgery at a Davis Vision provider.

Some facilities may offer a flat rate, which equates to these discount levels. You are responsible for paying all fees directly to the provider or facility. Davis Vision and Citigroup assume no financial responsibility for access to these discounts in your location.

The list of doctors and facilities performing laser vision correction is different from the routine vision provider listing. For more information about laser vision correction, call Davis Vision at 1-877-923-2847 or visit **www.davisvision.com**. Enter Citigroup code 2227 for a list of participating providers.

Employee Assistance Program (EAP)

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

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

All EAP services are completely confidential.

The EAP is a core benefit available to all benefits-eligible employees. You do not have to enroll or make any contributions to use this benefit. Citigroup provides an employee assistance program through a contract with Harris Rothenberg International, LLC.

Disability

The Disability Plan provides for a Short-Term Disability (STD) and a Long-Term Disability (LTD) benefit to replace a portion or all of your earnings if you are unable to work due to an illness, injury, or pregnancy.

Definition of years of service for the Disability Plan (Short-Term and Long-Term disability benefits)

For purposes of the Disability Plan, your years of service are based on your actual time providing services to Citigroup as an employee. You are credited with service from your hire date, or if you have had one or more breaks in service, from your adjusted service date. You will have a year of service for this purpose for each 12 months of service, counting any part of a month in which you provided service. Service before a break in service will be allowed (or not) under rules similar to the Citigroup Pension Plan credited service rules, such as not counting service prior to five consecutive one-year breaks in service. In no event will the time between your periods of Citigroup service be counted.

STD

The STD benefit is a core benefit available to all benefits-eligible employees. No enrollment is necessary. However, you must report all disabilities to the Claims administrator before you can receive a benefit.

STD pays 100% or 60% of base salary (not total compensation) during an approved disability of up to 13 weeks based on your years of service.

STD schedule of benefits for benefits-eligible salaried employees			
Years of service	**Weeks at 100% of base salary**	**Weeks at 60% of base salary**	**Total weeks of base salary**
Less than 1 month	0	0	0
1 month to less than 1 year	1	12	13
1 year to less than 2 years	4	9	13
2 years to less than 3 years	6	7	13
3 years to less than 4 years	8	5	13
4 years to less than 5 years	10	3	13
5 or more years	13	0	13

For Financial Advisors, Financial Advisor Associates, and Investment Associates in Global Wealth Management and Account Executives in Citi Markets & Banking the following schedule of benefits applies:

Years of service	Minimum benefit (% of total compensation)	Plus additional benefit	Maximum benefit (% of total compensation)
1 month to less than 3 years	60%	Commissions	100%
3 years to less than 7 years	70%	Commissions	100%
7 or more years	80%	Commissions	100%

Pregnancy leave For benefits-eligible salaried employees			
Years of service	**Weeks at 100% of base salary**	**Weeks at 60% of base salary**	**Total weeks of benefit**
Less than 1 month	0	0	0
1 month to less than 1 year	1	12	13
1 or more years	13	0	13

Pregnancy leave For benefits-eligible commission-paid Account Executives and Financial Advisors				
Years of service	**Minimum benefit (% of total compensation)**	**Plus additional benefit**	**Maximum benefit (% of total compensation)**	**Total weeks of benefit**
Less than 1 month	0	0	0	0
1 month to less than 1 year	70%	Commissions	100%	13
1 year or more	80%	Commissions	100%	13

For employees paid on commission working in the Global Consumer Group: You will receive STD benefits based on a phantom salary (and not based on total compensation). If any commissions are generated while you are on an STD leave, they will be paid in addition to the STD benefit based on your length of service.

If you are a Smith Barney Business Analyst paid a monthly commission: You will receive STD benefits based on a recoverable draw against commissions.

For other employees paid on commission: Ask your HR representative for details.

When STD benefits are payable

STD benefits are payable if you incur a total disability while actively employed. A "total disability" is defined as a serious health condition, pregnancy, or injury that results in your inability to perform the essential duties of your regular occupation for more than seven consecutive calendar days. If you remain totally disabled and are unable to work on the eighth calendar day, STD benefits — if approved — will begin on the eighth day of disability and will be paid retroactive to the first day of disability.

You are not considered to have a disability if your illness, injury, or pregnancy prevents you from commuting to and from work only. To qualify for STD benefits, you must be receiving appropriate care and treatment on a continuing basis from a licensed health care provider. You cannot qualify for STD benefits if you return to work on a part-time basis unless you work in California.

If you qualify for STD benefits, return to work, and then within a 30-day period you are unable to work as a result of the same or a related total disability, your absence will be processed as a recurrent claim and you will be eligible to receive the balance of your STD benefits (for a reduced period to reflect the STD benefits paid during the prior absence).

For employees in California

If you are eligible for disability benefits and work in California, you are covered by the Citigroup California Voluntary Disability Insurance (VDI) Plan, unless you reject the plan. The VDI Plan replaces the state plan. For details, ask your HR representative.

If you are covered by the VDI plan, you are not eligible to file a claim with the state. You must report your disability to MetLife. See the telephone numbers on page 5.

LTD

LTD coverage is offered to replace 60% of your total compensation as of the first day of your approved disability when your disability continues for more than 13 weeks. For purposes of calculating your LTD benefit, total compensation is limited to a maximum of $500,000.

Citigroup provides Company-paid LTD coverage to employees whose total compensation is less than or equal to $50,000.99, while employees with total compensation of $50,001.00 and above are required to pay for their coverage. The cost of LTD coverage is shown on the Citigroup Benefits Web Site and on your Personal Enrollment Worksheet.

If you have been enrolled in the Plan for one year and leave Citigroup (other than to retire, which could occur if you terminate employment after attaining age 55 with at least five years of service or after attaining age 50 with 10 years of service), you can convert your Citigroup LTD coverage under the group policy to an individual policy within 31 days after your employment ends. The maximum benefit of this individual policy is $3,000 per month. To obtain a conversion form, call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative.

You may be eligible to receive LTD benefits after 13 weeks of an approved STD leave. Benefits are paid monthly and continue for as long as your approved disability continues, up to age 65 (or longer, depending on your age when your disability begins). See the schedule on page 55.

Unless you are financially independent, you should think of LTD protection as an essential element of your personal financial plan since LTD coverage protects you in the event your ability to work is impaired by an accident or illness.

You do not have to enroll in Citigroup LTD coverage. However,

If your total compensation is:	
$50,000.99[1] or less	Citigroup provides LTD coverage at no cost to you.
From $50,001 to $500,000	You will pay for coverage with after-tax dollars.

[1] If your total compensation increases above $50,000.99 during the year and you want LTD coverage for the following year, you must enroll during annual enrollment; otherwise, you will not have any LTD coverage as of the first of the following year. You do not have to provide evidence of good health to enroll at this time.

LTD BENEFITS	
Age when total disability begins	**Date monthly LTD benefits will stop**
Under 60	Upon attaining age 65
60	The date the 60th monthly benefit is payable
61	The date the 48th monthly benefit is payable
62	The date the 42nd monthly benefit is payable
63	The date the 36th monthly benefit is payable
64	The date the 30th monthly benefit is payable
65	The date the 24th monthly benefit is payable
66	The date the 21st monthly benefit is payable
67	The date the 18th monthly benefit is payable
68	The date the 15th monthly benefit is payable
69 or over	The date the 12th monthly benefit is payable

if you decide to enroll in LTD coverage at any time other than when first eligible (either 31 days after your date of hire or during annual enrollment for the plan year after your total compensation exceeds $50,000.99) or as the result of a qualified change in status, you must take a physical exam and/or provide evidence of good health. In addition, the Plan will not cover any disability caused by, contributed to by, or resulting from a pre-existing condition until you have been enrolled in the Plan for 12 consecutive months.

A pre-existing condition is an injury, sickness, or pregnancy for which – in the three months before the effective date of coverage – you received medical treatment, consultation, care, or services; took prescription medications or had medications prescribed; or had symptoms that would cause a reasonably prudent person to seek diagnosis, care, or treatment.

When LTD benefits are payable

For purposes of initially qualifying for LTD benefits, a disability means that due to sickness, pregnancy, or accidental injury, you are receiving appropriate care and treatment from an attending physician on a continuing basis and are unable to perform your own occupation for any employer in your local economy. After a period up to 60 months, and depending on your predisability earnings, you may continue to qualify for benefits if you are unable to earn more than 60% of your predisability earnings at any occupation for which you are reasonably qualified.

LTD benefits become payable after you are approved for and receive 13 weeks of continuous STD benefits. To qualify for LTD benefits, you must be under the continuous care of an attending physician during the STD period.

If you qualify for STD benefits, return to work, and then, within a 30-day period, you are unable to work as a result of the same or a related total disability, your absence will be processed as a recurrent claim and you will be eligible to receive the balance of your STD benefits. If you continue to be disabled and satisfy the 91-day waiting period, LTD benefits will begin once your LTD is approved.

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

If you do not have access to the Citigroup intranet or the Internet, you can request a copy of the Plan document at no cost to you by speaking with a Benefits Service Center representative. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts for the Benefits Service Center.

Life insurance benefits

Basic Life/AD&D insurance

Citigroup provides Basic Life insurance (through MetLife) and Accidental Death and Dismemberment (AD&D) insurance (through CIGNA) at no cost to you. AD&D pays a benefit if you are dismembered or die as a result of an accidental injury.

The benefit is equal to your total compensation, rounded

up to the nearest $1,000, to a maximum of $200,000. Total compensation is recalculated each year, and the new amount is effective each January 1.

Since Citigroup pays the full cost of your Basic Life insurance, you must pay taxes on the value of the coverage above $50,000. As required by the IRS, this amount, called "imputed income," is shown on your pay statement and Form W-2 Wage and Tax Statement for the year in which coverage was effective. Imputed income is not a deduction but an amount added to your taxable pay based on the amount of Basic Life insurance coverage above $50,000.

If your total compensation is more than $50,000, you may elect to limit your Basic Life insurance to $50,000. You will not be subject to the imputed income, but you also will forego the additional benefit. You will not have the opportunity to enroll in Basic Life equal to your total compensation or to reduce coverage until the next annual enrollment period.

Basic Life accelerated benefits option

The accelerated benefits option (ABO) of your life insurance coverage is available if you become terminally ill due to injury or sickness and are expected to die within six months.

Under the ABO, you may receive up to 50% of your Basic Life amount not to exceed $100,000, less any applicable expense charges. The minimum amount that will be paid is the lesser of 25% of your Basic Life amount or $5,000. The accelerated benefit will be paid in a lump sum unless you or your legal representative selects another payment mode.

To receive an accelerated benefit, MetLife will require the following proof of your terminal illness:

- A completed accelerated benefit claim form, available from MetLife;
- A signed physician's certification that states you are terminally ill; and
- An examination by a physician of MetLife's choice, if requested, at no expense to you.

Accelerated benefits will be paid only once in your lifetime. Upon your death, the Basic Life benefit paid to your beneficiary will be decreased by the amount of the accelerated benefit paid plus any interest and expense charge.

Converting to an individual policy

You can convert your Basic Life/AD&D to an individual policy by contacting MetLife within 31 days after your termination of employment from Citigroup.

Optional GUL/Supplemental AD&D insurance

You can enroll in Optional GUL insurance (provided by MetLife) for yourself from one to 10 times your total compensation up to a maximum coverage amount of $5 million. If your total compensation is not an even multiple of $1,000, your coverage amount will be rounded up to the next $1,000.

If you are enrolling outside your initial eligibility period (31 days from your date of hire), or for an amount greater than three times your compensation or $1.5 million, you must provide evidence of good health and be actively at work before the coverage will be effective. Actively at work means that you are regularly scheduled to work in the office or at home and you are not away from work due to a disability. You must be able to perform all the activities of your job.

Your cost is based on the amount of coverage you elect, your age, and whether you have used tobacco products in the past 12 months.

If your total compensation is reduced, your Optional GUL amount will continue to be based on the higher total compensation unless you call the Benefits Service Center to request that the Optional GUL amount be reduced. Once you reduce coverage, you can increase it only by purchasing additional multiples of your total compensation. You may be asked to provide satisfactory evidence of good health before the increased coverage will become effective.

Once enrolled in Optional GUL, you automatically receive Supplemental AD&D coverage in the same amount as your GUL coverage. Supplemental AD&D coverage is provided by CIGNA.

If you leave Citigroup, you can continue coverage under an individual policy. MetLife will bill you directly at a higher rate than the Citigroup group rate. The rate will become effective in the month following your termination of employment.

Optional GUL accelerated benefits option

The accelerated benefits option (ABO) of your GUL coverage is available if you become terminally ill due to injury or sickness and are expected to die within six months.

Under the ABO, you may receive up to 50% of your GUL insurance amount, not to exceed $250,000, less any charges. The accelerated benefit will be paid in a lump sum unless you or your legal representative selects another payment mode.

To receive an accelerated benefit, MetLife will require the following proof of your terminal illness:

- A completed accelerated benefit claim form available from MetLife;
- A signed physician's certification that states you are terminally ill; and
- An examination by a physician of MetLife's choice, if requested, at no expense to you.

Accelerated benefits will be paid only once in your lifetime. Upon your death, the GUL benefit paid to your beneficiary will be decreased by the amount of the accelerated benefit paid plus any charge.

Accelerated benefits are not payable if:

- You have assigned the death benefit;
- All or a portion of your death benefit is to be paid to your former spouse as part of a divorce agreement;
- You attempt suicide or injure yourself on purpose;
- The amount of your death benefit is less than $15,000; or
- You are required by a government agency to request payment of the accelerated benefit so you can apply for, obtain, or keep a government benefit or entitlement.

Cash Accumulation Fund (CAF)

When you enroll in Optional GUL/Supplemental AD&D coverage, you can participate in the CAF. The CAF allows you to save money that earns a competitive rate of interest on a tax-deferred basis. Contributions are deducted from your pay each pay period. The minimum contribution is $10 a month or $120 a year.

The IRS determines the annual maximum you can contribute based on your Optional GUL coverage amount, your age, and other factors. You will see your minimum and maximum contributions on the Citigroup Benefits Web Site and on your Personal Enrollment Worksheet.

The maximum contribution amounts listed on your Personal Enrollment Worksheet and the Web site are an estimate of the annual contributions that could be made to Optional GUL, including the CAF, within the Internal Revenue Code limits for life insurance for participants within your age range and coverage level.

If your contributions for Optional GUL, including the CAF, exceed the actual limits of the coverage for which you are enrolled, MetLife will notify you about a refund. For the actual amount that applies to you under the applicable tax laws, you may call MetLife at 1-800-523-2894. To contribute an amount in excess of that shown on your Personal Enrollment Worksheet, you can mail a check directly to MetLife.

You can change the amount of your CAF contribution at any time. **Note:** A decrease in coverage amounts could affect your CAF contributions.

You will not pay taxes on the interest while it remains in the CAF. The interest is taxable only when you withdraw more than the total you have paid up to that point for Optional GUL coverage (your premiums) plus your CAF contributions.

For more information about the CAF, call MetLife at 1-800-523-2894.

Coverage for your spouse/domestic partner

You can enroll in Optional GUL insurance coverage for your spouse/domestic partner in increments of $10,000 to a maximum of $100,000. You do not need to buy Optional GUL/Supplemental AD&D for yourself to elect coverage for your spouse/domestic partner.

Within 31 days of your initial eligibility, you can enroll for up to $30,000 of spouse/domestic partner coverage without your spouse/domestic partner providing evidence of good health.

If you enroll at any other time, your spouse/domestic partner must provide evidence of good health for any amount of spouse/domestic partner coverage.

The cost is based on the amount of your spouse's/domestic partner's coverage, his or her age, and whether he/she has used tobacco products in the past 12 months.

You also can open a Cash Accumulation Fund in your spouse's/domestic partner's name.

Once enrolled in Optional GUL (provided by MetLife), your spouse/domestic partner automatically will receive Supplemental AD&D coverage in the same amount as his/her Optional GUL coverage. AD&D is provided by CIGNA.

If you leave Citigroup or terminate your marriage or domestic partner relationship, your spouse/domestic partner can continue coverage under an individual policy. MetLife will bill him or her directly at a higher rate than the Citigroup group rate. The rate will become effective in the month following your termination of employment, divorce, or termination of your domestic partnership.

Coverage for your children

If you have enrolled in Optional GUL/Supplemental AD&D coverage for yourself or your spouse/domestic partner, you can enroll for life/AD&D insurance from $5,000 to $20,000, in $5,000 increments, for your eligible dependent children. *A child must be at least 14 days old to be covered.*

When you enroll in child life coverage, all your eligible children are covered. If you are enrolled in child coverage and have or adopt another child, you must report your child's birth or adoption to the Benefits Service Center so the new child can be covered.

Once enrolled for child life (provided by MetLife), your child automatically receives Supplemental AD&D coverage in the same amount as the child life coverage. AD&D coverage is provided by CIGNA.

Business Travel Accident insurance

Business Travel Accident (BTA) provides accident insurance only and pays benefits for bodily injury and/or death; it does not provide coverage for sickness. Coverage is provided by AIG.

All regular full-time and part-time employees have BTA coverage equal to five times total compensation to a maximum benefit of $2 million. Your spouse/domestic partner and/or dependent children are considered covered persons and have BTA coverage while accompanying you on a business or relocation trip paid for by the Company.

- An eligible spouse/domestic partner has a coverage amount of $150,000.
- Each eligible dependent child has a coverage amount of $25,000.

BTA benefits are paid in the event of death, dismemberment, paralysis, and loss of speech and/or hearing while traveling on an approved trip made on behalf of the Company. Certain covered losses are subject to limitations. Depending on the nature of your loss, you may be entitled to recover less than your total coverage amount. If you suffer more than one loss in an accident, you will be paid only for the loss that provides the largest benefit. Each aircraft accident is subject to a maximum benefit limit, regardless of the number of covered persons who incur a loss or the severity of the loss.

Your BTA beneficiary, the person or persons designated to receive any benefit payable at your death, is the same beneficiary of your Basic Life insurance.

Converting to an individual policy

You can convert your BTA coverage to an individual AD&D policy within 31 days of your termination of employment from Citigroup if you are under age 70 and you submit an application and appropriate premium. The coverage under the individual policy must be for at least $25,000 and cannot be more than the greater of the amount of your employee coverage or $500,000.

Long-Term Care (LTC) insurance

You can purchase LTC coverage for yourself and eligible members of your family at any time.

To be eligible, you and your family members must reside in the United States (50 states and the District of Columbia and Puerto Rico). Eligible family members may apply for the benefit even if you do not. Eligible family members are:

- Your spouse or domestic partner[14];
- Your parents or your parents-in-law;
- Your adult children or the adult children of your spouse or domestic partner[14]; and
- Spouses of your adult children.

Family members must be 18 or older.

If you are a new hire and enroll during your initial benefits enrollment: You will not have to provide evidence of good health.

If you enroll at any other time: You must provide evidence of good health acceptable to John Hancock.

In either case, coverage will be effective the first of the month after your application is approved, as long as you are actively at work on that date. If you are not at work on the date your coverage would otherwise have become effective, your coverage will become effective the first of the month following your return to work as an active employee.

[14]Coverage is not available to domestic partners residing in LA and VA or to same-sex domestic partners residing in ID.

Premiums for yourself and spouse/domestic partner will be deducted from your pay. You will pay for coverage with after-tax dollars; the cost is based on your age when you become insured.

Your family members can complete an application form and must provide evidence of good health acceptable to John Hancock before coverage will be approved. Coverage will be effective the first of the month after their application is approved, provided they are not disabled on that date.

Family members, other than spouses/domestic partners, will be billed directly. If they are disabled on that date, coverage will take effect the first of the month after their disability ends, provided they are still eligible.

For information on the cost of LTC coverage for yourself or other eligible family members, you can request an enrollment kit or obtain a personal rate quote by visiting the John Hancock Web site at **http://groupltc.jhancock.com**. The user name is "groupltc," and the password is "mybenefit." You also can call John Hancock at 1-800-222-6814.

Family members who visit the Web site or call to obtain information should provide your name as the Citigroup employee.

Enrolling in LTC coverage

Enrolling in LTC coverage will be different from enrolling in other Citigroup health and welfare benefits. You will enroll in LTC coverage directly with John Hancock by submitting the appropriate form to John Hancock or clicking on a link from the Citigroup Benefits Web Site. Eligible family members must complete an application.

When LTC benefits are payable

In general, LTC benefits become payable if a licensed health care practitioner certifies that:

- You require substantial assistance from another person to perform at least two "activities of daily living" due to a loss of functional capacity that is expected to continue for at least 90 days, or
- You need substantial supervision due to a "cognitive impairment" and you complete the qualification period.

Activities of daily living are bathing, maintaining continence, dressing, toileting, eating, and transferring into or out of a bed or chair. Cognitive impairment is a deterioration or loss of intellectual capacity comparable to Alzheimer's disease and similar forms of irreversible dementia.

You become eligible for benefits only upon confirmation of your qualifying condition by a care coordinator from John Hancock.

With limited exceptions, LTC benefits generally will not be payable until the end of a 90-day "qualification period" that begins from the date John Hancock certifies that you meet the benefit eligibility requirements. The qualification period needs to be met only once as long as you remain continuously insured.

Your qualifying condition must continue through this period, but you do not have to actually incur expenses, receive long-term care services, or be hospitalized during this period. LTC benefits are payable for covered charges you incur after the qualification period is met as long as you remain eligible for benefits.

Benefits and services covered

LTC benefits will cover actual charges incurred for qualifying services, which generally include nursing home care, alternate-care facility care, community-based professional care, informal care, and stay-at-home services. Depending on the type of service, benefits are subject to a maximum, which will vary based on the coverage level you choose.

Choosing a level of coverage

From the six options in the table on page 60, you must choose a daily maximum benefit (DMB) from $115 to $405 a day. The DMB is the most the Plan may pay for all covered services received on any day. Each DMB has a corresponding lifetime maximum benefit (LMB), which is the total amount payable for covered LTC services while you are insured for other than the stay-at-home benefit. Informal care is also subject to a calendar-year maximum.

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Nursing home DMB	$115	$175	$230	$290	$345	$405
Alternate care facility DMB[15]	$115	$175	$230	$290	$345	$405
Community-based professional care DMB[16]	$86.25	$131.25	$172.50	$217.50	$258.75	$303.75
Informal care DMB	$28.75	$43.75	$57.50	$72.50	$86.25	$101.25
Informal care calendar year maximum[17]	$862.50	$1,312.50	$1,725	$2,175	$2,587.50	$3,307.50
Lifetime maximum benefit (excluding stay-at-home benefit)	$209,875	$319,375	$419,750	$529,250	$629,625	$739,125
Stay-at-home lifetime maximum	$3,450	$5,250	$6,900	$8,700	$10,350	$12,150

[15]If you are a KS resident, this benefit varies slightly. Call John Hancock at 1-800-222-6814 for details.

[16]This includes adult day care (WA state refers to this as adult day health care) and the following services provided in your home: home health care, hospice care, and homemaker services provided by a person certified or employed through a licensed home health care agency.

[17]The total benefits payable for all informal care received in any calendar year is 30 times the informal care DMB.

Stay-at-home benefit

The stay-at-home benefit can be used to pay for expenses for a care planning visit, home modifications, emergency medical response system, durable medical equipment, caregiver training, home safety check, and provider-care check.

The stay-at-home benefit amount is the most the Plan will pay for the cost of all covered services received while you are insured and will not exceed 30 times the DMB. This lifetime maximum for the stay-at-home benefit is separate and in addition to the lifetime maximum for your other LTC benefits.

It is available during the qualification period; it is not available if coverage is in reduced paid-up status and cannot be restored under the restoration-of-benefits provision. The stay-at-home benefit amount will be recalculated whenever your DMB changes as a result of inflation or benefit increases or decreases, provided you have not exhausted this benefit.

Any benefits paid will be subtracted from the recalculated amount. Except for the care-planning visit, you must be residing in your home to be eligible. The maximum amount payable for caregiver training will not exceed five times your DMB.

Choosing a non-forfeiture LTC benefit or a contingent non-forfeiture LTC benefit

For an additional cost, you also can choose to include a non-forfeiture benefit (reduced lifetime maximum paid-up benefit) in your coverage at enrollment. If you do not elect this option, the contingent non-forfeiture benefit will be included in your coverage at no additional cost.

If you have been continuously insured under the Plan for at least three years, the non-forfeiture benefit (reduced lifetime maximum paid-up benefit) will allow you to stop making premium payments for any reason and retain a reduced level of coverage.

If you exercise this benefit, you will keep your full DMB amount, but the LMB will be reduced. Your reduced LMB will equal the greater of 30 times your DMB or the sum of premiums paid. If you exercise this benefit after a minimum of 10 years of continuous coverage, the reduced LMB would equal the greater of 90 times the DMB or the sum of premiums paid.

The contingent non-forfeiture benefit can be exercised only in the event of a substantial premium increase. The contingent

non-forfeiture benefit allows you to stop paying premiums and keep a reduced level of coverage.

If you exercise this benefit, you will keep your full DMB amount, but the LMB will be reduced. Your reduced LMB will equal the greater of the total amount of premiums paid for your insurance since your coverage was issued or 30 times the DMB. A substantial premium increase would range from 10% at issue-age 90 or older to 200% at issue-age 29 or younger as detailed in the certificate that you will receive if you are approved for coverage.

Choosing inflation protection: ABI or future purchase option

You also have the choice of including the automatic benefit increase (ABI) inflation protection provision at enrollment for an additional cost. If you do not elect this option, the future purchase option provision will be included in your coverage.

Under the ABI option, increases to your benefit amounts occur automatically each year. Each January 1, the DMB amount will be increased at an annual rate of 5% compounded. The LMB will be increased in proportion to the increase in the nursing home DMB. If your insurance becomes effective January 1, no increase will apply on your effective date of coverage.

The benefit increase will continue to be made annually regardless of your age or whether you have met the benefit eligibility requirements under the policy. However, no future increases in benefit amount will apply if you stop paying premiums and continue coverage in effect on a reduced paid-up basis under the non-forfeiture benefit.

Under the future purchase option, you will be offered additional amounts of coverage every three years to keep up with inflation. The amount of each adjustment will reflect an increase to the DMB of at least 5% compounded annually for the applicable period.

The premium rates for the inflation increase will be based on your issue age on the effective date of the increase and will include an additional charge to account for the added risk associated with accepting these offers.

The LMB will be increased in proportion to the increase in the nursing home DMB. An inflation adjustment will not be available if you are issue-age 85 or older or if you have met the benefit eligibility requirements under the policy in the six months prior to the increase effective date or if your coverage is in reduced paid-up status. (If you are a resident of CT, DE, IN, or KS, this provision varies slightly. Call John Hancock at 1-800-222-6814 for details.)

Visit the John Hancock Web site at **http://groupltc.jhancock.com** (the user name is "groupltc," and the password is "mybenefit") for an online tool that can help you determine which inflation protection provision may suit your needs.

Additional features

Return of premium at death benefit

A return of premium at death benefit is included in your coverage. This benefit will pay to your estate a portion of the premiums you paid, less any benefits paid or payable should you die prior to age 75 while covered under the Plan. The portion of the premium is based on your age at the time of death as shown below. Premiums are not returned if you are age 75 or older or if coverage is in reduced paid-up status.

Age	Percentage of premium
65 or younger	100%
66	90%
67	80%
68	70%
69	60%
70	50%
71	40%
72	30%
73	20%
74	10%
75 or older	0%

Waiver of premium

Once you complete the qualification period, and provided you meet the benefit eligibility requirements under the policy on that date, your premium payments will be waived. The waiver will continue as long as you remain eligible for benefits.

Portability

If you retire or leave Citigroup, you may continue coverage at group rates. You will pay premiums directly to John Hancock.

Bed reservation benefit

The Plan will continue to pay nursing home or alternate-care facility benefits for up to 60 days per calendar year if you leave the facility on a short-term basis while receiving Plan benefits.

Alternate plan of care

An alternate plan of care can be established by mutual agreement among you, a licensed health care practitioner, and John Hancock if the John Hancock care coordinator identifies alternatives to the current plan that are both appropriate for you and cost-effective. The alternate plan of care may provide benefits for services or supplies not otherwise covered by the Plan. Any benefits paid under an alternate plan of care will reduce the LMB.

Restoration of benefits

The restoration of benefits feature allows you to restore your LMB if you provide proof that you:

- Have not met the benefit eligibility criteria during the 24-month period up to and immediately preceding the date you request to restore your LMB;
- Have not exhausted your LMB; and
- Have been continuously insured on a premium-paying basis for at least 24 months just prior to your request.

Restoration does not apply if coverage is in reduced paid-up status. Your stay-at-home benefit lifetime maximum will not be restored.

Coordination of benefits and exclusions

To prevent duplication of benefits, the Plan contains a coordination of benefits provision that may reduce or eliminate the benefits otherwise payable under the Plan when benefits are payable under another plan. (This provision does not apply to residents of CT.)

John Hancock will not pay benefits for charges incurred by the insured in certain circumstances, such as intentional self-inflicted injury; charges that are reimbursable or would be reimbursable under Medicare except for coinsurance, copayment, or deductible provisions under Medicare; or for treatment specifically provided for detoxification or rehabilitation for alcohol or drug addiction.

These exclusions may not apply in all states and may vary depending on the state in which you live. The Certificate of Insurance you will receive once you are approved for coverage will outline the exclusions for your state. If you move to another state, the state guidelines where the Certificate of Insurance was originally delivered to you will apply.

LTC providers must meet the qualifications specified in the Certificate of Insurance, and services and supplies must be provided in accordance with a plan of care prescribed by a licensed health care practitioner.

Tax implications

The Citigroup LTC Insurance Plan is funded through a group policy intended to be a qualified LTC insurance contract under Section 7702B(b) of the Code.

Subject to specified dollar limits that vary depending on your age, you may be able to include your premium in your itemized deductions on your federal income tax return if your total medical expenses, including the allowable portion of your premium, exceed 7.5% of adjusted gross income. The allowable dollar limits are reviewed each year by the U.S. Treasury and adjusted accordingly. The benefits you receive under the policy generally are not considered taxable income. Consult your tax adviser if you have any questions or need details.

For more information

To obtain details of the coverage available and its cost, contact John Hancock either by:

- Calling the John Hancock Long-Term Care Insurance Department at 1-800-222-6814, or
- Visiting the John Hancock Web site at **http://groupltc.jhancock.com**. The user name is "groupltc," and the password is "mybenefit."

Your family members who call or visit the Web site should provide your name as the Citigroup employee.

Spending accounts

Spending accounts allow you to pay for certain health care, dependent care, and transportation expenses with pretax contributions from your pay.

Is the Limited Purpose Health Care Spending Account for you?

The Limited Purpose Health Care Spending Account (LPSA) is for employees who enroll in the High Deductible Health Plan—Basic or Premier *and* establish[18] a Health Savings Account. Employees who enroll in an HDHP or establish a Health Savings Account are not eligible to enroll in a Health Care Spending Account.

To have continued coverage in the Health Care Spending Account, the Limited Purpose Health Care Spending Account and/or Dependent Care Spending Account from year to year, you *must* enroll each year. *Your election does not roll over from year to year.*

To have coverage in TRIP: Coverage is effective the first of the month after you enroll if administratively possible; otherwise, your coverage will begin the first of the following month. Your coverage continues indefinitely until you change it.

- Health Care Spending Account (HCSA): Use the HCSA to pay for certain health care expenses for yourself and your qualified dependents that are not paid by any medical, dental, or vision plan. You are eligible to enroll in the HCSA if you are not enrolled in a High Deductible Health Plan. If you enroll in a High Deductible Health Plan, you cannot enroll in the HCSA.
- Limited Purpose Health Care Spending Account (LPSA): Use the LPSA if you are enrolled in a High Deductible Health Plan and establish a Health Savings Account (HSA) to pay for dental, vision, and/or preventive care medical expenses for yourself and your qualified dependents that are not paid by any medical, dental, or vision plan or your HSA.
- Dependent Care Spending Account (DCSA): Use the DCSA to pay for certain dependent day care expenses so that you (and your spouse, if you are married) can work or look for work. **Reminder:** This account cannot be used to pay health care expenses for your dependents.
- Transportation Reimbursement Incentive Program (TRIP): Use the TRIP to pay for the cost of public transportation and parking so you can commute to work. **Note:** TRIP is not part of annual enrollment. You can enroll at any time; coverage will begin the first of the month after you enroll, if administratively possible; otherwise, your coverage will begin the first of the following month.

Once enrolled, you can obtain information about your own account online by:

- Visiting the Citigroup Spending Account Web site through Total Comp at Citi at **www.totalcomponline.com** or
- Going directly to **www.flexdirect.adp.com/citigroup**. You will need your user name and password.

Contributions from your pay to the spending accounts will be available to you as follows:

If you enroll during the annual enrollment period:

- **HCSA and LPSA:** The entire amount of your 2008 contributions will be posted to your account January 1.
- **DCSA and TRIP:** Contributions will be posted to your account each pay period. You can be reimbursed up to the amount available in your account. The balance of any claim will be paid as additional contributions are deposited into your account.

If you enroll as a new hire:

- **HCSA and LPSA:** The entire amount of your 2008 contributions will be posted to your account within 31 days after you enroll.
- **DCSA and TRIP:** Contributions will be posted to your account each pay period. You can be reimbursed up to the amount available in your account. The balance of any claim will be paid as additional contributions are deposited into your account.

18"Establish" an account means you apply for an account and are approved because you meet certain credit and "know your customer" requirements. If your account is not established, you cannot receive the employer contribution.

SPENDING ACCOUNTS AT A GLANCE				
	Health Care Spending Account (HCSA)	**Limited Purpose Health Care Spending Account (LPSA)**	**Dependent Care Spending Account (DCSA)**	**Transportation Reimbursement Incentive Program (TRIP)[19]**
Why enroll?	To reduce your taxes by paying for eligible expenses with pretax dollars			
What is reimbursed	IRS-qualified health care expenses for you and your family that are not paid by any medical, dental, or vision plan.	IRS-qualified vision care, dental, and preventive care medical expenses for you and your family that are not paid by any medical, dental, or vision plan or your HSA.	IRS-qualified dependent day care expenses for your qualified dependents so that you (and your spouse, if you are married) can work or look for work.	Eligible transit and parking expenses.
How much you can contribute	From $120 to $15,000 per year per family; money is deducted in equal amounts each pay period.	From $120 to $5,000 per year per family; money is deducted in equal amounts each pay period.	From $120 to $5,000 per year per family; money is deducted in equal amounts each pay period.	**Transit:** From $10 to $110[20] per month **Parking:** From $10 to $215[20] per month
Forfeiture provisions	You will forfeit any money you contribute each calendar year but you do not use by the end of the calendar year.	You will forfeit any money you contribute each calendar year but you do not use by the end of the calendar year.	You will forfeit any money you contribute each calendar year but you do not use by the end of the calendar year.	If your account remains inactive for 12 consecutive months, you will forfeit any remaining contributions.
Changing your election	You can change your election as the result of a qualified status change; you cannot enroll in December for the current year.	You can change your election as the result of a qualified status change; you cannot enroll in December for the current year.	You can change your election as the result of a qualified status change; you cannot enroll in December for the current year.	You can enroll or change your election at any time; enrollment/changes are effective the first of the following month if administratively possible; otherwise, your coverage will begin the first of the following month.
Filing a claim	You must file claims for 2008 expenses so they are postmarked no later than June 30, 2009.	You must file claims for 2008 expenses so they are postmarked no later than June 30, 2009.	You must file claims for 2008 expenses so they are postmarked no later than June 30, 2009.	You must file claims for expenses within 12 months of the date on which the expense was incurred. Claims must be filed within 12 months of your termination-of-employment date.

[19] TRIP is not part of annual enrollment. You can enroll in TRIP at any time, and your enrollment and coverage will be effective the first of the following month if administratively possible; otherwise, your coverage will begin the first of the following month.

[20] These are the 2007 limits; 2008 limits were not available at the time this book was printed.

Health Care Spending Account (HCSA)

You can contribute between $120 and $15,000 a year on a pretax basis to reimburse yourself for eligible out-of-pocket health care expenses. Contributions are taken each pay period before federal and, in most locations, state and local taxes are withheld.

You must actively elect to participate during each annual enrollment or within 31 days of a qualified change in status. You may enroll in the HCSA if you are not enrolled in a High Deductible Health Plan.

You can be reimbursed for expenses incurred only during the time you are enrolled. You can enroll as a new employee, during the annual enrollment period, or within 31 days of a qualified change in status. However, you cannot enroll in December for the current calendar year.

HCSA claims must be filed by June 30 following the year in which the expense was incurred. You may change or stop your contributions as a result of a qualified change in status.

The amount of your payroll contributions will appear on your Form W-2 Wage and Tax Statement for the year in which you were enrolled.

In accordance with IRS guidelines, the Plan Administrator, in its discretion, may reduce the rate of contribution by certain participants to ensure that the HCSA is not deemed to discriminate in favor of highly compensated employees.

Health Care Spending Account Reimbursement Card

When you enroll in the HCSA, you automatically will receive a Health Care Spending Account Reimbursement Card to use at any provider that accepts MasterCard as a form of payment. **Note:** The Health Care Spending Account Reimbursement Card cannot be used with any of the other spending accounts.

Each time you "swipe" your reimbursement card be sure to save your receipt in case you are required at a later date to substantiate that your expense was eligible for reimbursement under the Plan. Unsubstantiated expenses may be considered taxable income.

HEALTH CARE SPENDING ACCOUNT RULES AND FEATURES	
General rules about expenses	Most health care expenses that the Internal Revenue Service (IRS) considers as deductible on your income tax return are eligible for reimbursement from the HCSA, provided the expenses are not reimbursed from any other source. You can be reimbursed for your expenses or those incurred by anyone you can claim as a dependent on your tax return, regardless of whether you or your dependent is covered under any Citigroup medical, dental, or vision Plan. Estimate expenses conservatively. You cannot receive a refund for contributions intended to reimburse yourself for a surgery or procedure that is later canceled.
Examples of eligible health care expenses	• Your share of expenses that are not paid by your medical, dental, and/or vision plan, such as deductibles, coinsurance, and copayments; • Other charges that exceed what your medical, dental, and/or vision plan will pay, such as charges above reasonable and customary amounts or other plan limits; • Vision expenses, such as exams, prescription eyeglasses and sunglasses, contact lenses, and laser surgery, that are not covered by your medical or vision plan; • Hearing care expenses, such as exams, hearing aids, and hearing aid batteries, that are not covered by your medical plan; • Certain equipment and training for disabled individuals; • Childbirth classes, such as Lamaze, for up to two people; • Chiropractic care that is not covered by your medical plan; • Physical therapy, psychiatric therapy, and counseling that are not covered by your medical plan; • Cholesterol tests, vaccines, and immunizations that are not covered by your medical plan; • Prescription contraceptives and infertility treatments that are not covered by your medical plan; • Smoking cessation programs; • Certain over-the-counter drugs for which you have a receipt; • Medicines prescribed by a doctor that your medical plan or prescription drug program does not cover; and • Transportation necessary to obtain certain health care services.
Ineligible health care expenses	• Expenses for which you have been reimbursed from another source, such as Citigroup's or another employer's medical, dental, and/or vision plan, Medicare, or Medicaid; • Elective cosmetic surgery or cosmetic dental work; • Vitamins or minerals taken for general health purposes, including those recommended by your doctor; • Maternity clothes or diaper services; • Nursing services to care for a healthy newborn; • Household help or custodial care at home or in an institution, even if recommended by your doctor; • Health club fees, exercise classes, or weight-loss programs for general health purposes, even if recommended by your doctor; • Cosmetics, toiletries, or toothpaste; • Amounts you pay for medical and dental insurance premiums; and • Long-term-care services including insurance premiums for long-term care insurance.
For more information	For more information about eligible expenses, see *IRS Publication 502: Medical and Dental Expenses* at **www.irs.gov** or contact your tax adviser. You also can call the IRS at 1-800-829-1040. **Note:** The IRS publication is a guideline for use in preparing tax returns; it is not a description of the Citigroup Plan.

Automatic claims submission

Automatic claims submission allows you to be reimbursed for many eligible expenses without having to file a claim. It is available only to those participants who do not use their Health Care Spending Account Reimbursement Card. *Once you use the reimbursement card, the automatic claims submission feature is turned off.*

If you enroll in the HCSA, claims will be submitted automatically for expenses you have incurred under the following Plans:

- ChoicePlan 100 or 500;
- Out-of-Area Health Plan;
- Hawaii Health Plan;
- All Aetna, Empire BlueCross BlueShield, CIGNA, and UHC HMOs/EPOs;
- Citigroup Prescription Drug Program;
- MetLife PDP; and
- Delta Dental.

After you pay a copayment or coinsurance or have eligible expenses applied toward a deductible, the amount of your payment will be sent electronically to your HCSA. If you have not used your Health Care Spending Account Reimbursement Card to pay for an eligible HCSA expense, your HCSA balance automatically will be debited for the amount of these expenses, and you will be reimbursed from your account.

Once you use your reimbursement card for an eligible HCSA purchase, claims submitted automatically will be used only to validate purchases made with the reimbursement card. You will then need to file a claim for any expenses for which you do not use your reimbursement card.

Filing a claim

See "How to file a claim" on page 20.

Generally, you will have until June 30 following the year in which you incur the eligible expense to file a claim for reimbursement. If mailing your claims, your envelope must be postmarked no later than June 30.

You can check the status of your claims at any time by accessing account information at **www.flexdirect.adp.com/citigroup**.

Reimbursements

At any time, you may be reimbursed for eligible expenses up to the total amount you elected to contribute for the year. If you increase your contributions during the year because of a qualified change in status, you may be reimbursed from the increased amount only for expenses incurred *after* the date of the qualified change in status.

Using HCSA after your termination of employment

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

Effect on other benefits

Even though you reduce your taxable income by using the spending account(s), you are not reducing your pay for determining any Citigroup pay-related benefits, such as disability, life insurance, or pension. Benefits under these Plans are based on your total compensation *before* your spending account contributions are deducted.

Effect on taxes

You receive a tax advantage by paying for eligible health care expenses through your HCSA *or* by claiming a federal income tax deduction for eligible expenses that exceed 7.5% of your adjusted gross income. However, you cannot claim a deduction for an expense on your tax return if you have been reimbursed for the same expense through the HCSA.

Social Security

Your spending account contributions will reduce the amount of your Social Security taxes. If your taxable pay is below the Social Security taxable wage base, your future Social Security retirement benefits also may be reduced.

For more information

Call the Citigroup Spending Account Information Line at 1-800-378-1823. Automated information is available 24 hours a day, and you can speak with a representative from 8 a.m. to 8 p.m. Eastern time on weekdays, excluding holidays.

You also can visit the Social Security Administration Web site at **www.socialsecurity.gov** for information on the taxable wage base for a given year and Social Security plans and provisions.

Limited Purpose Health Care Spending Account (LPSA)

You can contribute between $120 and $5,000 a year on a pretax basis to reimburse yourself for eligible out-of-pocket vision care, dental, and preventive care medical expenses. Contributions are taken each pay period before federal and, in most locations, state and local taxes are withheld.

You must be enrolled in the Citigroup High Deductible Health Plan–Basic or Premier to enroll in the LPSA. You can enroll as a new employee, during the annual enrollment period, or within 31 days of a qualified change in status. However, you cannot enroll in December for the current calendar year. You may change or stop your contributions as a result of a qualified change in status.

To participate on a continuing basis you must actively enroll. Your enrollment does not carry over from year to year.

You can be reimbursed for expenses incurred only during the time you are enrolled.

The amount of your payroll contributions will appear on your Form W-2 Wage and Tax Statement for the year in which you were enrolled.

In accordance with IRS guidelines, the Plan Administrator, in its discretion, may reduce the rate of contribution by certain participants to ensure that the LPSA is not deemed to discriminate in favor of highly compensated employees.

LIMITED PURPOSE HEALTH CARE SPENDING ACCOUNT RULES AND FEATURES	
General rules about expenses	Since the LPSA is intended to be used in conjunction with a High Deductible Health Plan and a Health Savings Account, eligible expenses are limited to those for vision care, dental, and preventive care medical expenses. Other medical care expenses should be paid from your HSA.
Examples of eligible health care expenses	• Your share of expenses that are not paid by your dental and/or vision plan, such as deductibles, coinsurance, and copayments and charges that exceed reasonable and customary amounts or other plan limits; • Vision expenses, such as exams, prescription eyeglasses and sunglasses, contact lenses, and laser surgery, that are not covered by your medical or vision plan; • Preventive care medical expenses as identified by the IRS, including: - Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals; - Routine prenatal and well-child care; - Child and adult immunizations; - Tobacco cessation programs; - Obesity weight loss programs; and - Screening services including routine cancer, heart disease, and infectious disease screening.
Ineligible health care expenses	• Expenses for which you have been reimbursed from another source, such as Citigroup's or another employer's medical, dental, and/or vision plan, Medicare, Medicaid, or your Health Savings Account; • Non-preventive-care medical expenses; • Elective cosmetic surgery or cosmetic dental work; • Vitamins or minerals taken for general health purposes, including those recommended by your doctor; • Maternity clothes or diaper services; • Nursing services to care for a healthy newborn; • Household help or custodial care at home or in an institution, even if recommended by your doctor; • Health club fees, exercise classes, or weight-loss programs for general health purposes, even if recommended by your doctor; • Cosmetics, toiletries, or toothpaste; • Amounts you pay for medical and dental insurance premiums; and • Long-term-care services including insurance premiums for long-term care insurance.
For more information	For more information about eligible expenses, see *IRS Publication 502: Medical and Dental Expenses* at **www.irs.gov** or contact your tax adviser. You also can call the IRS at 1-800-829-1040. **Note:** The IRS publication is a guideline for use in preparing tax returns; it is not a description of the Citigroup Plan.

Paying for your expenses out of pocket

You can submit claims for certain expenses under the following plans:

- High Deductible Health Plan—Basic and Premier;
- Dental;
- Vision; and
- Certain preventive prescription drugs under the Citigroup Prescription Drug Program.

However, you must pay for expenses out of pocket and submit eligible expenses for reimbursement using the LPSA Claim Form (Form 315).

Filing a claim

See "How to file a claim" on page 20.

Generally, you will have until June 30 following the year in which you incur the eligible expense to file a claim for reimbursement. If mailing your claims, your envelope must be postmarked no later than June 30.

You can check the status of your claims at any time by accessing account information at **www.flexdirect.adp.com/citigroup**.

Reimbursements

At any time, you may be reimbursed for eligible expenses up to the total amount you elected to contribute for the year. If you increase your contributions during the year because of a qualified change in status, you may be reimbursed from the increased amount only for expenses incurred *after* the date of the qualified change in status.

Using LPSA after your termination of employment

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

Effect on other benefits

Even though you reduce your taxable income by using the spending account(s), you are not reducing your pay for determining any Citigroup pay-related benefits, such as disability, life insurance, or pension. Benefits under these Plans are based on your total compensation *before* your spending account contributions are deducted.

Effect on taxes

You receive a tax advantage by paying for eligible health care expenses through your LPSA or by claiming a federal income tax deduction for eligible expenses that exceed 7.5% of your adjusted gross income. However, you cannot claim a deduction for an expense on your tax return if you have been reimbursed for the same expense through the LPSA.

Social Security

Your spending account contributions will reduce the amount of your Social Security taxes. If your taxable pay is below the Social Security taxable wage base, your future Social Security retirement benefits also may be reduced.

For more information

Call the Citigroup Spending Account Information Line at 1-800-378-1823. Automated information is available 24 hours a day, and you can speak with a representative from 8 a.m. to 8 p.m. Eastern time on weekdays, excluding holidays.

You also can visit the Social Security Administration Web site at **www.socialsecurity.gov** for information on the taxable wage base for a given year and Social Security plans and provisions.

Dependent Care Spending Account (DCSA)

You can contribute between $120 and $5,000 a year on a pretax basis to reimburse yourself for day care expenses for qualified dependents so that you (and your spouse, if you are married) can work or look for work. See the definition of qualified dependents and a list of eligible expenses on page 69.

You can be reimbursed for expenses incurred only during the time you are enrolled. You can enroll as a new employee, during the annual enrollment period, or within 31 days of a qualified change in status. However, you cannot enroll in December for the current calendar year.

The amount of your payroll contributions will appear on your Form W-2 Wage and Tax Statement for the year in which you were enrolled.

In accordance with IRS guidelines:

- The Plan Administrator, in its discretion, may reduce the rate of contribution by certain participants during the year to ensure that the DCSA is not deemed to discriminate in favor of highly compensated employees.

- Eligible expenses submitted via paper claim with future dates of service will not be reimbursed prior to the last day of the billing period.

Quick tip: You cannot use the DCSA to reimburse yourself for your dependents' health care expenses; you can use the HCSA/LPSA for that purpose.

Qualifying individuals

According to IRS rules, you may be reimbursed only for expenses incurred in caring for a qualifying individual. Generally, a qualifying individual includes:

- Each of your children under age 13 who must share your residence for more than half the year and must not provide more than half of his or her own support;
- Your spouse who is physically or mentally unable to care for himself or herself and resides with you for more than half the year; and
- Dependents who are mentally or physically unable to care for themselves, reside with you for more than half the year, and who have gross income of less than the dependency exemption threshold ($3,400 in 2007).

Marital status and your DCSA contribution

If you file a joint tax return: You and your spouse together may contribute up to $5,000 a year before taxes to DCSAs. For example, if your spouse contributes $2,000 to his or her employer's DCSA, you can contribute up to $3,000 to yours. If either you or your spouse earns less than $5,000 annually, the combined amount you and your spouse contribute cannot exceed the lower salary.

If you file separate tax returns: You and your spouse each may contribute up to $2,500 a year before taxes to your respective DCSA.

If your spouse does not work: In general, you cannot use the DCSA if your spouse does not work, unless he or she is a full-time student for at least five months during the calendar year, is looking for work, or is disabled.

To determine the maximum contribution in these cases, your spouse is considered to earn $250 a month if you have one qualified dependent or $500 a month if you have two or more qualified dependents. For Plan purposes, count only the months that your spouse is either in school or disabled.

These limits are subject to change.

DEPENDENT CARE SPENDING ACCOUNT RULES AND FEATURES	
Examples of eligible dependent care expenses	• Care at a licensed nursery school, day camp (including specialty camps), or day care center (the facility must comply with state and local regulations, serve more than six individuals, and receive fees for services); • Services from individuals who provide dependent day care in or outside your home, unless the provider is your spouse, your own child under age 19, or any other dependent (these individuals must provide their Social Security numbers to you); • After-school care for children under age 13; • Household services related to the care of an elderly or disabled adult who lives with you; • Expenses for a care provider for the transportation between your house and the place that provides day care services; • Your portion of FICA and other taxes that you pay for a care provider; and • Any other services that qualify as dependent care under IRS rules.
Examples of ineligible dependent care expenses	• Expenses for food, clothing, or education; • Your expenses for transportation between your house and the place that provides day care services; • Expenses for dependent care when either you or your spouse is not working; • Charges for convalescent or nursing home care for a parent or disabled spouse; • Overnight camp expenses; • Expenses for dependent care that enables you or your spouse to do volunteer work; • Payments made to your spouse, your own child under age 19, or any other dependent; and • Expenses for which you take the federal child care tax credit.
For more information	For more information about eligible dependents and expenses, see *IRS Publication 503: Child and Dependent Care Expenses* at **www.irs.gov** or contact your tax adviser. You also can call the IRS at 1-800-829-1040. **Note:** The IRS publication is a guideline for use in preparing tax returns; it is not a description of the Citigroup Plan.

Filing a claim

See "How to file a claim" on page 20.

Generally, you will have until June 30 following the year in which you incur an eligible expense to file a claim for reimbursement. For example, you will have until June 30, 2009, to file claims for reimbursement of expenses incurred in 2008. (Your envelope must be postmarked no later than June 30, 2009.)

Reimbursements

You cannot be reimbursed for expenses that exceed the amount of your contributions.

If your claim exceeds your current account balance, you will be reimbursed up to your account balance. Any outstanding amount of your claim will be paid to you automatically after the next pay period when new contributions are added to your account until the total amount is paid or the money in your account is depleted.

The maximum you can receive tax-free from your DCSA is reduced by the value of any employer-provided day care you use, whether provided through Citigroup or your spouse's employer.

For example, if you receive a DCSA subsidy of $1,000, then you can receive up to $4,000 tax-free from your DCSA. If you contribute more than $4,000, any amount reimbursed above $4,000 will be included as taxable income on your Form W-2 Wage and Tax Statement for that year.

Effect on other Citigroup benefits

Even though you reduce your taxable income by using the spending account(s), you are not reducing your pay for determining any Citigroup pay-related benefits, such as disability, life insurance, or pension. Benefits under these Plans are based on your compensation before your spending account contributions are deducted.

Effect of DCSA participation on Social Security

Your spending account contributions will reduce the amount of your Social Security taxes. If your taxable pay is below the Social Security taxable wage base, your future Social Security retirement benefits also may be reduced.

Using DCSA after your termination of employment

You cannot use the balance in your account to reimburse yourself for expenses incurred after you terminate employment. However, you will have until the following June 30 to submit your claims.

For more information

Call the Citigroup Spending Information Line at 1-800-378-1823. Automated information is available 24 hours a day, and you can speak with a representative from 8 a.m. to 8 p.m. Eastern time on weekdays, excluding holidays.

DCSA subsidy

If you are eligible *and* you elect the DCSA subsidy during enrollment (either as a new hire or during annual enrollment), Citigroup will pay up to 30% of your DCSA contribution. The percentage will depend on the amount of your total compensation and whether you work part time or full time.

You must enroll for the subsidy during your enrollment period. You cannot receive the subsidy through any other process.

You cannot become eligible for the DCSA subsidy midyear as a result of a qualified change in status, such as a divorce or death of your spouse.

You are eligible for a subsidy if you enroll in the DCSA and on your enrollment date:

- **You are a sole financial provider:** Your total compensation *and* your total annual household income together do not exceed $90,000, or
- **You are in a dual-income household:** Your total compensation does not exceed $45,000 *and* your total annual household income does not exceed $90,000.

The amount of your subsidy will not change during the year even if you change your DCSA contribution amount as a result of a qualified change in status. Your subsidy will be credited to you during the first quarter if you enroll during annual enrollment or within 31 days after you enroll as a new hire or newly eligible employee.

If you are rehired

If you terminate employment with Citigroup and then are rehired by Citigroup in the same year and you re-enroll in the DCSA, you are not eligible to re-enroll in the subsidy since your subsidy was credited during your employment earlier in the same year. (Subsidies are credited during the first quarter if you enroll during annual enrollment or within 31 days after you enroll as a new hire or newly eligible employee.)

Transportation Reimbursement Incentive Program (TRIP)

You can enroll and/or change your TRIP contributions at any time. Enrollments and changes are effective the first of the month after you enroll, if administratively possible; otherwise, your coverage and contributions will begin the first of the following month.

TRIP is a spending account program that allows you to set aside pretax dollars to pay for the cost of qualified public transportation and parking expenses incurred so you can commute to and from work. By enrolling in TRIP, you lower your taxable income and, as a result, pay less in federal and FICA taxes, and, in most locations, state and local taxes.

You can enroll in, increase, or decrease contributions or stop contributing to TRIP at any time.

Spending Account Reimbursement Card no longer offered with TRIP

Effective January 1, 2008, the card can no longer be used for the TRIP Transit Account or the Parking Account. See "Reimbursements" on page 73 for instructions on how to use the balances in your Transit Account and Parking Account.

Are you eligible to enroll in TRIP?

You are eligible to enroll in TRIP if:

- You commute to work by public transportation (bus, subway, train, ferry, or van pool) or you commute to work by car and have out-of-pocket parking expenses.
- You do *not* participate in a Company-sponsored parking or mass transportation program. If you enroll in TRIP and later begin participating in a Company-sponsored parking or mass transportation program, you must change your TRIP contribution amount to "zero."

If your total compensation is*	Your DCSA subsidy will be:	
	For full-time employees	**For part-time employees**
Up to $25,000	30% of your DCSA contribution; maximum subsidy is $1,500	22½% of your DCSA contribution; maximum subsidy is $1,125
$25,001-$35,000	20% of your DCSA contribution	15% of your DCSA contribution
$35,001-$45,000	15% of your DCSA contribution	11¼% of your DCSA contribution
$45,001-$90,000 if you are the sole financial provider of your dependents	15% of your DCSA contribution	11¼% of your DCSA contribution

*And your total household income does not exceed $90,000 at the time you enroll.

EXAMPLES OF ELIGIBLE EXPENSES	
Parking Account	**Transit Account**
• Parking at or near your work location and • Parking at or near a location from which you commute to work by mass transportation, car pool, or other means	• Transportation passes; • Any pass, token, fare card, ticket, or similar item that entitles you to ride public transportation to and from work; • Transportation between work and your residence in a "commuter highway vehicle" that: - Seats six or more adults excluding the driver; - Is used 80% or more (based on mileage) for transporting employees between work and home; and - Includes at least three commuters, excluding the driver, on each trip.
EXAMPLES OF INELIGIBLE EXPENSES	
Parking Account	**Transit Account**
• Non-work-related parking expenses; • Parking at or near your residence; • Parking for which you receive a pretax benefit; • Parking paid for by your employer; • Parking expenses incurred by family members; and • Expenses eligible to be reimbursed from the Transit Account.	• Car pooling and/or van pooling in a vehicle seating fewer than six passengers, excluding the driver; • Taxi fares; • Highway, bridge, or tunnel tolls; • Expenses incurred for business travel (such as traveling from the office to a business or client meeting); • Gas or mileage expenses; • Transit expenses incurred by family members; and • Expenses eligible to be reimbursed from the Parking Account.

TRIP is made up of two accounts:

- **A Transit Account** to reimburse yourself for eligible transit expenses. The Code defines transit expenses as those for bus, subway, train, metro passes, ferry, and van pooling. A van must be a "licensed commuter highway vehicle" with seating capacity of six or more adults, excluding the driver. You can contribute up to $110 a month from your pay in pretax dollars The minimum contribution is $10 a month.
- **A Parking Account** to pay for the cost of parking on or near Citigroup's business premises or near a location from which you commute to work by mass transit, van pool, or car pool. You can contribute up to $215 a month from your pay in pretax dollars. The minimum contribution is $10 a month.

You can enroll to contribute to either or both accounts, depending on the type of commuting expenses you incur. Contributions to one account cannot be used to pay claims filed against the other account.

Once enrolled, you can change your monthly contribution amount or stop participating at any time.

Note: Typically, the IRS will announce annual maximum contributions for the following year after Citigroup's enrollment materials have been printed. Look for maximum contribution amounts at **www.flexdirect.adp.com/citigroup**.

Tax exemptions

TRIP accounts are exempt from all federal income and employment taxes and most state and local taxes. If you live in a state that does not exempt TRIP contributions from state or local tax, you will be taxed on the benefit, and the amount reported as "state wages" on your Form W-2 Wage and Tax Statement for the year of the contribution will be higher than the amount reported for federal wages.

Changing your TRIP contribution amount

You can change your monthly contribution amount at any time; the change will be effective the first of the month after you enroll, if administratively possible; otherwise, your coverage and contributions will begin the first of the following month.

If you forget to make a change ahead of time, for example, before you go on vacation or a business trip, you can reduce your future election amount so you can use unclaimed funds. You also can change your monthly contribution to zero and continue to send in receipts for any balance in your account.

To change your election once enrolled:

- Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts for the Benefits Service Center and then the prompts to change your TRIP election.
- Visit Total Comp at Citi at **www.totalcomponline.com**. From the "quick links" page, click on the link for the Citigroup Benefits Web Site.

Reimbursements

You can be reimbursed by completing and returning a TRIP claim form and any required documentation. Reimbursements are processed each business day. Most reimbursements will be made via direct deposit into a bank account.

You also can visit the Citigroup Spending Account Web Service Center where you can purchase your monthly transit pass or pay your parking provider from your TRIP account. The Web site will allow you to purchase a transit pass that costs more than your pretax contribution by using a personal credit card to pay the difference.

Filing a claim

See "How to file a claim" on page 20.

You can check the status of your claims at any time by accessing account information at **www.flexdirect.adp.com/citigroup**.

Carryovers

Your contributions carry forward from month to month. However, you can make a qualified purchase or be reimbursed only up to the statutory pretax maximum, currently $110 for transit expenses and $215 for parking expenses.

For example, if you enroll to contribute $110 a month to a Transit Account and submit monthly receipts for January 2007 for $120, you will be reimbursed for $110 only. The remainder of the claim ($10) will not be paid.

Your balance at year-end

Claims must be filed within 12 months of the date of service. Unclaimed 2008 contributions will be rolled over into your 2009 account as of January 1, 2009.

Forfeiting your contributions

If your Transit and/or Parking Account is inactive for 12 consecutive months (no contributions made or claims filed), you will forfeit any remaining contributions.

If you terminate employment

If you terminate employment with Citigroup, your payroll deductions will stop and your account will be closed as of your termination or transfer date. You will have 12 months from the date of your termination of employment to submit claims incurred through that date. You will forfeit any unclaimed amounts.

For more information

Call the Citigroup Spending Account Information Line at 1-800-378-1823. Automated information is available 24 hours a day, and you can speak with a representative from 8 a.m. to 8 p.m. Eastern time on weekdays, excluding holidays.

Citi for you. HEALTH

Section 3

Legal and Administrative Information

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When coverage ends

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

- The date the Plan is terminated;
- The last day for which the necessary contributions are made;
- Midnight of the last day of the month in which your employment is terminated, you retire, you die, or you otherwise cease to be eligible for coverage;
- The date benefits paid on your behalf equal the lifetime maximum benefit under the 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.

Basic Life insurance coverage, Short-Term Disability, Long-Term Disability, and coverage under the Health Care Spending Account and Limited Purpose Health Care Spending Account end on the date your employment is terminated. Optional GUL insurance coverage ends on the last day of the month in which your employment is terminated.

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

- Midnight of the last day of the month in which your coverage ends; an exception is your death in which case coverage will continue for six months;
- The date you elect to end your eligible dependent's coverage;
- The last day for which the necessary contributions are made;
- The date your eligible dependent ceases to be eligible for coverage; coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student (although coverage under some HMOs may end at the end of the month in which the child reaches the maximum age); coverage will remain in effect through the end of the month in which the child gets married or obtains a benefits-eligible job;
- The date the eligible dependent is covered as an employee under the Plan;
- The date the eligible dependent is covered as the dependent of another employee under the Plan;
- The date the eligible dependent enters the armed forces of any country or international organization; or
- The date the dependent is no longer eligible for coverage under a Qualified Medical Child Support Order.

You and your eligible covered dependents may be able to continue coverage under COBRA. See "COBRA" beginning on page 85.

Coverage when you retire

You could be eligible for retiree health care coverage if:

- You are at least age 55 with at least five years of service when you leave Citigroup, or
- Effective for terminations of employment on or after March 1, 2007, you are at least age 50 with at least 10 years of service when you leave Citigroup.

For more information about eligibility for retiree medical coverage, call the Benefits Service Center as instructed on page 4. You must contribute to the cost of retiree medical coverage.

Coverage for surviving dependents

When an active employee dies, the surviving spouse and/or dependent children who were enrolled in active coverage at the time of the employee's death 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/or dental coverage will continue for the covered individuals for six months at no cost. ADP, Citigroup's COBRA administrator, will send your dependents a COBRA notification package. For your dependents to have six months of free medical and/or dental coverage, they must elect COBRA continuation coverage by signing and returning the election form to ADP. See "COBRA" beginning on page 85.

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

Coverage if you become disabled

If you are disabled, you and your eligible dependents may continue medical, dental, and vision care coverage and participate in the Health Care Spending Account/Limited Purpose Health Care Spending Account for up to 13 weeks, as long as you make the active employee contributions.

If you are totally disabled, coverage will continue as follows: **Medical coverage** will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. After that, you may continue medical coverage by making the same contributions as active employees, based on your years of service (as shown below). After 52 weeks of disability, your employment will be terminated.

Citigroup years of service as of the LTD effective date	Medical continuation period after week 52 (the termination of your employment)
Less than 2 years	6 months
2 years to less than 5 years	Equal to your length of service
5 years or more	As long as you are disabled or have not reached the maximum age limit to receive LTD benefits

The disability administrator will medically manage your disability if you are a totally disabled employee who has been denied LTD due to a pre-existing condition, did not enroll in LTD coverage, or who has reached the maximum benefit under the two-year limitation rule.

If the administrator determines that you are totally disabled, medical coverage will continue at the active employee rate for the lesser of a length of time based on your years of service shown above or the length of your disability.

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

Dental coverage will continue for 52 weeks (including the 13-week period of STD) as long as you pay the active employee contributions. You then may continue coverage under COBRA.

Vision care coverage will continue for the 13-week period of STD as long as you pay the active employee contributions. You may then continue coverage through Davis Vision.

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

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

Dependent Care Spending Account (DCSA) participation ends on your first day of STD. When you return to work from your approved disability, you can re-enroll. You can incur expenses through the end of the calendar year and will have until June 30 of the following calendar year to submit claims. You will not be reimbursed for any claims incurred while your coverage was terminated. With the exception of military leave, you cannot continue DCSA during a leave of absence.

Basic Life/Accidental Death and Dismemberment (AD&D) and Optional Group Universal Life (GUL)/AD&D insurance coverage stops after 52 weeks, but you can convert your Basic Life/AD&D coverage to an individual policy and continue your GUL coverage at a higher rate by calling MetLife as instructed on page 6.

Transportation Reimbursement Incentive Program (TRIP) coverage ends on your first day of STD. When you return to work from your approved disability, you can re-enroll. You can be reimbursed for expenses incurred prior to your first day of STD. You must file claims for expenses within 12 months of the date on which the expense was incurred.

Continuing coverage during an FMLA leave

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

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

If you take an unpaid leave of absence that qualifies under the FMLA, you may continue medical, dental, and vision care coverage for yourself and your dependents and continue participating in the HCSA or LPSA as long as you continue to contribute your share of the cost of coverage during the leave. Your monthly contributions during a leave are made on an after-tax basis. You will be billed directly.

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

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

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

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

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

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

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

Coverage if you take a leave of absence

If you are on an approved leave of absence, call the Benefits Service Center, as instructed on page 4, about your rights to continue medical, dental, vision care, and HCSA/LPSA coverage.

Continuing coverage during a military leave

The Citigroup Paid Military Leave of Absence Policy was last updated March 11, 2006. For the latest copy of the policy, visit Citigroup.net. From the home page, use the search function and enter "military leave." Then click on the most current policy.

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

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

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

Call the Benefits Service Center, as instructed on page 4, or your HR representative for more information about a military leave.

Important notices about your Citigroup prescription drug coverage and Medicare

Citigroup has determined that prescription drug coverage provided through the medical options offered by Citigroup, other than through the Basic and Premier High Deductible Health Plans are "creditable" under Medicare and that both High Deductible Health Plans provide "non-creditable" coverage.

This means that if you become eligible for Medicare in the 12 months beginning January 1, 2008, and you are enrolled in a High Deductible Health Plan during that period, and you later elect Medicare Part D prescription drug coverage, you may pay more for it. See more information about Medicare and your choices on the next page.

Creditable Coverage Disclosure Notice

For employees and former employees enrolled in Citigroup medical plans (excluding the Basic and Premier High Deductible Health Plans)

This notice, required by Medicare to be delivered to Medicare-eligible individuals,[21] contains information about your current prescription drug coverage with Citigroup and prescription drug coverage available since January 1, 2006, to people with Medicare.

Keep this notice. If you enroll in Medicare prescription drug coverage, you may be asked to present this notice to prove that you had "creditable coverage" and, therefore, are not required to pay a higher premium than the premiums generally charged by the Medicare Part D plans. You may receive this notice at other times in the future, for example, before the next period in which you can enroll in Medicare prescription drug coverage and/or if your Citigroup 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 ConnectOne 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

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

'Creditable coverage'

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

Understanding the basics

It is up to you to decide what prescription drug coverage option makes the most financial sense for you and your family given your personal situation. If you are considering the option of joining a Medicare prescription drug plan available in your area, you need to carefully evaluate what that plan has to offer vs. the coverage you have through your Citigroup 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 Citigroup medical plan. Your prescription drug coverage under the Citigroup medical plan is considered primary to Medicare, if you are a current employee of Citigroup. This means that your Citigroup plan pays benefits first. Although you can choose to join a Medicare prescription drug plan in addition to your enrollment in a Citigroup medical plan, you should consider how Citigroup plan coverage would affect the benefits you receive under the Medicare prescription drug plan.
- If you drop your Citigroup prescription drug coverage and enroll in a Medicare prescription drug plan, you may not be able to get your Citigroup coverage back at a later date. You should compare your current coverage carefully — including which drugs are covered — with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.
- Your existing Citigroup 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 Citigroup coverage and *not* pay extra if you decide you want to join a Medicare prescription drug plan. People can enroll in a Medicare prescription drug plan when they first become eligible for Medicare. In addition, people with Medicare have the opportunity to enroll in a Medicare prescription drug plan during an annual enrollment period from November 15-December 31 for coverage effective the first day of the following year.

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

- If you drop or lose your coverage with Citigroup and do not immediately enroll in a Medicare prescription drug plan after your current coverage ends, you may pay more to enroll in a Medicare prescription drug plan later. If you lose your prescription drug coverage under the Citigroup medical plan, through no fault of your own, you will be eligible for a 60-day Special Enrollment Period (SEP) to enroll in a Medicare prescription drug plan.
- In addition, if you lose or decide to terminate your coverage under the Citigroup Prescription Drug Program, you will be eligible to enroll in a Medicare prescription drug plan at that time under the SEP as well. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will increase at least 1% for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay for the same coverage. You must pay this higher premium percentage as long as you have Medicare coverage. In addition, you may have to wait until the next annual enrollment period to enroll.

For more information about Medicare

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

- Visit **www.medicare./gov** for personalized help.
- See the "Medicare & You" handbook, which Medicare mails to you each year.
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for the telephone number).
- Call 1-800-MEDICARE (1-800-633-4227); for 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 ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative.

For TDD service, call the Telecommunications Relay Services at 711. Then call ConnectOne at 1-800-881-3938 as instructed above.

Note: You will receive this notice each year, before the next period you can join a Medicare prescription drug plan, and if this coverage through Citigroup changes. You also may request a copy through the Benefits Service Center. For instructions to call the Benefits Service Center, see instructions immediately above.

Non-Creditable Coverage Disclosure Notice

For employees and former employees enrolled in the Citigroup Basic and Premier High Deductible Health Plans

This notice, required by Medicare to be delivered to Medicare-eligible individuals,[22] 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 prescription drug plan. You may receive this notice at other times, for example, before the next period in which you can enroll in Medicare prescription drug coverage and/or if your 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 ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative.

[22] 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.

Prescription drug coverage and Medicare

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

'Non-creditable coverage'

Citigroup has determined that the prescription drug coverage offered by the High Deductible Health Plans (Basic and Premier) is, on average for all plan participants, not expected to pay as much as standard Medicare prescription drug coverage pays and, therefore, is considered "non-creditable coverage." This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan than if you have prescription drug coverage from a Citigroup High Deductible Health Plan.

Understanding the basics

You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you enroll in that coverage. Read this notice carefully because it explains your options.

Consider joining a Medicare drug plan. You can keep your coverage from the Citigroup High Deductible Health Plan regardless of whether it is as good as a Medicare prescription drug plan. However, because your existing coverage is, on average, not at least as good as standard Medicare prescription drug coverage, you may pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from November 15-December 31. This may mean that you may have to wait to join a Medicare prescription 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 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 Program, you will be eligible to join a Medicare prescription drug plan at that time under the SEP.

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

If you go 63 continuous days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, 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 19 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 enroll.

For more information about Medicare

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. Each year Medicare will mail a copy of the handbook to you. You also may 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 the "Medicare & You" handbook for its telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227); TDD 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 the Social Security Web site at **www.socialsecurity.gov**, or call Social Security at 1-800-772-1213 (TDD 1-800-325-0778).

For more information about this notice

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

For TDD service: Call the Telecommunications Relay Services at 711. Then call ConnectOne at 1-800-881-3938 as instructed above.

Note: You will receive this notice each year. You also will receive it before the next period you can join a Medicare prescription drug plan and if this coverage through Citigroup changes. You also may request a copy through the Benefits Service Center.

Notice of HIPAA Privacy Practices

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

This notice also sets out Component Plans' legal obligations concerning your protected health information and describes your rights to access and control your protected health information. The Component Plans have all agreed to abide by the terms of this notice. This notice has been drafted in accordance with the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule, contained in the Code of Federal Regulations at 45 CFR Parts 160 and 164. Terms that are not defined in this notice have the same meaning as they have in the HIPAA Privacy Rule.

For answers to your questions and for additional information. If you have any questions or want additional information about this notice, call the Benefits Service Center as instructed on page 4. To exercise any of the rights described in this notice, contact the third-party administrator for the relevant Component Plan as instructed beginning on page 99.

Component Plans' responsibilities

Each Component Plan is required by law to maintain the privacy of your protected health information. The HIPAA Privacy Rule defines "protected health information" to include any individually identifiable health information (1) that is created or received by a health care provider, health plan, insurance company, or health care clearinghouse; (2) that relates to the past, present, or future physical or mental health or condition of such individual; the provision of health care to such individual; or payment for such provision of health care; and (3) that is in the possession or control of an entity covered by the HIPAA Privacy Rule (called "covered entities"), including a group health plan.

Component Plans are obligated to provide you with a copy of this notice setting forth their legal duties and privacy practices regarding your protected health information. Component Plans must abide by the terms of this notice.

Uses and disclosures of Protected Health Information

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

Payment and health care operations

Each Component Plan has the right to use and disclose your protected health information for all activities that are included within the definitions of "payment" and "health care operations" as defined in the HIPAA Privacy Rule.

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

Health care operations. Component Plans will use or disclose your protected health information to fulfill Component Plans'

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

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

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

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

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

Required by law. Component Plans may use or disclose your protected health information to the extent required by federal, state, or local law.

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

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

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

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

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

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

Organ and tissue donation. Component Plans may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

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

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

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

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

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

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

Disclosures to the plan sponsor. Component Plans (or their respective health insurance issuers or HMOs) may disclose your protected health information to Citigroup and its employees and representatives in the capacity of the sponsor of the Component Plans.

Others involved in your health care. Component Plans may disclose your protected health information to a friend or family member involved in your health care, unless you object or request a restriction (in accordance with the process described under "Right to request a restriction" on page 84). Component Plans also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then, using professional judgment, Component Plans may determine whether the disclosure is in your best interest.

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

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

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

Other uses and disclosures of your Protected Health Information

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

Contacting you

Each Component Plan (or its health insurance issuers, HMOs, or third-party administrators) may contact you about treatment alternatives or other health benefits or services that might be of interest to you.

Your rights

The following is a description of your rights regarding your protected health information. If you wish to exercise any of these rights, you must contact the third-party administrator of the Component Plan that you wish to have comply with your request using the contact information beginning on page 99.

Right to request a restriction. You have the right to request a restriction on the protected health information that a Component Plan uses or discloses about you for payment or health care operations. You also have a right to request a limit on disclosures of your protected health information to family members or friends involved in your care or the payment for your care.

You may request such a restriction using the contact information beginning on page 99. A Component Plan is not required to agree to any restriction that you request. If a Component Plan agrees to the restriction, it can stop complying with the restriction upon providing notice to you. Your request must include the protected health information you wish to limit; whether you want to limit such Component Plan's use, disclosure, or both; and (if applicable) to whom you want the limitations to apply (for example, disclosures to your spouse).

Right to request confidential communications. If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that a Component Plan communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. You may request a confidential communication using the contact information beginning on page 99.

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

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

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

Right to request an amendment. You have the right to request an amendment of your protected health information held by a Component Plan if you believe that information is incorrect or incomplete. If you request an amendment of your protected health information, your request must be submitted in writing using the contact information beginning on page 99 and must set forth a reason(s) to support the proposed amendment. In certain cases, a Component Plan may deny your request for an amendment.

For example, a Component Plan may deny your request if the information you want to amend is accurate and complete or was not created by such Component Plan. If a Component Plan denies your request, you have the right to file a statement of disagreement. Your statement of disagreement will be linked

with the disputed information, and all future disclosures of the disputed information by such Component Plan will include your statement.

Right to request an accounting. You have the right to request an accounting of certain disclosures Component Plans have made of your protected health information. You may request an accounting using the contact information beginning on page 99. You can request an accounting of disclosures made up to six years prior to the date of your request, except that Component Plans are not required to account for disclosures made prior to April 14, 2003.

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

Right to a paper copy of this notice. You have the right to a paper copy of this notice, even if you have agreed to accept this notice electronically. To obtain such a copy, call the Benefits Service Center as instructed on page 4.

Complaints

If you believe a Component Plan has violated your privacy rights, you may complain to such Component Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with such Component Plan using the contact information beginning on page 99. Component Plans will not penalize you for filing a complaint.

Changes to this notice

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

Effective date

This Notice of HIPAA Privacy Practices became effective April 14, 2003.

Contact information

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

Citigroup Privacy Officer
c/o Corporate Benefits Department
125 Broad St., 8th Floor
New York, NY 10004.

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

If you are enrolled in any of these Plans:	Call:
• Citigroup Medical Plan **Note:** If you are enrolled in an HMO/EPO, call your HMO/EPO directly. • Citigroup Dental Plan • Citigroup Vision Plan • Health Care Spending Account • Limited Purpose Health Care Spending Account	ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts to speak with a Benefits Service Center representative. **From outside the United States** Call 469-220-9600. **If you are hearing-impaired and using a TDD** Call the Telecommunications Relay Services at 711. Then call ConnectOne as instructed above.

COBRA

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

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

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

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

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

Who is covered

You have a right to choose this continuation coverage if:

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

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

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

1. The death of your spouse;
2. The termination of your spouse's employment (for reasons other than your spouse's gross misconduct) or a reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse's entitlement to Medicare.

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

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

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

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

Separate elections

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

Electing COBRA

To inquire about COBRA coverage, call ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and follow the prompts for a Benefits Service Center representative.

Several weeks after your COBRA-qualifying event, you automatically will receive COBRA election information from ADP, Citigroup's COBRA administrator. Under the law, you must elect continuation coverage within 60 days from the date you lost coverage as a result of one of the events described previously, or, if later, 60 days after Citigroup provides notice of your right to elect continuation coverage. An employee or family member who does not choose continuation coverage within the time period described above will lose the right to elect continuation coverage.

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

Note: Continuation coverage for vision care is administered through Davis Vision.

Duration of COBRA

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

COBRA continuation coverage is available for up to 36 months when the qualifying event is the death of the covered employee, divorce or legal separation, the covered employee becoming entitled to Medicare, or a dependent child's loss of eligibility as a dependent child.

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

If you lose coverage because of a termination of employment or a reduction in hours, these events can, but do not always, result in an extension of an 18-month continuation period to 36 months for your spouse and dependent children. However, in no event will COBRA coverage last beyond 36 months from the date of the event that originally allowed a qualified beneficiary to elect such coverage. You must notify Citigroup if a second qualifying event occurs during your continuation coverage period.

When COBRA medical coverage ends, generally you cannot convert your coverage to an individual medical policy. However, some HMOs/EPOs do offer conversion to individual coverage. Contact your HMO/EPO directly.

Special rule for HCSA and LPSA

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

Special rules for disability

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

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

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

Medicare

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

Early termination of COBRA

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

1. Citigroup no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time (within the applicable grace period);
3. The person who elected COBRA becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain

any applicable exclusion or limitation for any pre-existing condition of the covered individual;

4. The person who elected COBRA becomes entitled to Medicare after the date COBRA is elected; or
5. Coverage has been extended for up to 29 months due to disability, and the disability carrier makes a final determination that the individual is no longer disabled.

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

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

COBRA and FMLA

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

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

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

- You or your dependent is covered by the Plan on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave) and
- You do not return to work at the end of the FMLA leave.

Your duties

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

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

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

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

The notice must be in writing and must include the following information: the applicable Plan name, the identity of the covered employee and any qualified beneficiaries, a description of the qualifying event or disability determination, the date on which it occurred, and any related information customarily and consistently requested by the Plan's COBRA administrator. Mail this information to the address below if the covered person is an active employee of Citigroup:

Citigroup Benefits Service Center
P.O. Box 56710
Jacksonville, FL 32241-6710.

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

Citigroup's duties

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

- The employee's death or termination of employment (for reasons other than gross misconduct);

- A reduction in the employee's hours of employment; or
- The employee's entitlement to Medicare.

Cost of coverage

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

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

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

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

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

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

You also may call the COBRA administrator at 1-800-422-7608.

Recovery provisions

Refund of overpayments

Whenever payments have been made by any of the Plans for covered or non-covered expenses in a total amount, at any time, in excess of the maximum amount payable under the Plan's provision ("Overpayment"), the covered person(s) must refund to the Plan the applicable Overpayment and help the Plan obtain the refund of the Overpayment from another person or organization. This includes any Overpayments resulting from retroactive awards received from any source, fraud, or any error made in processing your claim.

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

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

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

Reimbursement

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

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

If the covered person receives payment from a third party or his or her insurance company as a result of an injury or harm due to the conduct of another party and the covered person has received benefits from the Plan, the Plan must

be reimbursed first. In other words, the covered person's recovery from a third party may not compensate the covered person fully for all the financial expenses incurred because acceptance of benefits from the Plan constitutes an agreement to reimburse the Plan for any benefits the covered person receives.

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

The covered person also must cooperate with the Plan Administrator's reasonable requests concerning the Plan's subrogation and reimbursement rights and must keep the Plan Administrator informed of any important developments in his or her action. The covered person also agrees that the Plan Administrator may withhold any future benefits paid by this Plan or any other disability or health plan maintained by Citigroup or its participating companies to the extent necessary to reimburse this Plan under the Plan's subrogation or reimbursement rights.

To secure the rights of the Plan under this section, the covered person hereby:

- Grants to the Plan a first-priority lien against the proceeds of any such settlement, verdict, or other amounts received by the covered person to the extent of all benefits provided in an effort to make the Plan whole;
- Assigns to the Plan any benefits the covered person may have under any automobile policy or other coverage; the covered person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such lien or to effect such assignment of benefits; and
- Will cooperate with the Plan and its agents and will:
  - Sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement;
  - Provide any relevant information; and
  - Take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the value of the benefits provided.

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

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

Subrogation

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

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

The covered person is obligated to cooperate with the Plan and its agents to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with relevant information requested by them; signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim; and obtaining the consent of the Plan or its agents before releasing any party from liability for payment.

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

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

Claims and appeals

If you do not receive a benefit to which you believe you are entitled under any Citigroup Health and Welfare Plan subject to ERISA, which excludes DCSA and TRIP, or if your application for benefits is denied, in whole or in part, you may file a claim with the Plan Administrator or Claims Administrators, as applicable. For more information about the Plan Administrator and Claims Administrators, see pages 96–101.

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

ERISA provides for different timetables and claims procedures that may vary by type of benefit. Each of the medical benefits (including dental and vision benefits), disability benefits, and all other types of benefits have a different timetable and claims and appeals procedures. General information about the claims and appeals procedures is set forth below. Detailed procedures governing claims for benefits, applicable time limits, and remedies available under the Citigroup medical, dental, vision, HCSA/LPSA, and disability Plans for the redress of claims that are denied are included in the Plan documents available at **www.benefitsbookonline.com**.

If you do not have access to this Web site, you can request a copy at no cost to you by speaking with a Benefits Service Center representative. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts for the Benefits Service Center.

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

Medical benefits claims

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

1. Preservice claim. A claim is a preservice claim if the receipt of the benefit is conditioned, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined below. Benefits under any Plan that requires approval in advance are specifically noted in this book or in the Plan document as being subject to preservice authorization.

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

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

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

4. Concurrent care claim. A concurrent care decision occurs when the Claims Administrator approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments and (b) where an extension is requested beyond the initially approved period of time or number of treatments.

Deciding initial medical benefit claims

A post-service claim must be filed within 90 days following receipt of the medical service, treatment, or product to which the claim relates unless (a) it was not reasonably possible to file the claim within such time and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than 12 months after the date of receipt of the service, treatment, or product to which the claim relates.

These claims procedures do not apply to any request for benefits that is not made in accordance with these procedures or other procedures prescribed by the Claims Administrator except that (a) in the case of an incorrectly filed preservice

claim, the claimant shall be notified as soon as possible but no later than five days following the receipt of the incorrectly filed claim, and (b) in the case of an incorrectly filed urgent care claim, you will be notified as soon as possible but no later than 24 hours following receipt of the incorrectly filed claim.

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

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

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

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

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

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

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

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

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

Notification of initial benefit decision by Plan

You will receive written notification of an adverse decision on a claim, and it will include the following:

- The specific reasons for the denial;
- The specific reference to the Plan documentation that supports these reasons;
- The additional information you must provide to perfect your claim and the reasons why that information is necessary; The procedure available for a further review of your claim, including a statement regarding your right to bring action under Section 502(a) of ERISA if your claim is denied on review;
- A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);

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

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

Appeals

You have the right to appeal an adverse decision under these claims procedures. The appeal of an adverse benefit decision must be filed within 180 days following your receipt of the notification of adverse benefit decision, except that the appeal of a decision to reduce or terminate an initially approved course of treatment (see the definition of concurrent care decision) must be filed within 30 days of your receipt of the notification of the decision to reduce or terminate. Failure to comply with this important deadline may cause you to forfeit any rights to any further review of an adverse decision under these procedures or in a court of law.

The appeal of a preservice claim shall be decided within a reasonable time appropriate to the medical circumstances but no later than 30 days after receipt of the appeal.

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

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

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

Notice of benefit determination on appeal

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

1. The specific reason or reasons for the denial of the appeal;
2. Reference to the specific Plan provisions on which the benefit determination is based;
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
4. A statement describing any voluntary appeal procedures offered by the Plan, and a statement of your right to bring an action under Section 502(a) of ERISA;
5. If an internal rule or guideline was relied on in making the adverse determination, either the specific rule or guideline, or a statement that such a rule or guideline was relied on in making the adverse determination and that a copy of such rule or guideline will be provided free of charge on request; and
6. If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

All other benefits claims

If your application to enroll in any of the health and welfare plans subject to ERISA is denied, you may file a claim with the Plans Administration Committee that shall be decided in accordance with the time frames set forth below. You also may file an appeal if the Plans Administration Committee denies your claim. To file an enrollment-related claim and for information on the claim review process, use the Health and Disability Benefits Eligibility Claims and Appeals Form available to you at no cost through the Benefits Service Center. Call the Benefits Service Center as instructed on page 4. Follow the instructions on the form and return the form to the Plans Administration Committee at the address on the form.

In addition, if you file a claim for benefits under the Citigroup Disability, Life Insurance, Business Travel Accident, Optional GUL/Supplemental AD&D, or the Long-Term Care Insurance Plans, your claim will be administered in accordance with the following timetable.

Notice of Adverse Benefit Determinations

If your claim is denied, you will receive a written or an electronic notice within 90 days after receipt of your claim (180 days if special circumstances apply and you are notified of the extension in writing within the initial 90-day period and informed of the anticipated benefit determination date). If your claim is for disability benefits, you will receive a written or an electronic notice within 45 days after receipt of your claim (105 days if special circumstances apply and you are notified of the extension in writing within the initial 45-day period and informed of the anticipated benefit determination date). The explanation will include the following:

1. The specific reasons for the denial;
2. The specific reference to the Plan documentation that supports these reasons;
3. The additional information you must provide to perfect your claim and the reasons why that information is necessary; and
4. The procedure available for a further review of your claim, including a statement regarding your right to bring action under Section 502(a) of ERISA if your claim is denied on review; and
5. A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request).

Appeals

You have a right to appeal a denied claim by filing a written request for review of your claim with the Claims Administrator within 60 days after receipt of the notice informing you that your claim has been denied. In the case of a disability claim, you have 180 days following receipt of the notification in which to appeal the decision.

The Claims Administrator will conduct a full and fair review of your claim and appeal. You or your representative may review Plan documents and submit written comments with your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The Claims Administrator's review will take into account all comments, documents, and other claim-related information that you submit regardless of whether that information was submitted or considered in the initial benefit determination.

The Claims Administrator will reach a determination regarding your appeal 60 days after its receipt (120 days if the Claims Administrator determines that special circumstances require an extension and, before the expiration of the initial 60 days, you are notified in writing of the circumstances warranting the extension and the anticipated determination date). In the case of a claim for disability benefits, the Claims Administrator will reach a determination regarding your appeal 45 days after its receipt (90 days if the Claims Administrator determines that special circumstances require an extension and, before the expiration of the initial 45 days, you are notified in writing of the circumstances warranting the extension and the anticipated determination date).

Notice of benefit determination on appeal

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

1. The specific reason or reasons for the denial of the appeal;
2. Reference to the specific Plan provisions on which the benefit determination is based;
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
4. A statement describing any voluntary appeal procedures offered by the Plan, and a statement of your right to bring an action under Section 502(a) of ERISA; and
5. If an internal rule or guideline was relied on in making the adverse determination, either the specific rule or guideline, or a statement that such a rule or guideline was relied on in making the adverse determination and that a copy of such rule or guideline will be provided free of charge upon request.

In the event that your appeal is denied, you have the right to bring a legal action under section 502(a) of ERISA, provided that you file any lawsuit or similar enforcement proceeding, commenced in any forum, regarding the Plans within 12 consecutive months after the date of receiving a final determination on review of your claim or, if earlier, within two years from the date on which you were aware, or should have been aware, of the claim at issue in the suit.

The two-year limitation shall be increased by any time a claim or appeal on the issue is under consideration by the

appropriate fiduciary. If any different period to begin suit is specified in an insurance contract forming part of the Plans or any shorter period is specified in the rules of the Claims Administrator, that period will apply to proceedings against the insurer or with regard to the ruling of that Claims Administrator, respectively.

You and the Plans may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency, as applicable. Generally, the determination reached by the Plans is final.

ERISA information

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

You may examine all documents governing the Plans (including group insurance policies, where applicable) and copies of all documents filed with the U.S. Department of Labor (and available at the Public Disclosure Room of the Employee Benefits Security Administration) such as annual reports (Form 5500 Series). You can review these documents at no cost to you upon request at the location of the Plan Administrator or other specified location.

Upon written request to the Plan Administrator, you may obtain copies of documents governing the operation of the Plans, including insurance contracts, a copy of the latest annual report (Form 5500), and the current Summary Plan Description. The Plan Administrator will mail these documents to your home free of charge. You also may receive a copy of the Plan's annual financial report. The Plan Administrator will furnish each participant with a copy of the Summary Annual Report.

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

You can reduce or eliminate an exclusionary period of coverage for pre-existing conditions under your group health Plan (if one exists), if you have creditable coverage from another plan.

You should be provided a Certificate of Creditable Coverage, free of charge, from your group health Plan or health insurance issuer:

- When you lose coverage under the Plan;
- When you become entitled to elect COBRA continuation coverage;
- When your continuation coverage ceases, if you request it before losing coverage; or
- If you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plans review and reconsider your claim and provide you with copies of documents relating to the decision without charge. For more information see the "Claims and appeals" section beginning on page 91.

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

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

U.S. Department of Labor or file a suit in federal court, subject to limitations imposed by Plan rules.

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

Answers to your questions

If you have questions about the Plans, contact the Plan Administrator.

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

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

Administrative information

This section contains a statement about the future of the Plans and Citigroup's right to amend, modify, suspend, or terminate the Plans as well as general information about the administration of the Citigroup Plans, Plan documents, sponsors, and Claims Administrators.

Future of the Plans

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

Citigroup Inc. (or its affiliate, if appropriate) has the right to amend, modify, suspend, or terminate any Plan, policy, or program, including the Plans described in this SPD in whole or in part, at any time, for any reason, without prior notice.

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

Plan administration

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

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

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

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

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

Plan information

Plan sponsor	Citigroup Inc. 75 Holly Hill Lane Greenwich, CT 06830
Employer identification number	52-1568099
Plan Administrator	Plans Administration Committee of Citigroup Inc. 125 Broad St., 8th Floor New York, NY 10004 1-800-881-3938 (ConnectOne). From the ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative. From outside the United States, call 469-220-9600. If you are hearing-impaired and using a TDD, call the Telecommunications Relay Services at 711. Then call ConnectOne at 1-800-881-3938 as instructed above.
PLAN NAMES AND NUMBERS	
Medical Plan: self-funded ChoicePlan, High Deductible Health Plans (Basic and Premier), Hawaii Health Plan, Out-of-Area Health Plan, and HMOs/EPOs, including prescription drugs	Citigroup Health Benefit Plan, Plan #508
Dental Plan	Citigroup Dental Benefit Plan, Plan #505
Vision Plan	Citigroup Vision Benefit Plan, Plan #533
Employee Assistance Program	Citigroup Employee Assistance Program, Plan #521
Health Care Spending Account and Limited Purpose Health Care Spending Account Dependent Care Spending Account	Citigroup Flexible Benefits Plan, Plan #512 Not applicable (DCSA is not an ERISA plan)
Transportation Reimbursement Incentive Program	Not applicable (TRIP is not an ERISA plan)
Basic Life insurance/AD&D and Optional GUL/Supplemental AD&D Business Travel Accident insurance Long-Term Care insurance	Citigroup Life Insurance Benefits Plan, Plan #506 Citigroup Business Travel Accident Plan, Plan #510 Citigroup Long-Term Care Insurance Plan, Plan #535
Short-Term Disability and Long-Term Disability	Citigroup Disability Plan, Plan #530

Section 3-Legal and administrative information

Agent for service of legal process	Citigroup Inc. General Counsel 399 Park Ave., 3rd Floor New York, NY 10043
Plan year	January 1 – December 31
FUNDING	
Medical Plan Dental Plan Vision Care Plan Employee Assistance Program Health Care Spending Account (HCSA) Limited Purpose Health Care Spending Account (LPSA)	The Medical Plan and Dental Plan are funded through insurance contracts, the general assets of Citigroup, or a trust qualified under section 501(c)(9) of the Code on behalf of the Plans. The Vision Plan is funded through an insurance contract. The medical spending accounts and the Employee Assistance Program are funded from the general assets of Citigroup. The cost of medical and dental coverage is shared by Citigroup and the participant. The cost of the Vision Plan and medical spending accounts is provided by employee contributions. Citigroup pays for the Employee Assistance Program.
Basic Life/AD&D insurance Optional GUL/Supplemental AD&D insurance Business Travel Accident insurance	Basic Life/AD&D, Optional GUL/Supplemental AD&D, and Business Travel Accident insurance are fully insured. Benefits are provided under insurance contracts between Citigroup and the Claims Administrator. The Claims Administrator, not Citigroup, is responsible for paying claims. Basic Life/AD&D and Business Travel Accident coverage is provided through employer contributions; Optional GUL/Supplemental AD&D is provided through employee contributions.
Disability Plan	STD benefits are paid from the general assets of the Company or a trust qualified under section 501(c)(9) of the Code. STD coverage is provided by Citigroup; no employee contributions are required. LTD benefits are fully insured. The Claims Administrator, not Citigroup, is responsible for paying claims. LTD coverage is provided through both employer and employee contributions.
Long-Term Care insurance (LTC)	LTC benefits are fully insured. The cost of LTC coverage is provided by employee contributions.
	Any refund, rebate, dividend adjustment, or other similar payment under any insurance contract entered into between Citigroup and any insurance provider shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse Citigroup for premiums it has paid or to reduce Plan expenses.
Type of administration	The Plans are administered by the Plans Administration Committee. However, the final decision on the payment of claims under certain Plans rests with the Claims Administrators.

Claims Administrators

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

MEDICAL PLAN AND PRESCRIPTION DRUG COVERAGE

ChoicePlans and the High Deductible Health Plans (Basic and Premier)	Aetna Citigroup 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[23] 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/EPOs	Call the Citigroup HMO Administrator at 1-800-422-6106.
For self-insured HMOs and EPOs	Aetna Citigroup 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 Group Health Plan of St. Louis Group Health Plan, Inc. Claims Department P.O. Box 460530 St. Louis, Missouri 63146 1-800-755-3901 1-877-231-0573 - TDD **www.gph.com** Harvard Pilgrim Claims for pharmacy services MedImpact DMR Department 10680 Treena St., 5th Floor San Diego, CA 92131

(continued)

[23]Empire BlueCross BlueShield is a trademark of Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. Empire does not underwrite or assume any financial risk for claims liability.

For self-insured HMOs and EPOs (*continued*)	Claims for mental health and drug and alcohol rehabilitation services: HPHC - Behavioral Health Access Center C/O PacifiCare P.O. Box 31053 Laguna Hills, CA 92654-1053 All other claims: HPHC Claims P.O. Box 699183 Quincy, MA 02269-9183 Tufts Health Plan Attn: Appeals and Grievances Department 705 Mt. Auburn St. P.O. Box 9193 Watertown, MA 02471-9193 1-800-462-0224 **UnitedHealthcare** P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845 UnitedHealthcare - Medical Self-Insured P.O. Box 659752 San Antonio, TX 78265-9752 1-877-311-7845
Hawaii Health Plan	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845
Out-of-Area Health Plan	Empire BlueCross BlueShield P.O. Box 5072 Middletown, NY 10940-9072 1-866-290-9098
Prescription Drug Program (paper claims address) (home delivery service)	Express Scripts Pharmacy P.O. Box 66583 St. Louis, MO 63166 Express Scripts Pharmacy Home Delivery Service P.O. Box 510 Bensalem, PA 19020-0510
DENTAL PLAN	
MetLife Preferred Dentist Program	Metropolitan Life Insurance Co. MetLife Dental Claims Unit P.O. Box 981282 El Paso, TX 79998-1282 1-888-832-2576
CIGNA Dental Care	CIGNA Dental/Member Services Suite 700 300 NW 82nd Ave. Plantation, FL 33324 1-800-244-6224
Delta Dental	Delta Dental One Delta Drive Mechanicsburg, PA 17055 1-877-248-4764
VISION	
Vision Plan	Davis Vision 159 Express St. Plainview, NY 11803 516-932-9500 1-800-DAVIS-2-U

SPENDING ACCOUNTS	
Health Care Spending Account Limited Purpose Health Care Spending Account Dependent Care Spending Account Transportation Reimbursement Incentive Program	ADP Claims Processing Center P.O. Box 1800 Alpharetta, GA 30023-1800 1-800-378-1823 Fax: 678-762-5693
LIFE INSURANCE	
Basic Life	Metropolitan Life Insurance Co. 200 Park Ave. New York, NY 10166 1-800-638-6420
Optional GUL	Metropolitan Life Insurance Co. group plan # 96731 P.O. Box 3016 Utica, NY 13504 1-800-523-2894
AD&D and Supplemental AD&D	Life Insurance Company of North America (CIGNA) 1601 Chestnut St. Philadelphia, PA 19192 215-761-1000
Business Travel Accident	AIG AIG Domestic Accident and Health Division National Union Fire Insurance Co. of Pittsburgh, PA 70 Pine St. New York, NY 10270 1-800-551-0824
Short-Term Disability Long-Term Disability	Metropolitan Life Insurance Co. P.O. Box 14590 Lexington, KY 40511-4590 1-888-830-7380
Long-Term Care	John Hancock Life Insurance Co. Group Long-Term Care, B-6 200 Berkeley St. Boston, MA 02117 1-800-222-6814

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 on the financial solvency of the employer or other entity sponsoring the Plans. No guaranty fund exists to cover claims that a bankrupt or otherwise insolvent employer or plan sponsor cannot pay.

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