Health and Insurance
Benefits Handbook

Puerto Rico Edition

For coverage effective
January 1, 2015

Live Well at Citi

citi

Benefits Handbook for health, disability and life insurance benefits

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

This Benefits Handbook will help you do just that. It contains the official documents for your Citi health care and insurance benefits plans to show you what's covered and provides general information to help you make the right decisions for you and your family.

This Handbook describes benefits available as of January 1, 2015, and contains the official documents for your Citi health care and insurance benefits plans.

If you need information about benefits coverage that is not included in this Handbook, contact the health plans directly as explained in the "Telephone and website directory" on page 93 or call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. You can choose to hear the enrollment menu in Spanish or in English. Representatives are available from 8 a.m. to 8 p.m. ET Monday through Friday, excluding holidays.

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About this handbook

Medicare Eligible?

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

This document describes health and insurance benefits for certain Puerto Rico employees of Citigroup Inc. ("Citigroup") and its participating companies (collectively the "Company") as in effect January 1, 2015. The benefits described in this document are:

- Citigroup Health Benefit Plan
  - Triple-S Preferred Provider Organization (PPO) Plan; and
  - Triple-S Prescription Drug Program
- Citigroup Dental Benefit Plan
  - Triple-S Dental Plans
- Citigroup Vision Benefit Plan
- Citigroup Employee Assistance Program
- Citigroup Disability Plan
- Citigroup Life Insurance Benefits Plan
  - Basic Life insurance
  - Basic Accidental Death and Dismemberment (AD&D) insurance;
  - Group Universal Life; and
  - Supplemental AD&D insurance
  - Business Travel Accident/Medical Insurance Plan (BTA/BTM)
- Citigroup Long-Term Care Insurance Plan (this coverage is not available to new enrollees)
- Citigroup Work/Life Program

The document serves as a summary plan description (SPD) for the health and insurance benefit plans described above (the "Citigroup Health and Welfare Plans or collectively the "Plans" and individually a "Plan").

This summary has been written, to the extent possible, in non-technical language to help you understand the basic terms and conditions of the Plans as they are in effect. This description is intended only to be a summary of the major highlights of the Plans.

The Plans are subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). To the extent applicable, the Plans will be interpreted and administered in accordance with ERISA 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 and any written or oral communication by an individual representing the Plans, and the Plan documents, 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.

The summary information is general in nature and is not meant as tax advice. Citigroup Inc. and its affiliates are not in the business of providing personal tax or legal advice to its employees. Any such taxpayer should seek advice, based on the taxpayer's particular circumstances, from an independent tax adviser.

Benefits overview

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

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

- Basic Life insurance, equal to your benefits eligible pay, if your benefits eligible pay is less than $200,000, on your date of eligibility. Coverage is administered by MetLife;
- Basic Accidental Death and Dismemberment (AD&D) insurance, equal to your benefits eligible pay, if your benefits eligible pay is less than $200,000, on your date of eligibility. Coverage is administered by MetLife;
- Business Travel Accident/Medical insurance, administered by ACE, of up to five times your benefits eligible pay to a maximum benefit of $2 million; medical coverage related to covered accidents and/or sickness while traveling on behalf of Citi;
- 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 Citi. See "Short-Term Disability (STD)" on page 40 for the STD schedule of benefits;
- Long-Term Disability (LTD) coverage, administered by MetLife, equal to 60% of your benefits eligible pay. This is a core benefit if your benefits eligible pay is less than or equal to $50,000.99.
- Employee Assistance Program, administered by Harris Rothenberg International, LLC provides confidential counseling and referral services to assist employees with various life issues.

Additional benefits to consider that require active enrollment are:

- Medical;
- Dental;
- Vision;
- Long-Term Disability (LTD), if your benefits eligible pay is $50,001 and above; if your benefits eligible pay is $50,000.99 and under, LTD is a core benefit provided at no cost to you;
- Group Universal Life (GUL); and
- Supplemental Accidental Death and Dismemberment (AD&D) insurance.

Enrollment instructions

As a new hire or newly eligible for benefits

As a newly-hired benefits-eligible employee or if you are newly eligible for benefits, you will have **31 days** from your date of eligibility to enroll in Citi health and welfare benefits. Enrolling in Citi health and welfare benefits is not mandatory. However, you must enroll during your initial enrollment period to have non-core benefits, including medical, dental, and vision coverage.

Annual enrollment

Each year in the fall, employees have the opportunity to add or change benefits coverage during an annual enrollment period. During this time, you will have an opportunity to evaluate your current coverage and select your benefits for the upcoming year. The benefits you select during annual enrollment will take effect the following January 1 and will generally remain in effect through December 31, unless you experience certain life events (known as a qualified change in status), such as getting married or having a baby, which may allow you to make changes to your benefits.

Dependent notification

The first time you enroll new dependents in Citi benefits, you will be asked to report information about each of your eligible dependents such as name, date of birth, Social Security number and, if age 26 or older, whether the child has a mental or physical disability. You will also be required to submit proof of the dependent's eligibility for coverage. For more information on the dependent verification process, see "Eligibility" on page 4.

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

You must also keep your dependent information current:

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

What happens if you do not enroll

If you do not enroll, you must wait until the next annual enrollment period or until you have a qualified change in status to enroll in medical, dental, or vision coverage. See "Qualified changes in status" on page 9 for information on qualified changes in status.

How to enroll

Your enrollment deadline is shown online and on your Personal Enrollment Worksheet. You can enroll by telephone or online by following the instructions below.

Online

You can link to the Your Benefits Resources™ (YBR™) website through TotalComp@Citi at www.totalcomponline.com. If you are a new employee, your information will not be available on TotalComp@Citi until approximately two months after your date of hire.

By telephone

You also can enroll by telephone. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option to speak to a Citi Benefits Center representative.

Enrollment in Triple-S Medical and Dental

If you elect both medical and dental coverage, you must enroll in the same coverage category for both dental and medical benefits. If you cover dependents under both the medical and dental plans, you must cover the same dependents in both the medical and dental plan.

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 benefit 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 Citi Benefits Center immediately.

If you enroll online, print the confirmation screen after you enroll for your records. You also will receive a confirmation statement in the mail.

Confirmation of default

If you do not enroll, you will receive a statement confirming your default elections within several weeks after your enrollment deadline. The confirmation statement will list your Citi benefits (if any) that will continue through the year and their costs. Retain this statement as proof of any coverage you may have.

Health care ID cards

If you enroll in the Triple-S medical plan or a dental plan for the first time, you will receive your ID cards within three weeks of enrolling. You will receive one ID card from Triple-S that shows your coverage for medical/prescription drugs and dental.

If you are enrolled in medical coverage and need to use a medical provider (doctor or hospital) before you receive your ID card, show your confirmation statement or default statement along with the Triple-S group number (SP0003726) to your provider. Call Triple-S at **1-787-774-6098** or **1-787-749-4777** to request coverage certification or a duplicate ID card.

If you enroll in the Aetna Vision plan for the first time, you will receive your ID cards within three weeks of enrolling.

Note: All ID cards are mailed to the Citigroup employee. If you have a student dependent living away from home, you will need to send that dependent his or her card. Cards are required to obtain services.

Beneficiary forms

Your beneficiary information should be on file with Citi. If you have never designated a beneficiary (either by completing a form or visiting Your Benefits Resources™) you should visit Your Benefits Resources™ to designate a beneficiary. You can link to Your Benefits Resources™ through TotalComp@Citi at www.totalcomponline.com.

You also can call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “pension, retiree health and welfare, and survivor support” option. Then follow the prompts for “pension beneficiary information” to name a beneficiary for Basic Life insurance, Basic AD&D insurance, the Citibuilder 401(k) Plan for Puerto Rico, Citigroup Pension Plan, and, if applicable, the Citigroup 401(k) Plan

If you enroll in GUL or Supplemental AD&D insurance for the first time, you must complete a MetLife Beneficiary Designation Form (available in the “Claim Forms” section of Citi Benefits Online at www.citibenefitsonline.com) for each coverage in which you are enrolled and return it to MetLife at the address on the form. You can also designate or change your beneficiary by visiting the MetLife MyBenefits website through TotalComp@Citi at www.totalcomponline.com, available from the Citi intranet and the Internet.

Eligibility

You are considered an employee eligible for health and welfare benefits if:

- You work in Puerto Rico for Consumer Banking, North America Cards, Institutional Client Group, or Corporate Center, and their participating businesses.
- You are an active[1]:
  - Full-time employee (regularly scheduled to work 30 hours or more a week); or
  - Part-time employee (regularly scheduled to work at least 20 or more hours a week);
- You receive regular biweekly or monthly pay; and
- You are employed by a participating employer.

A "participating employer" is Citigroup Inc. and any subsidiary in which Citi owns at least an 80% interest.

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

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

Note: if you are hired as a temporary employee and work for at least 90 days, and you satisfy the definition of a part-time or full-time employee noted above, you become benefits eligible on the date you are employed 90 days without regard for the temporary classification.

If both you and your spouse (same or opposite sex)/civil union partner/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.

Special enrollment rights

If you or your dependents lose eligibility for Medicaid or the Children's Health Insurance Program, you have special enrollment rights under the Plan. You must request coverage under the medical plans within 60 days of the noted occurrence. Call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option and then speak to a Citi Benefits Center representative.

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 499R-2/W-2 PR (commonly known as a Form W-2 PR) 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; or
- You are classified by Citigroup as an independent contractor or consultant.

No pre-existing condition limitations

The Citigroup Health Benefit Plan does not have a pre-existing condition limitation or exclusion that would prevent you and your eligible dependents from enrolling in the Plan or receiving benefits for a specific condition or illness.

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1 If you are on an approved leave of absence, you may be eligible to enroll in Citigroup benefits (other than LTD and GUL); other enrollment restrictions may apply.

Definition of eligible dependents

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

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

- Your lawfully married spouse (irrespective of sex), or your common-law spouse, if Puerto Rico recognizes common-law marriages (same or opposite sex), or your civil union partner/domestic partner, if Puerto Rico recognizes such partnerships.
- If you are legally separated or divorced, your spouse is not an eligible dependent unless mandated by state law; at any time, you cannot cover more than one person as your spouse/civil union partner or domestic partner.

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

- Your domestic partner;
- Your domestic partner's eligible dependents;
- Your children under age 26 as of December 31 of the plan year that precedes the year in which the coverage applies who are:
  - Your biological children;
  - Your legally adopted children; for purposes of coverage under the Plans, adopted children will be considered eligible dependents when they are lawfully placed in your home for adoption or when the adoption becomes final, whichever occurs first.
  - Your stepchildren; and
  - Other children for whom you are the legal guardian, in accordance with the laws of Puerto Rico.

Note: Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age.

No person 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.

About disabled children

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

If your eligible dependent child is permanently and totally disabled as defined for purposes of obtaining Social Security benefits and (a) is covered under the Plans before reaching age 26 as described above, or (b) you enroll this dependent within the first 31 days of your eligibility under the Plans, this child may continue to be considered an eligible dependent under the Plans beyond the date his or her eligibility for coverage would otherwise end. You must provide written proof of this incapacity to the Claims Administrator within 31 days after the date eligibility would otherwise end or as requested thereafter. This eligible dependent must still meet all other eligibility qualifications to continue coverage, including, but not limited to, continuing to be permanently and totally disabled.

Paying for your benefits

In addition to paying for core benefits, Citigroup contributes toward the cost of medical and dental coverage for you and your dependents. You will find the cost to enroll in all coverage categories on your Personal Enrollment Worksheet or on Your Benefits Resources™ (YBR™) accessible through TotalComp@Citi at www.totalcomponline.com.

Your contribution for medical coverage will depend on the amount of your benefits eligible pay and your coverage category.

Benefits eligible pay and your benefits

Benefits eligible pay is used to determine:

- Medical contributions;
- Long-Term Disability (LTD) benefits and, where applicable, LTD contributions;
- Basic Life insurance benefits;
- Basic Accidental Death & Dismemberment (AD&D) insurance benefits;
- Group Universal Life (GUL) insurance benefits and costs
- Supplemental AD&D insurance benefits and costs;
- Short-Term Disability benefits for ICG and CPWM employees that hold the title of Financial Advisor ("FA") or its equivalent and receive commissions as a component of their benefits eligible pay; and
- Business Travel Accident/Medical insurance benefits.

Definition of benefits eligible pay

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

Your benefits eligible pay at the time you are hired is equal to your annual salary. If you are to be paid on commissions only, your benefits eligible pay 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 benefits eligible pay will be based on a formula that includes your actual base pay plus commissions, performance-based bonuses, and any annual incentive bonus. **Note:** Your benefits eligible pay does not necessarily equal the amount reported as salaries and wages on your Form W-2 PR.

If you are enrolling during the annual enrollment period for coverage effective January 1, 2015

Your benefits eligible pay is made up of the following:

- Annual base pay as of June 30, 2014;
- 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, 2013, will be used for the 2015 annual enrollment calculation;
- Cash bonuses (other than the cash portion of any annual discretionary incentive/retention award package) paid in the period January 1 - December 31 in the year prior to enrollment; cash bonuses paid in the period January 1 - December 31, 2013, excluding the cash portion of the annual discretionary incentive award/retention package dated January 2013, will be used for the 2015 annual enrollment calculations;
- Annual discretionary incentive/retention award package dated in the year of enrollment includes, as applicable, cash bonus, Capital Accumulation Program (CAP) Award, and Deferred Cash Award. Annual discretionary incentive/retention award packages dated January/February 2014 will be used for the 2015 annual enrollment calculation;
- Guaranteed bonus effective in current year 2014; and
- Short-Term Disability benefits paid from January 1 - December 31, 2013, for employees paid commissions only.

For new hires in the Institutional Clients Group: Any guaranteed bonus will be considered in the calculation of your benefits eligible pay for benefit purposes.

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

For Financial Advisors

In your first year of employment, your benefits eligible pay 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 PR to your HR representative within 30 days of your hire date. Providing a copy of your previous year's Form W-2 PR is optional.

If you provide a copy of your W-2 PR form, your Basic Life and Basic AD&D insurance amounts will be set at the higher amount (up to $200,000) as shown on the form. (Basic Life and Basic AD&D is available only to those employees whose benefits eligible pay is less than $200,000.) Your contributions for medical coverage, GUL and Supplemental AD&D amounts, and LTD benefits and contributions also will be based on the higher amount.

Your decision to have your benefits eligible pay set at $60,000 or your actual W-2 PR form earnings amount is irrevocable and applies only in your first year of employment.

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 Health Benefit Plan, the Citigroup Dental Benefit Plan, and the Citigroup Vision Benefit Plan (the "Plans") contain a coordination of benefits provision that may reduce or eliminate the benefits otherwise payable under the applicable Plan when benefits are payable under another plan. Certain provisions are summarized below, and additional terms and conditions may apply under the terms of the Plan documents.

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

How coordination of benefits works

- When the Plans are primary: The Plans consider benefits as if secondary plans do not exist, and it will pay benefits first.
- When the Plans are secondary: The Plans 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 plans. Total benefits will never equal more than what the Plans would have paid alone. If a service is not covered or coverage is denied, you will be responsible for payment.

The Citigroup Plans 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 enrolled in a Citigroup plan as an eligible dependent and 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. When a child's parents are legally separated or divorced and there is no court decree, then benefits will be determined in the following order:

- The plan of the parent with custody of the child;
- The plan of the spouse of the parent with custody of the child;
- The plan of the parent 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.

Coverage categories

Citi offers four coverage categories for medical and dental coverage:

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

If you elect both medical and dental coverage, you must enroll in the same coverage category for both dental and medical benefits. If you cover dependents under both the medical and dental plans, you must cover the same dependents in both the medical and dental plan.

Each category has a different cost. You will find your costs in your enrollment materials.

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

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

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

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

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

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

Depending on the event, you may be permitted to:

- Enroll in or drop your medical, dental, or vision coverage;
- Enroll in LTD without having to provide evidence of good health; and
- Enroll in or increase GUL insurance without having to provide evidence of good health. (You may increase your coverage if the first, second, third, or sixth events below apply. When you experience one of those events, if you have not elected the GUL maximum benefit, you may elect to increase your GUL coverage by one times your benefits eligible pay, not to exceed $500,000 without providing evidence of insurability. Initial election of spouse/civil union partner/domestic partner or child coverage under this program is available if you marry, establish an eligible domestic partnership, or in the event of the birth or adoption of a child.)

Examples of qualified changes in status are:

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

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

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

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

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

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

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

Consistency requirements

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

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

Coverage and cost events

In some instances, you can make changes to your benefits coverage for other reasons, such as midyear events affecting your cost or coverage, as described below.

Coverage events

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

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

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

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

Cost events

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

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

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

Other rules

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

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

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

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

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

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

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

How to report a qualified change in status event

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

To add a dependent, report the name, date of birth, and, if available, Social Security number for each dependent you want to add or remove from your coverage. If a newborn does not yet have a Social Security number, you must report all other information within 31 days and add the Social Security number once you obtain it. When you add a new dependent to your coverage, you will be required to submit proof of the dependent's eligibility for coverage (for example, a marriage license or birth certificate). If proof is not received by the deadline stated in the dependent verification package, the dependent(s) will be dropped from coverage.

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

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

- Call the Citi Benefits Center via ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.
- Visit Your Benefits Resources™, available through TotalComp@Citi at www.totalcomponline.com.
- To enroll in or change your Group Universal Life (GUL) or Supplemental AD&D insurance coverage, call MetLife at **1-888-830-7380** or visit the MetLife MyBenefits website available through TotalComp@Citi at www.totalcomponline.com.

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

Deadline to report qualified changes in status

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

Newborns/newly adopted children

Even if you are not enrolled for dependent coverage, Citi will pay benefits under the Citigroup Health Benefit Plan (self-funded plans) for your newborn child from birth through 31 days.

If you have coverage under the Citigroup Health Benefit Plan, you must report this qualified change in status to the Citi Benefits Center within 31 days of the child's birth to add the child to your coverage.

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

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

- Extension of benefits; and
- Continuation of coverage.

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

Plan changes you can make at any time

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

- Long Term Disability (LTD): As a newly hired employee or if your benefits eligible pay increases to $50,001 or above, for benefits purposes (for the next plan year), you will automatically be enrolled in LTD coverage. If you elect to decline the LTD coverage, you can enroll at any time; however, you must provide evidence of good health except when you enroll as a result of certain qualified changes in status.

  The Citigroup 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.

- Group Universal Life (GUL):
  - You can enroll in GUL coverage at any time. GUL coverage is administered by MetLife. MetLife does not require evidence of good health to enroll:
    - When first eligible (as a new hire or newly eligible for Citi benefits) if enrolling for up to three times the amount of your benefits eligible pay, not to exceed $500,000, and the total is less than $1.5 million; and
    - For one times your benefits eligible pay as a result of losing Basic Life coverage because your benefits eligible pay increased to $200,000 or above.

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

  - To enroll at any other time;
  - To enroll for an amount greater than three times your benefits eligible pay, not to exceed $500,000, or $1.5 million; or
  - To increase the amount of your current coverage after you initially enrolled.

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

Supplemental Accidental Death and Dismemberment (AD&D) insurance

You can enroll in Supplemental AD&D insurance at any time. Enrollment in this coverage does not require evidence of good health.

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

Long-Term Care insurance (LTC)

If you did not enroll prior to January 1, 2012, you will not be permitted to enroll in the LTC plan. Participants who enrolled before that date may continue to be participants under the Plan. See “Long-Term Disability (LTD)” on page 42 for more information.

Domestic partner/civil union partner/same-sex spouse benefits

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

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

- Medical,
- Dental;
- Vision;
- Group Universal Life (GUL) insurance; and
- Supplemental AD&D insurance for domestic partners and life insurance for children.

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/domestic partner GUL, Supplemental AD&D insurance and/or the Vision Care Plan even if you do not enroll in those Plans

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 the submission of a registration, if applicable, or the completion of a Certification of Domestic Partnership form, available through the Citi Benefits Center, and the submission of the required supporting documentation;
- 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 who is a U.S. citizen or legal resident of Puerto Rico in Citigroup coverage if you are an employee who is active or on an approved leave of absence. However, if you are not actively at work, you cannot enroll your domestic partner in GUL insurance until after you return to work.

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

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

- You have mutually agreed to be responsible for each other's common welfare; and
- You are in a relationship intended to be both permanent and one in which each is the sole domestic partner of the other.

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

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

If your domestic partnership ends, you and your domestic partner must attest to the termination of your domestic partnership. Alternatively, if your registration (as noted above) is terminated or no longer effective pursuant to state law or local government authority, documentation to that effect will be accepted as proof of the termination of your domestic partnership. You can obtain the required documents by calling the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. You must wait six months from the time your termination attestation form is received before you can add a new domestic partner.

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

- Biological children;
- Legally adopted children;
- Stepchildren; and
- Other children for whom your domestic partner is the legal guardian, in accordance with the laws of Puerto Rico.

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

If your disabled child was covered under the Plans before age 26 and became incapable of self-sustaining employment due to a disability while covered, your eligible dependent may be eligible for coverage beyond such age.

Maternity benefits

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

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

Women's Health and Cancer Rights Act notice

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

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.

The Mental Health Parity and Addiction Equity Act of 2008

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

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

Genetic Information Nondiscrimination Act

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

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 Health Benefit Plan, Citigroup Dental Benefit Plan, or Citigroup Vision Benefit Plan who is an alternate recipient under a QMCSO will be considered as having a right to dependent coverage under the Plans.

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

Call the Plan Administrator to receive, at no cost, a detailed description of the procedures for a QMCSO. However, if you have a question about filing a QMCSO, call the Citi Benefits Center as instructed on “Contact information” on page 72. You can file your QMCSO by mailing it to:

Attention: QMCSO Team
P.O. Box 1542
Lincolnshire, IL 60069-1542

Telephone: **1-800-881-3938** (ConnectOne; from the main menu, choose the “health and welfare benefits” option and then speak to a Citi Benefits Center representative.)
Fax: 1-847-442-0899

Medical

Citigroup offers coverage in Puerto Rico through Triple-S, a preferred provider organization (PPO). This plan does not have a pre-existing condition limitation or exclusion.

Triple-S PPO

The Triple-S PPO is self-insured, meaning the Plan is not subject to the laws of Puerto Rico and Citi pays the claims incurred.

In brief, the PPO allows you a choice each time you need medical care. You can choose an in-network provider and make a copay for each visit for most medical services. You can choose an out-of-network provider and pay a coinsurance percentage for your visits after meeting an annual deductible. If you go to out-of-network providers you will need to meet the annual deductible before the Plan will pay any benefits. You pay more out of your pocket when using an out-of-network provider.

The Triple-S PPO gives you the freedom to choose any doctor or hospital — without a referral — when you need medical treatment. The choice is always yours.

When you visit a doctor who participates in the PPO network, you will pay a $10 copay for each office visit to a generalist physician and a $15 copay for each visit to a specialist or sub-specialist.

PPO network features

- Triple-S has a network of providers throughout Puerto Rico.
- Triple-S is a member of the Blue Cross and Blue Shield Association. Access to providers in the United States and around the world is available through the BlueCard® Program and BlueCard® Worldwide.
- You may visit a specialist at any time without a referral.
- No annual deductible for in-network services.
- The annual out-of-pocket expense maximum is $6,350 for an individual and $12,700 for a family. Medical and prescription drug coinsurance and copayments apply to this limit.
- For an in-network hospital admission or hospitalization, the plan will pay 100% of covered charges after a $150 copay ($50 copay for partial hospitalizations).
- Most outpatient services are covered after paying 10% coinsurance.
- You do not need to file a claim for covered services delivered by an in-network provider.

Preventive care

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

Both exams and immunizations are covered by in-network providers at 100% with no deductible to meet and no annual maximums. Preventive care services include, but are not limited to:

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

In addition to well-woman exams, the following women's preventive services are covered by in-network providers at 100% with no deductible to meet:

- Well-woman office visit to obtain recommended preventive services that are age- and developmentally appropriate, including preconception and prenatal care;
- Certain Food and Drug Administration (FDA)-approved contraceptive devices, including diaphragms and certain surgical implantable devices (Mirena), voluntary sterilization procedures (such as sterilization implants, tubal ligation and tubal occlusion), and patient education and counseling for women with reproductive capacity (excluding drugs that induce abortion);
- Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period (including costs for renting breast pumps and nursing-related supplies);
- Human papillomavirus (HPV) DNA testing as part of cervical cancer screenings for women;
- Human immune-deficiency virus (HIV) counseling and screening for all sexually active women;
- Interpersonal and domestic violence screening and counseling;
- Counseling on sexually transmitted infections for all sexually active women; and
- Screening for gestational diabetes.

Screening recommendations include:

- Alcohol misuse: Covered for adults, including pregnant women, in primary care setting;
- Colorectal cancer: Covered for adults 50-75, using fecal occult blood testing, flexible sigmoidoscopy, or colonoscopy;
- High blood pressure: Covered every two years if between 120 and 139 systolic or 80 to 90 diastolic;
- Cholesterol/Lipid disorders: Covered for men 20-35 and women 20-45 if at high risk, or men over 35 and women over 45 if at normal risk;
- Type 2 diabetes: Covered for asymptomatic adults with blood pressure higher than 135 systolic/80 diastolic;
- Depression: Covered for adults when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment and follow-up; covered for adolescents age 12-18 for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive behavior or interpersonal), and follow-up;
- HIV: Covered for adolescents and adults at increased risk and all pregnant women, as determined by treating physician;
- Syphilis: Covered for adults at increased risk and all pregnant women, as determined by treating physician;
- Abdominal aorta aneurysm: Covered one time for men 65-75 who have ever smoked;
- Breast cancer: Covered every one to two years starting at 40;
- Genetic Testing Breast and Ovarian Cancer (BRCA: Covered for women with family history BRCA1 or BRCA2
- Cervical cancer: Covered for sexually active women 21-65;
- Osteoporosis: Covered for post-menopausal women 60-85;
- Obesity: Covered for adults and children age 6 and older, including intensive counseling and behavioral interventions;
- Chlamydia: Covered for sexually active women who are under age 24 or are pregnant;
- Gonorrhea: Covered for sexually active women who are under age 24 or are pregnant; includes prophylactic ocular topical medication for all newborns;
- Asymptomatic bacteriuria: Covered during 12-16 weeks gestation;
- Hepatitis B: Covered during the first prenatal visit;

- Iron deficiency anemia: Covered for asymptomatic women during first prenatal visit;
- Rh (D) incompatibility: Covered during first prenatal visit;
- Congenital hypothyroidism: Covered for newborns;
- Phenylketonuria (PKU): Covered for newborns;
- Sickle cell anemia (SSA: Covered for newborns;
- Hearing loss: Covered for newborns; and
- Visual Impairment under age 5: Covered to detect amblyopia, strabismus, and visual acuity defects.

Wellness Alliance and Servicio de Salud Industrial de Ponce

Employees enrolled in the Triple-S medical plan can receive a routine physical, well-child care, gynecological exam, routine vision exam, and lab and X-rays at Wellness Alliance and at Servicio de Salud Industrial de Ponce.

Infertility

The Triple-S PPO covers the medical and prescription drug expenses associated with infertility treatment. The medical infertility treatment includes in-vitro fertilization, artificial insemination, GIFT, ZIFT, and other non-experimental/investigational treatments.

The infertility benefit covers:

- Prescription drug expenses (managed by Triple-S) associated with infertility treatment up to a $7,500 family lifetime maximum for participants. This maximum is combined with any infertility benefits used under the Citigroup Prescription Drug Program for U.S. employees; and
- Medical expenses up to a $24,000 family lifetime maximum. This maximum is combined with any infertility benefits used in any of the U.S non-HMO/EPO medical plans. Only advanced services (e.g., IVF, GIFT, ZIFT) and comprehensive services (e.g., artificial insemination) expenses accumulate toward the lifetime maximum. Expenses for diagnosis and treatment of the underlying medical condition do not count toward the lifetime maximum.

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

The lifetime maximum per family can be spent in one year or over a number of years. If you become a U.S. employee, the Plan administrators and Triple-S will keep track of the amount you have remaining toward this benefit.

Precertification is required for all infertility services. Penalties, up to and including no coverage, apply if the treatment is received without precertification. Call Triple-S if you have questions about specific procedures or treatments or the penalties for not precertifying.

PPO out-of-network features

You must meet an annual $50 individual deductible ($150 family) before the plan will pay any benefits.

- The annual out-of-pocket expense maximum is $3,000 for an individual and $6,000 for a family. Medical and prescription drug coinsurance and copayments apply toward this limit.
- Most covered expenses are reimbursed at 80% of the maximum allowed amount (MAA) after the annual deductible is met.
- You must notify Triple-S before undergoing certain procedures and receiving certain services. See “Precertification”.
- You must file a claim to be reimbursed for covered expenses delivered by out-of-network providers.

Medical plan features

Type of service	In-network	Out-of-network
Annual deductible	None	$50 individual / $150 family
Out-of-pocket maximums *(Both medical and prescription drug copays and coinsurance will apply toward the out-of-pocket maximum)*	$6,350 individual / $12,700 family	$3,000 individual / $6,000 family
Generalist office visits	$10 copay per visit	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR
Specialist office visits	$15 copay per visit	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR
Lab and X-ray	Covered at 75%	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR
Maternity care/prenatal office visits	$10 copay per visit	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR
Hearing Evaluations	Covered at 100% as part of a wellness exam; 90% for a diagnostic evaluation	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are covered outside PR
Routine Vision Exam	Covered at 100% as part of a wellness exam; 90% for a diagnostic exam	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are covered outside PR
Inpatient hospitalization	$150 copay per hospitalization	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR

Type of service	In-network	Out-of-network
Anesthesia	Covered at 100%, not subject to deductible	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR
Outpatient surgical care		
Surgical care	Covered at 100%, not subject to deductible	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR
Lab and X-ray	Covered at 75%	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR
Temporomandibular joint treatment	Covered at 90%	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR
Emergency/urgent care	$50 copay per visit (waived if admitted to the hospital or referred by Teleconsulta). **Note:** ER and urgent care covered at 80% if services rendered outside Puerto Rico.	$50 copay per visit (waived if admitted to the hospital or referred by Teleconsulta) if a true emergency; if not a true emergency, then same as above** **Note:** ER and urgent care covered at 80% after deductible if services rendered outside Puerto Rico.
Preventive care		
Preventive Care services required by PPACA (see “Preventive care” on page 19)	Covered at 100%, not subject to deductible	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR
Routine physical, well-child care, GYN exam, and lab and X-rays at Wellness Alliance and at Servicio de Salud Industrial de Ponce (This benefit refers to a specific package of services contracted with these providers.)	Covered at 100%, not subject to deductible	Not covered as a package if service is provided by an out-of-network provider
Adult and child routine immunizations	Covered at 100%, not subject to deductible, if screening meets guidelines specified (see “Preventive care” on page 19). All non-preventive screenings are $5 copay.	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR

Type of service	In-network	Out-of-network
Routine cancer screenings (PAP test, mammogram, sigmoidoscopy, colonoscopy, PSA screening)	Covered at 100%, not subject to deductible, if screening meets guidelines specified (see "Preventive care" on page 19). All non-preventive screenings covered at 90%.	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR
Contraceptive devices	Covered 100%, not subject to deductible for FDA approved implantable devices. All other implantable devices covered at 90% after deductible.	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR
Voluntary sterilization (tubal ligation, sterilization implants and surgical sterilizations)	Covered 100%, not subject to deductible	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR
Mental health/substance abuse		
Inpatient	Covered at 100% after a $150 copay per admission; for substance abuse and alcoholism conditions	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR
Outpatient	Covered at 100% after a $15 specialist copay per visit for substance abuse and alcoholism conditions.	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR
Other professional care		
Outpatient physical therapy	$5 copay per visit; limited to 40 visits per calendar year for all therapies combined in- and out-of network (including outpatient speech and occupational therapy)	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; Covered 80% of MAA after deductible if services are rendered outside PR; limited to 40 visits per calendar year for all therapies combined in- and out-of-network (including outpatient speech and occupational therapy)
Outpatient speech/occupational therapy	Covered at 100% of Triple-S established fee* after deductible if services are rendered in PR; Covered 80% of MAA after deductible if services are rendered outside PR; limited to 40 visits per calendar year for all therapies combined (including outpatient physical therapy) **Note:** There is no occupational or speech therapy network, so you can see any provider you choose.	
Chiropractor therapy	Covered at 100% of Triple-S established fee* after deductible if services are rendered in PR; Covered 80% of MAA after deductible if services are rendered outside PR; limited to 20 visits per calendar year **Note:** There is no chiropractic network, so you can see any provider you choose.	

Type of service	In-network	Out-of-network
Infertility	All infertility services must be precertified. Copays apply to covered services up to a $24,000 lifetime medical maximum and a $7,500 prescription drug maximum. Contact Triple-S for more details.	
Acupuncture	Covered at 80% based on Triple-S' established fee* after Major Medical annual deductible. Covered at 80% after deductible if services are rendered outside PR.	
Applied Behavioral Analysis therapy	$10 copay	Covered at 80% of Triple-S established fee* after deductible if services are rendered in PR by out-of-network providers; covered at 80% of MAA after deductible if services are rendered outside PR

* The Triple-S established fee is the maximum amount on which a payment is based for covered health care services (or the allowed amount). If you provider charges more than the established fee, you may have to pay the difference.

Mental health and substance abuse benefits

Triple-S PPO provides confidential mental health and substance abuse services through a network of counselors and specialized practitioners. Contact Triple-S at **1-787-774-6098** for information on network providers or visit the website at www.ssspr.com.

Precertification

Precertification helps ensure that you obtain the most appropriate care for your condition. You are required to precertify certain services as described in this section. The penalty for failure to precertify services may mean you are responsible for up to 100% of the cost (no coverage).

You must precertify all infertility services with Triple-S at least five business days before receiving any services. To precertify or to get information on precertification, call Triple-S at **1-787-774-6098**.

You are not required to obtain precertification for emergency hospitalization or other emergency services occurring outside Puerto Rico or the United States.

If you are using services outside the Triple-S PPO network in Puerto Rico, you will be reimbursed based on the contracted fees established with Triple-S participating providers.

For outpatient services and diagnostic testing

You should notify Triple-S at least five business days before receiving any of the following services:

- All infertility services;
- Certain surgeries, such as upper eyelid surgery, breast reconstruction (other than following surgery for cancer), breast reduction, and any other surgery that could be related to cosmetic surgery. In the case of eyelid surgeries and surgeries related to cosmetic surgeries, a second opinion is required
- Out-of-network care;
- Specialist-to-specialist referrals; and
- Rehabilitation care.

The penalty for failure to precertify services may be up to 100% (no coverage).

Centers of Excellence (COEs)

Triple-S, in partnership with Anthem Blue Cross and Blue Shield and the Blue Cross and Blue Shield Association, grants you access to Blue Distinction Centers for treatment of serious medical conditions. Blue Distinction Centers are facilities that provide the highest quality of care in these specialties:

- Bariatric surgery
- Knee and hip replacement
- Cardiac care
- Spine surgery
- Complex and rare cancers
- Transplants

To find a Blue Distinction Center, visit www.bcbs.com:

- Select “Find a Doctor”
- Enter the type of health professional you are looking for and location
- Select “Recognition / Awards.”

If you believe that you were incorrectly denied a benefit under the Plan, you can file a claim. For information on the claims and appeals procedures, see “Claims and appeals” on page 85.

If there is a location near you, you will find a Blue Distinction recognition/award next to the provider’s name. If you visit this provider, provide your Triple-S IDC. Triple-S will provide any applicable payment for your care, and all claims should be coordinated with Triple-S.

Prescription drugs

When you enroll in the Triple-S PPO, you have prescription drug coverage in the Triple-S Prescription Drug Program.

Triple-S offers two ways to purchase prescription drugs:

- A network of retail pharmacies at which you can obtain prescription drugs for your immediate short-term needs, for example, an antibiotic to treat an infection.
- The mail order pharmacy through which you may save money by buying up to a 90-day supply of your maintenance drugs delivered by mail. You will make one copay for each prescription or refill for less than what you would pay to purchase the same amount at a retail in-network pharmacy.

Retail network pharmacies

Triple-S has a network of retail pharmacies throughout Puerto Rico and the United States where you can obtain prescription drugs.

To find out whether a pharmacy participates in the Triple-S network:

- Ask your pharmacist; or
- Visit and use the online pharmacy locator on www.ssspr.com.

To have your prescription filled at an in-network pharmacy, present your Medical/Prescription Drug ID card. You will be charged the appropriate copay based on whether your pharmacy participates in the primary network and your prescription is for a generic or brand-name drug.

The copay structure is outlined below. Acute drugs are limited to a 15-day supply; maintenance drugs are limited to a 30-day supply. You will never pay more than the cost of the drug.

Triple-S Prescription Drug Program	
Copay/coinsurance for up to a 15-day supply (acute drugs) or 30-day supply (maintenance drugs) at a retail primary network pharmacy	
Generic drug*	$2 copay
Brand-name drug	20% coinsurance with a $4 minimum
Generic oral contraceptives, and brand contraceptives if prior authorization is obtained	Covered at 100%
Copay/coinsurance for a 90-day supply through the mail order pharmacy	
Generic drug*	$6 copay
Brand-name drug	$12 copay
Generic oral contraceptives, and brand contraceptives if prior authorization is obtained	Covered at 100%
Benefits at a pharmacy outside the primary network	
Generic drug*	10% coinsurance with a $5 minimum
Brand-name drug	20% coinsurance with a $10 minimum
Generic oral contraceptives	Covered at 100%

* The use of generic equivalents whenever possible is more cost-effective. If the physician allows a brand-name drug to be substituted for a generic drug, and you choose to buy the brand-name drug, you will be required to pay the difference in price between the generic and brand drugs as well as your copay. For example, if the generic product has a maximum allowable cost of $10, and you choose a brand-name drug that costs $50, you will be charged your generic copay of $2 plus the differential cost of $40.

Managed drug limitations

Some medications, such as migraine agents and proton pump inhibitors, will be limited under clinical guidelines to a certain quantity within a given time frame.

Acute drugs are covered up to a 15-day supply at an in-network retail pharmacy.

The guidelines for use and quantity were developed by doctors and pharmacists based on accepted medical practices, Food and Drug Administration (FDA) guidelines, the recommendations of the drug manufacturer, and the cost-effective use of medicines.

In some cases, the quantity of your medication may require approval before it can be dispensed. If this is the case, your pharmacist can call Triple-S at a special toll-free number that will be identified to the pharmacy at the time it processes the claim. You also can ask your doctor to call Triple-S directly.

If you or your pharmacy calls Triple-S, Triple-S will need to contact your doctor. This typically takes one to two business days. Once your doctor provides the required information, Triple-S will review your case based on clinical criteria and the information from your doctor. After the review is completed, Triple-S will advise your doctor and pharmacist of the decision.

If your medication or the requested quantity is not approved for coverage under the Citigroup Prescription Drug Program, you will be responsible for paying the full cost of the drug.

Triple-S mail-order pharmacy

For prescription drugs you take over an extended period of time, such as blood pressure medication, insulin, or contraceptives, you may want to use the Triple-S mail-order pharmacy to save on the cost of the drug.

Through the Triple-S mail-order pharmacy, you can buy up to a 90-day supply of medication for one copay per prescription or refill for the same or less than what you would pay to purchase the same amount at a retail in-network pharmacy with the convenience of having the medication delivered to your home.

With the Triple-S mail-order pharmacy:

- Your medications are dispensed by one of the Triple-S mail-order pharmacies and delivered to your home.
- Medications are shipped by standard delivery at no additional cost to you. Overnight or second-day shipping is available for an added charge.
- You can order your refill by calling Triple-S at **1-866-881-6221**.
- Registered pharmacists are available 24 hours a day/seven days a week for consultations.

How to use the Triple-S mail-order pharmacy

Ask your doctor to write two prescriptions:

- One for a short-term supply (e.g., 30 days) to be filled immediately at a participating retail pharmacy.
- A second for up to a 90-day supply with as many as three refills (if appropriate) to mail to the Triple-S mail-order pharmacy.

Complete the Triple-S Mail Service order form available on Citi For You (intranet only). An incomplete form can cause a delay in processing.

Mail your order form, along with your prescription and payment, in the Triple-S envelope. Triple-S accepts VISA, MasterCard, Discover, or American Express credit cards. You also can pay by check or money order. Do not send cash.

Allow 10-14 days from the day you mail your order for the delivery of your medication.

Refills: The information included with your order will show the date that you can request a refill and the number of refills remaining. You may order your refills by calling the toll-free number on your prescription label.

Triple-S Specialty Pharmacy Program

Triple-S offers a Specialty Pharmacy Program to dispense oral and injectable specialty medications for the treatment of chronic diseases, including but not limited to, multiple sclerosis, cancer, rheumatoid arthritis, Crohn's disease, and asthma.

The Triple-S Specialty Pharmacy offers additional advantages such as:

- No delivery charges (some restrictions may apply);
- Express delivery; and
- Access to a pharmacist and other health experts 24 hours a day/seven days a week.

Procedure

All new specialty drug prescriptions should be dispensed by the Triple-S Specialty Pharmacy and can be delivered to your home, office, or doctor's address.

To enroll in the Triple-S Specialty Pharmacy, call **1-866-881-6221** and speak with a help desk representative. Spanish-speaking representatives are available.

For information about the Triple-S Specialty Pharmacy services, and to find out if your prescription is for a specialty drug, call Triple-S at **1-866-881-6221**.

If you believe that you were incorrectly denied a benefit under the Plan, you can file a claim. For information on the claims and appeals procedures, see "Claims and appeals" on page 85.

Dental

Citigroup Dental Benefit Plan offers two dental options: Basic and Comprehensive.

Both dental plans are administered by Triple-S. You can enroll in dental coverage even if you do not enroll in medical coverage. You can enroll in coverage for you and/or your eligible dependents in one of the same four coverage categories available for medical coverage. See “Coverage categories” on page 9.

Dental options at a glance		
	Basic Dental	**Comprehensive Dental**
Preventive and diagnostic services	Covered at 100%	Covered at 100%
Basic services	Covered at 100%	Covered at 100%
Endodontic services	Covered at 100%	Covered at 100%
Amalgam, silicate acrylic, synthetic porcelain filling restorations to diseased or fractured teeth	Covered at 100%; 30% coinsurance for composite filing restoration	Covered at 100%; 30% coinsurance for composite filing restoration
Space retainers	Not covered	50% coinsurance
Prosthodontic services, subject to precertification	Not covered	50% coinsurance; maximum benefit $800 per participant per year (combined maximum for both prosthodontic and periodontal services)
Periodontal services	Not covered	$50 copay and 50% coinsurance; maximum benefit $800 per participant per year (combined maximum for both prosthodontic and periodontal services)
Orthodontia	Not covered	Covered at 50% of the maximum allowed amount after $50 deductible; $3,000 per individual per lifetime limit.
Implants	Not covered	Covered at 50%; no maximum

Basic Dental

- Preventive and diagnostic services are covered at 100% of contracted fees.
- Basic and endodontic services are covered at 100% of contracted fees.
- Prophylaxis, dental exams, and fluoride are limited to two per policy year, in intermissions of no less than six months from the last date of service. Fluoride is covered only for participants younger than 19 years of age.
- X-rays: One full mouth series every 6 months and supplementary bitewing X-rays no more than once during any 12-month period.
- Minor or emergency treatments and extractions including surgical removal of impacted teeth.
- Amalgam, silicate acrylic, and synthetic porcelain filling restorations to diseased or fractured teeth are covered at 100% of contracted fees. Composite filing restoration is covered at 70% of contracted fees.
- You or your dentist must submit a claim to be reimbursed for covered expenses.

Comprehensive Dental

- Preventive and diagnostic services are covered at 100% of contracted fees.
- Basic and endodontic services are covered at 100% of contracted fees.
- Amalgam, silicate acrylic, and synthetic porcelain filling restorations to diseased or fractured teeth are covered at 100% of contracted fees. Composite filing restoration is covered at 70% of contracted fees.
- Space retainers are covered at 50% of contracted fees.
- Implants are covered at 50%.
- Prosthodontic services, subject to predetermination by Triple-S are covered at 50% coinsurance up to a maximum of $800 per insured per policy year (combined with the periodontal services maximum).
- Periodontal services are covered at 50% after a $50 deductible up to a maximum of $800 per insured per policy year (combined with the prosthodontic services maximum).
- Orthodontia is covered for all participants at 50% coinsurance with a $3,000 lifetime maximum per covered person.
- You or your dentist must submit a claim to be reimbursed for covered expenses.

The benefit coverage described above refers to Triple-S Preferred Dentist Program, except for Orthodontia services, which are covered by reimbursement. Triple-S Preferred Dentist Program allows you to select from a network of dentists who have agreed to charge discounted fees. You may still elect to receive services from a non-network dentist for the following benefit:

- If you receive the service in Puerto Rico: The Plan will pay the lesser amount between the 90% of the expenses incurred and the 90% of the fees that would have been paid to a Participating network Dentist after deducting any applicable deductibles or coinsurance.
- If you receive the service outside Puerto Rico: The Plan will pay the lesser amount between the 100% of the expenses incurred and the 100% of the fees that would have been paid to a Participating network Dentist for the same service after deducting any applicable deductibles or coinsurance.

Claims and appeals

If you believe that you were incorrectly denied a benefit under the Dental Plan, you can file a claim. For information on the claims and appeals procedures, see “Claims and appeals” on page 85.

Vision

The Citigroup Vision Benefit Plan (the "Plan"), offers a variety of routine vision care services and supplies.

You may enroll in the Plan as a new hire or during annual enrollment. When you enroll in the Plan, you will receive two ID cards in the mail.

The Plan offers both in-network and out-of-network benefits. For example, you can obtain an annual eye exam from an in-network provider while purchasing frames and lenses out of network. However, before taking a prescription from one vendor to be filled at another vendor, you should confirm that the prescription will be honored.

The Plan is underwritten by Aetna Life Insurance Company. Certain claims administration services are provided by First American Administrators, Inc., and certain network administration services are provided through EyeMed Vision Care, LLC.

To receive the greatest value for your dollar, you should receive vision care services from an Aetna Vision network provider. However, you can use out-of-network providers and receive a benefit.

In-network benefit	Coverage
Routine eye exam	Covered at 100% including dilation, one exam per 12-month period
Frames and lenses	One pair of frames and lenses per 12-month period Lenses covered at 100% Frames covered at 100% up to the frame allowance below $150 frame allowance; member pays 80% of balance over the $150 plan allowance 40% discount on additional pairs of glasses
Contact lenses (in lieu of glasses)	Covered at 100% up to the contact lens allowance below; one allowance per 12-month period in lieu of eyeglasses $130 allowance for conventional or disposable contact lenses; member pays 85% of balance over $130 allowance for conventional contact lenses and 100% over $130 allowance for disposable contact lenses 15% discount on additional conventional contact lens purchases Medically necessary contact lenses covered in full
Laser vision correction (Lasik)	15% off retail price or 5% off promotional price; must use the U.S. Laser Network to receive discount
Maximum benefit	The most the Plan will pay for the service or benefit; excludes copays and allowances
Out-of-network benefit	**Coverage**
Routine eye exam	Up to $50
Frames/lenses	Frames; up to $100 Single vision lenses up to $50, bifocal up to $60, trifocal up to $90, and lenticular up to $125
Contact lenses	Contact lenses; up to $130 Medically necessary contact lenses; up to $225

In-network services and providers

In-network providers are licensed doctors in your area who have contracted to provide vision care services at a discount. You and your covered family members can select a different Aetna Vision network provider each time you receive vision care services.

Your doctor may apply to join the Aetna provider network by calling EyeMed at **1-800-521-3605**. Membership in the network is not guaranteed

To find an in-network provider in your area and schedule an appointment, follow these instructions.

- If you are a member: Visit Aetna Navigator at www.aetna.com or visit www.aetnavision.com, and enter the employee's member ID number.
- You may also call the Plan at **1-877-787-5354**. An automated voice response unit (available 24 hours a day/seven days a week) or a Member Services representative (available from 7:30 a.m. to 11 p.m. ET Monday through Saturday and 11 a.m. to 8 p.m. on Sunday) will assist you.

Once you have obtained the name of an in-network provider, call him or her to schedule an appointment and provide the Citi employee's member ID number. If you are calling for services for a covered dependent, you will need to provide your dependent's date of birth.

Note: Claim forms are not required when obtaining in-network services.

In-network benefits

In-network benefits include:

- Routine eye exam: One eye exam, including dilation, when professionally indicated, each 12-month period covered at 100%;
- Frame and spectacle lenses: One pair of eyeglasses each 12-month period; frame allowance of $150 per calendar year; members pay 80% of the balance over this allowance;
- Progressive lenses: $0 copay for standard; $20 copay for premium tier 1; $30 copay for premium tier 2, $45 copay for premium tier 3, and $120 copay for premium tier 4;
- Anti-reflective coating: $0 copay for standard; $15 copay for premium tier 1; $30 copay for premium tier 2, and $110 copay for premium tier 3;
- Hi-index lenses: $30 copay
- Contact lenses in lieu of eyeglasses: $130 allowance per 12-month period and a 15% discount over the allowance for conventional contact lenses; and
- A 40% discount on additional pairs of glasses at most in-network providers.

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

Note: Some brand exceptions may apply and may require a copay.

Mail-order contact lenses

You can purchase replacement or additional pairs of contact lenses by calling the Plan at **1-877-787-5354** or visiting www.aetnavision.com.

Travel and student coverage

If you or a covered dependent(s) requires vision care services while traveling or away at school, call the Plan at **1-877-787-5354**.

Out-of-network benefits

If you receive services outside the Aetna network, the Plan will provide reimbursements of up to the following amounts:

- Annual exam: $50;
- Lenses: Single vision, $50; bifocal, $60; trifocal, $90; lenticular, $125;
- Frame only: $100; and
- Contact lenses: $130 elective; $225 medically necessary.

When you receive services outside the provider network, you will need to submit your itemized paid receipts with a Vision Claim Submission Form. You can visit www.aetnavision.com to obtain the form. Mail the completed form and your itemized paid receipts to:

Aetna Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Allow at least 14 calendar days for your claims to be processed after receipt. A check and/or explanation of benefits will be mailed within seven calendar days of the date your claim is processed. If you have any questions about your claims, call the Plan at **1-877-787-5354**.

Laser vision correction

Laser vision correction is not covered under the Plan. However, if you use a provider in the U.S. Laser Network, you are eligible for up to a 15% discount off the retail price or a 5% discount off any promotional price. The U.S. Laser Network comprises hundreds of provider locations, including LasikPlus Vision Centers nationwide (and currently includes a provider in Puerto Rico), and offers a broad choice of the latest technologies in the industry.

The list of doctors and facilities performing laser vision correction is different from the routine vision provider listing. To locate the nearest participating U.S. Laser Network provider, call the Plan at 1-800-442-6600 or visit www.aetnavision.com.

What is not covered

Below is a partial list of exclusions and limitations:

- Special vision procedures, such as orthoptics, vision therapy, or vision training;
- Vision services that are covered, in whole or in part, under any other plan of group benefits provided by Citigroup, or under any Workers' Compensation law, or any other law of like purpose;
- An eye exam that is required by an employer as a condition of employment, or that an employer is required to provide under a labor agreement, or that is required by any law of a government;
- The cost of prescription sunglasses in excess of the amount that would be covered for non-tinted lenses;
- Replacement of lost, stolen, or broken prescription lenses or frames; and
- Any exams given during your stay in a hospital or other facility for medical care.

Other exclusions and limitations may apply.

Complaints

If you are dissatisfied with the service you receive from the Vision Plan or want to complain about a provider, you may write to Aetna Customer Service within 30 calendar days of the incident.

Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156

You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter.

Aetna will review the information and provide a written response within 30 calendar days of receipt of the complaint, unless additional information is needed and the information cannot be obtained within this period. The notice of the decision will tell you what to do to seek an additional review.

Claims and appeals

Aetna will make an appeal decision within 30 days with one 15-day extension available if notice of the need for an extension is given within 30 days. Aetna must also give notice that more information is needed within 30 days after the claim is filed. You will then have 45 days to submit any additional information needed to process the claim.

See ""Out-of-network benefits" on page 33 more information on submitting a claim.

Appeals process

If Aetna notifies you of an adverse benefit determination — that is, a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service, supply or benefit — you may submit an appeal.

An adverse benefit determination may be based on:

- Your eligibility for coverage;
- The results of any utilization review activities;
- A determination that the service or supply is experimental or investigational;
- A determination that the service or supply is not medically necessary; or
- Contractual issues.

The Vision Plan provides two levels of appeal. It will also provide an option to request an External Review of the adverse benefit determination.

You have 180 calendar days following receipt of notice of an adverse benefit determination to request your first-level appeal. Your appeal may be submitted in writing and should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

You may file your appeal in writing or by telephone:

- In writing: Send your appeal to Customer Service at the address on your Aetna Vision Plan ID card; or
- By telephone: Call the Aetna Vision Plan at 1-877-787-5354.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna.

First-level appeal

A first-level appeal of an adverse benefit determination shall be made by Aetna personnel who were not involved in making the adverse benefit determination.

Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Second-level appeal

If Aetna upholds an adverse benefit determination at the first-level of appeal, you or your authorized representative has the right to file a second-level appeal. The appeal must be submitted within 60 calendar days following receipt of notice of a first-level appeal.

A second-level appeal of an adverse benefit determination of an urgent care claim, a preservice claim, or a post-service claim shall be made by Aetna personnel who were not involved in making the adverse benefit determination.

Aetna shall issue a decision within 30 calendar days of receipt of the request for a second-level appeal.

Exhaustion of process

You must exhaust the applicable first-level and second-level processes of the Aetna appeal procedure before you do any of the following regarding an alleged breach of the policy terms by Aetna Life Insurance Company or any matter within the scope of the appeals procedure:

- Contact your state's Department of Insurance to request an investigation of a complaint or appeal;
- File a complaint or appeal with your state's Department of Insurance; or
- Establish any litigation, arbitration, or administrative hearing.

External review

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is experimental or investigational in nature. In either of these situations, you may request an External Review if you or your provider disagrees with Aetna's decision. An External Review is a review by an independent physician, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, all following requirements must be met:

- You have received notice of Aetna's denial of a claim;
- Your claim was denied because Aetna determined that the care was not necessary or was experimental or investigational;
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the applicable internal appeals processes.

Aetna's claim denial letter will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim-denial letter. You must also include a copy of the final claim-denial letter and all other pertinent information that supports your request.

Aetna will contact the Independent Review Organization that will conduct the review of your claim. The Independent Review Organization will select a physician reviewer with appropriate expertise to perform the review. In making a decision, the External Reviewer may consider any appropriate credible information that you send along with the Request for External Review Form and will follow Aetna's contractual documents and plan criteria governing the benefits.

You will be notified of the decision of the Independent Review Organization usually within 30 calendar days of Aetna's receipt of your request form and all necessary information. A quicker review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the requested service or supply would endanger your health. Expedited reviews are decided within three to five calendar days after Aetna receives the request.

Aetna will abide by the decision of the independent reviewer, except where Aetna can show conflict of interest, bias, or fraud.

You are responsible for the cost of compiling and sending to Aetna the information that you wish to be reviewed by the Independent Review Organization. Aetna is responsible for the cost of sending this information to the Independent Review Organization and for the cost of the external review.

For more information about Aetna's External Review program, call the Vision Plan at 1-877-787-5354.

Wellness benefits

Health Assessment

The Health Assessment is a brief, online questionnaire that provides a snapshot of your current health status and may recommend ways to make healthy changes.

The Health Assessment is available to Citi benefits-eligible employees enrolled in Triple-S medical coverage offered by Citi. Same or opposite sex spouses/civil union partners/domestic partners may also complete the Health Assessment if they are enrolled in the Triple-S medical coverage offered by Citi.

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

24-Hour Nurseline

The 24-Hour Teleconsulta Nurseline is available 24/7 to active, benefits-eligible employees and their spouses/civil union partners/domestic partners and dependents enrolled in the Triple-S medical plan offered by Citi. You can call the 24-Hour Nurseline at any time to speak with a registered nurse who can answer questions about an immediate health issue or any other health topic.

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

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

Call **1-800-255-4375** to access the 24-Hour Teleconsulta Nurseline.

Healthy Choices Rewards

Citi offers the Healthy Choices Rewards program to employees and spouses/civil union/domestic partners covered under the Triple-S medical plan.

Through this program, you can earn Rewards to reduce the cost of your medical contributions.

- **Health Assessment:** You can complete the Triple-S Health Assessment and receive a Reward per adult participant. The Health Assessment, which you will complete on the Triple-S website at www.ssspr.com, is a secure, online health questionnaire that can help you learn more about your health.
- **Tobacco-free:** During your annual enrollment period, you will have the opportunity to attest that you are tobacco-free or that you promise to try to become tobacco-free. You can also attest on behalf of your spouse/domestic partner who is covered under the Triple-S medical plan offered by Citi. You may earn a Reward toward the cost of benefits; spouses/civil union partners/domestic partners may earn an additional Reward.

Employees and spouses/domestic partners who are covered under Triple-S medical coverage and identified as eligible may also participate in Triple-S' health management program. If you are eligible to participate, Triple-S will contact you directly. If you or your spouse/domestic partner is invited to participate and you each complete the program as established by Triple-S, you each may earn an additional Reward. The Reward will be applied after all sessions are completed. Visit www.ssspr.com for more information

Healthy Choices Rewards at a glance

Reward	Who can participate	How to earn the Reward	When you will receive
Health Assessment	Citi benefits-eligible employees enrolled in Triple-S medical coverage through Citi; spouses/civil union/domestic partners if they are enrolled in Triple-S medical coverage through Citi	Complete the Health Assessment on the Triple-S website at www.ssspr.com	Starting January 1, your Reward will be equally divided among the pay periods throughout the year
Tobacco-free	Citi benefits-eligible employees enrolled in Triple-S medical coverage through Citi; spouses/civil union/domestic partners if they are enrolled in Triple-S medical coverage through Citi	Complete the Tobacco Free Attestation for you and, if applicable, your spouse/civil union/domestic partner who is enrolled in Triple-S medical coverage through Citi on the Your Benefits Resources™ (YBR™) website during annual enrollment	
Health Management	Citi benefits-eligible employees enrolled in Triple-S medical coverage through Citi and their spouses/domestic partners enrolled in Triple-S medical coverage through Citi and who are invited to participate	Work with health professionals from Triple-S Salud on a specific program to address your health conditions	Starting the quarter after you complete the program as established by Triple-S your Reward will be equally divided among the remaining pay periods in that calendar year

Employee Assistance Program (EAP)

Citi's EAP provides confidential assessment and referrals to mental health and substance abuse services through a network of counselors. Additionally, the EAP provides an online library of thousands of articles, self-assessments, links, and related resources.

When you or an immediate family member calls the EAP at the toll-free number (**1-866-723-7223**) you will speak with an intake counselor who will listen to your concern and refer you to an appropriate EAP provider in your community. You may attend up to six free sessions. If you require additional counseling, you will be responsible for any fees. You should check with Triple-S to find out how additional treatment will be reimbursed. In an emergency, the intake counselor also will provide immediate assistance and, if necessary, arrange for treatment at an appropriate facility

EAP services are provided on a per-issue basis and are not restricted solely to six sessions per person annually.

Work/Life Program

Citi's Work/Life Program is designed to save you time by providing valuable advice on a number of common everyday challenges facing Citi employees. Whether you are researching options for child care, need to speak with a financial counselor, or are dealing with the concerns of your elderly parent, Citi's Work/Life Program can help. All Work/Life services are completely confidential.

Call Citi's Work/Life Program for information and practical solutions, customized referrals, and resources and research information on a wide variety of topics ranging from parenting/child care to adoption, identity theft, legal and wills, and advice and resources about caring for older adults. You can also obtain assistance with common challenges, such as what size home or mortgage you can afford or the cost of living in another city.

The Work/Life Program is a core benefit available to all benefits-eligible employees. You do not have to enroll or make any contributions to use this benefit. Citi provides the Work/Life Program through a contract with Health Advocate Inc.

Contact Citi's Work/Life Program from 8 a.m. to 9 p.m. ET Monday through Friday, excluding holidays.

- Telephone: **1-866-449-9933**, select option #2 for Work/Life program
- Website: www.HealthAdvocate.com/citiworklife

Disability coverage

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

This section describes the STD and LTD benefits available. The receipt of STD and LTD benefits is subject to the terms and conditions of the Plan. If you incurred a disability prior to 2002 or you became a Citi employee in connection with a corporate transaction with benefits provided under another disability plan, your benefit may not be described in this Handbook. Please see the prior plan and/or related summary plan description that was applicable when you became disabled. For complete details about your coverage under the LTD benefit, see the insurance certificate, which is also part of the Plan, at Citi Benefits Online at www.citibenefitsonline.com. If there is any discrepancy between the provisions in this section of the Handbook and the related insurance certificate provided by the insurance company, the provisions of the insurance certificate shall prevail.

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

Definition of years of service for the Plan (STD and LTD benefits)

For purposes of the Disability Plan, your years of service are based on your actual time providing services to Citi as an employee. You will have a year of service for this purpose for each 12 months of service, counting any part of a month in which you provided service.

Service before a break in service will be allowed (or not) under rules similar to the Citigroup Pension Plan credited service rules, such as not counting service prior to five consecutive one-year breaks in service. In no event will the time between your periods of Citi service be counted.

Short-Term Disability (STD)

The STD benefit is a core benefit available to all benefits-eligible employees. No enrollment is necessary. However, you must report all disabilities to the Claims administrator before you can receive a benefit. To report your disability, call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu choose the “disability” option. You also can call MetLife, Citi’s disability claims administrator, directly at **1-800-826-0547**. For a complete description of your responsibilities and those of MetLife when you report a disability, see the Managed Disability brochure available on Citi For You.

STD pays 100% or 60% of base salary (not benefits eligible pay) during an approved disability of up to 13 weeks based on your years of service. For newly hired or rehired employees (regardless of years of prior service), there is a 90-day waiting period before you are eligible for disability benefits (as shown in the following schedules of benefits).

STD schedule of benefits — 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 90 days	0	0	0
90 days 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

Paid Pregnancy Leave — 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 90 days	8	0	8
90 days to less than 1 year	8	5	13
1 or more years	13	0	13

For non-salaried employees: The STD benefit will be calculated by your business but will not exceed 100% of your benefits eligible pay for benefits purposes.

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

No STD benefit is payable for claims submitted more than 6 months after the date of disability. However, you can request that benefits be paid for late claims if you can show that:

- It was not reasonably possible to give written proof of disability during the 6 month period; and
- Proof of disability satisfactory to the claims administrator was given as soon as was reasonably possible.

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.

To qualify for STD benefits, you must be receiving appropriate care and treatment on a continuing basis from a licensed health care provider. You are not considered to have a disability if your illness, injury, or pregnancy prevents you from commuting to and from work only. If you are able to perform the essential duties of your job at home or elsewhere, and are unable to commute to work, this limitation does not constitute a disability for benefits purposes. You can’t qualify for an STD benefit if you return to work on a part-time basis (except for statutory benefits required under applicable state law).

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 a prior absence) and may qualify for LTD benefits.

If either a recurrent disability or an unrelated disability occurs after you returned to work for more than 30 days following an initial disability, you may be eligible for an additional short-term disability benefit, not to exceed 13 weeks, if approved.

STD benefits are taxable as ordinary income. Citigroup will withhold taxes, as well as deductions for other employee benefits, from STD benefits.

Short-term disability benefits may be offset by any monies owed to Citi and/or by any mandated disability benefits in Puerto Rico, including Worker's Compensation and Social Security disability benefits. However, the Plan does not subrogate short-term disability payments.

Exclusions

You will not receive STD benefits for any of the following:

- A disability when your care is not supervised by a qualified physician;
- Injuries caused by war, international armed conflict, riot, or civil disobedience;
- Intentional self-inflicted injury;
- A disability that begins during an unapproved leave of absence;
- A disability that results from an attempted or committed felony, assault, battery, other public offense, or during incarceration; or
- A disability resulting from cosmetic surgery, which is a surgical procedure that is not necessary to correct a sickness or injury (except for statutory benefits required under applicable law in Puerto Rico).

Long-Term Disability (LTD)

LTD benefits are provided through a MetLife group disability policy in the event you suffer a covered disability. You may be eligible to receive LTD Benefits if your approved STD claim was paid for 13 weeks LTD coverage is offered to replace 60% of your benefits eligible pay (pre-disability earnings) determined on the day before your approved STD. Your "pre-disability earnings" under the MetLife group disability policy constitutes your benefits eligible pay (as defined by the plan) for purposes of the LTD benefit.

For purposes of calculating your LTD benefit, benefits eligible pay is limited to a maximum of $500,000. In no event shall the monthly benefit exceed $25,000 per month.

Disability benefits received from any disability plan benefit in Puerto Rico, Social Security, and the LTD portion of the Plan, combined, won't exceed 60% of your benefits eligible pay.

Participation

Citi provides Company-paid LTD coverage to employees whose benefits eligible pay is less than or equal to $50,000.99. If your benefits eligible pay is less than or equal to $50,000.99, you do not need to enroll for coverage and there is no cost to you.

If as a new hire, your benefits eligible pay exceeds $50,000.99, you may be automatically enrolled in LTD coverage with an option to decline coverage.

If your benefits eligible pay increases to $50,001 or above for benefits purposes for annual enrollment in the next plan year, you will be automatically enrolled in LTD coverage so your coverage continues uninterrupted. The cost of LTD coverage will be deducted from your pay beginning January 1 of the next plan year (following annual enrollment) unless you decline coverage. Refer to the Your Benefits Resources™ website available through TotalComp@Citi at www.totalcomponline.com during annual enrollment for the cost.

If you do not elect "no coverage" during annual enrollment (or as a new hire) you will be automatically enrolled. You have the option to decline coverage. If you do so within the first 90 days following your enrollment, you will receive a refund of your paid premiums. You can also decline coverage after the initial 90-day period, however, premiums will not be refunded to you.

If your benefits eligible pay is:	
$50,000.99 or less*	Citi provides LTD coverage at no cost to you
From $50,001 to $500,000	You will pay for coverage with after-tax dollars. The LTD benefit under the Citi plan is tax free, meaning you don't pay taxes on the benefit you receive from MetLife.

* If your benefits eligible pay increases to above $50,000.99 during the year, you will be automatically enrolled in LTD coverage, during annual enrollment, for the following year. Effective January 1 of the following year, contributions will be deducted from your pay. If you do not want LTD coverage for the following year, you must select "no coverage" during annual enrollment. However, if you do not opt out of LTD coverage during annual enrollment you will have 90 days beginning January 1 to opt out. If you opt out within this 90-day period, these contributions will be refunded to you.

Benefits are paid monthly and continue for as long as your approved disability continues, up to age 65 (or longer, depending on your age when your disability begins). See the following schedule.

LTD benefits	
Age when total disability begins (when LTD becomes effective)	**Date monthly LTD benefits will stop**
Under age 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

You will be billed for your health and welfare benefits to the extent you are enrolled. The cost of benefits is not deducted from your LTD benefit. For more details about your benefits and eligibility while on a continued LTD leave, see "Participation" on page 42.

Unless you have other disability coverage, you should consider enrolling in LTD since LTD coverage protects you in the event your ability to work is impaired by an accident or illness.

You do not have to enroll in LTD coverage despite automatic enrollment, as described. However, if you decide to enroll in LTD coverage at any time, other than when first eligible or as the result of a qualified change in status, you must take a physical exam and/or provide evidence of good health before coverage will be approved.

Note: The Plan will not cover any disability caused by or contributed to, 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

If you are enrolled in LTD coverage (pursuant to the terms of the Disability Plan on your date of hire) and have received 13 weeks of STD benefit payments, you may be eligible for an LTD benefit.

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 of 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.

If you have a disability, which continues for a period of more than 13 weeks and if eligible and approved, you will receive an LTD benefit from MetLife. If you're approved for Social Security Disability Insurance (SSDI) for you and/or your dependents, your monthly LTD benefit will be offset by SSDI, dependent SSDI, and any state disability benefits you may receive. The state and Social Security benefits may be subject to tax.

To review the Disability Plan document, visit www.citibenefitsonline.com. If you do not have access to this website, you can request a copy at no cost to you by speaking with a Citi Benefits Center representative. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu choose the "health and welfare benefits" option.

Converting your coverage

If you have been enrolled in the Plan at least one year and leave Citigroup (other than to retire, which could occur if you terminate employment after your age plus your year of Citi service equals 60 and you have attained age 50 with at least five years of Citi service, you can convert your Citigroup LTD coverage under the group policy to an individual policy within 31 days after your employment ends. 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 Citi Benefits Center representative. The maximum benefit of this individual policy is $3,000 per month.

Claims and appeals

You should file an STD claim as soon as you know you will be out of work for more than seven consecutive calendar days due to an illness or injury.

To file a claim, call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu choose the "disability" option. You may also contact MetLife directly at **1-800-826-0547**. The Claims Administrator will provide the appropriate forms and can help you file for disability benefits in Puerto Rico, where applicable.

You should expect to provide the Claims Administrator with the following information when you call:

- Name, address, telephone number, and Social Security number;
- Manager's/supervisor's name, telephone number, e-mail address, and mailing address;
- Your attending physician's name, address, and telephone number; and
- Information about your illness. **Note:** You should not give specifics, such as a medical diagnosis, for non-work-related injuries or illnesses to your manager/supervisor.

After you report a claim, the Claims Administrator will contact you if any additional information is necessary for MetLife to evaluate your claim. Once the Claims Administrator has collected and reviewed all of the relevant data, the Claims Administrator will approve or deny your claim.

The case manager assigned to the claim will notify both you and your manager of the Claims Administrator's decision regarding your claim. The Claims Administrator will specify a date that you are expected to return to work from an approved claim. If you are unable to return to work on the specified date, contact the Claims Administrator immediately.

MetLife, as the fiduciary, is responsible for adjudicating claims for benefits under the Plan and for deciding any appeals of denied claims. The Claims Administrator shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Claims Administrator shall be final and binding on participants and beneficiaries to the fullest extent permitted by law.

Except as otherwise prescribed by the rules of the Plan Administrator or Claims Administrator, the procedures will be as follows.

The Claims Administrator has 45 days from the date it receives your claim for disability benefits to determine whether or not benefits are payable in accordance with the terms and provisions of the Plan. The Claims Administrator may require more time to review your claim, if necessary, due to circumstances beyond its control. If this should happen, the Claims Administrator must notify you in writing that its review period has been extended for up to two additional periods of 30 days, as warranted. If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You will have up to 45 days to furnish the requested information.

During the review period, the Claims Administrator may require you to have a medical exam, at its own expense or to provide additional information regarding the claim. If a medical exam is required, the Claims Administrator will notify you of the date and time of the exam and the physician's name and location. You should keep the appointment since rescheduling an exam will delay the claim process. If additional information is required, the Claims Administrator must notify you in writing specifying the information needed and explaining why it is needed.

If your claim is approved, you will receive the STD benefit from Citi; if the LTD benefit is approved, it will be paid by the Claims Administrator.

If your claim is denied, in whole or in part, you will receive a written notice from the Claims Administrator within the review period. The Claims Administrator's written notice must include the following information:

- The specific reason(s) the claim was denied;
- Specific reference to the Plan provision(s) on which the denial was based;
- Any additional information required for your claim to be reconsidered and the reason this information is necessary;
- Identification of any internal rule, guideline, or protocol relied on in making the claim decision and an explanation of any medically related exclusion or limitation involved in the decision; and
- A statement informing you of your right to appeal the decision, including your right to file a claim under Section 502(a) of ERISA in the event of an adverse benefit determination upon review, and an explanation of the appeal procedure, as outlined below.

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Claims Administrator within 180 days of the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by the Claims Administrator, a prompt and complete review of your appeal must take place. This review will give no deference to the original claim decision and will not be made by the person who made the original claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the appeal, including the documents that establish and control the Plan. Any medical or vocational experts consulted by the Claims Administrator will be identified. You may also submit issues and comments that you believe might affect the outcome of the review.

The Claims Administrator has 45 days from the date it receives your request to review your appeal and to notify you of its decision. Under special circumstances, the Claims Administrator may require more time to review your appeal. If this should happen, the Claims Administrator must notify you in writing that its review period has been extended for an additional 45 days. Once its review is complete, the Claims Administrator must notify you in writing of the results of the review. If your appeal is denied, the Claims Administrator's notice must include the following:

- The specific reason(s) the appeal was denied;
- Specific reference to the Plan provision(s) on which the denial was based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access and copies of all documents, records, and other information relevant to your appeal for benefits; and
- Identification of any internal rule, guideline, or protocol relied on in making the appeal decision and an explanation of any medically related exclusion or limitation involved in the decision.

In the event that your appeal is denied, you have the right to bring a legal action under Section 502(a) of ERISA; provided, that you file any lawsuit or similar enforcement proceeding, commenced in any forum, relating to the Plan within 12 consecutive months after the date of receiving a final determination on review of your appeal, or if earlier, within two years from the date on which you were aware, or should have been aware, of the claim at issue in the suit. The two-year limitation shall be increased by any time a claim or appeal on the issue is under consideration by the appropriate fiduciary. If any different period to commence suit is specified in an insurance contract forming part of the Plan or any shorter period is specified in the rules of the Claims Administrator, that period will apply to proceedings against the insurer or with regard to the ruling of that Claims Administrator, respectively.

You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency, as applicable. Generally, the determination reached by the Plan is final.

Insurance Benefits

Citi offers various insurance programs for you and your dependents:

- Basic Life insurance, if your benefits eligible pay is less than $200,000;
- Basic Accidental Death and Dismemberment (AD&D) insurance, if your benefits eligible pay is less than $200,000;
- Group Universal Life (GUL) insurance for you and your spouse/civil union partner/domestic partner;
- Supplemental AD&D insurance for you and your spouse/civil union partner/domestic partner;
- Business Travel Accident/Medical insurance;
- Term life and Supplemental AD&D insurance for your children; and
- Long-Term Care insurance (if enrolled prior to January 1, 2012).

Insurance benefits are fully-insured. Benefits are provided under the contracts entered into between Citigroup (the "Plan Sponsor") and the insurers. The insurers, not the Plans Administration Committee of Citigroup Inc. (the "Plan Administrator") or the Plan Sponsor, administer benefit claims and appeals procedures and are responsible for paying claims.

Basic Life insurance

Citi provides Basic Life insurance through MetLife at no cost to you if your benefits eligible pay is less than $200,000. If your annual benefits eligible pay is equal to or above $200,000, you are *not* eligible for company-paid Basic Life insurance.

The benefit is equal to your benefits eligible pay, rounded up to the nearest $1,000, to a maximum of $200,000. Benefits eligible pay is recalculated each year (June 30), and the new coverage amount is effective the following January 1.

Since Citi pays the full cost of Basic Life insurance, you must pay taxes on the value of the coverage above $50,000 as required by the Puerto Rico Internal Revenue Code of 2011. This amount, called "imputed income," is shown on your pay statement and Form W-2 PR 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 benefits eligible pay is more than $50,000, you may elect to limit your Basic Life insurance to $50,000. You will not be subject to the imputed income, but you will also forego the additional benefit. You will not have the opportunity to enroll in Basic Life equal to your benefits eligible pay or to reduce coverage until the next annual enrollment period.

If your benefits eligible pay is increased to $200,000 or above

If you become ineligible for Basic Life and Basic AD&D due to an increase in benefits eligible pay such that it is equal to or exceeds $200,000, you may have the opportunity to enroll in Group Universal Life (GUL) coverage equal to one times your benefits eligible pay up to $500,000 *without providing evidence of good health,* subject to the Plan's maximum coverage limits.

If you are enrolled in GUL up to the maximum coverage amount — the lesser of 10 times your benefits eligible pay, not to exceed $500,000, or $5 million — then you are not eligible to increase GUL coverage. You can convert your Basic Life or Basic AD&D benefits into individual policies.

Basic Life Accelerated Benefits Option

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

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

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

- A completed Accelerated Benefit Claim form, available from the Citi Benefits Center by calling ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option;
- A signed physician's certification that states you are terminally ill; and
- An exam by a physician of MetLife's choice, if requested, at no expense to you.

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

Basic Accidental Death and Dismemberment (AD&D) insurance

Citi provides Basic Accidental Death and Dismemberment (AD&D) insurance through MetLife at no cost to you if your benefits eligible pay is less than $200,000. AD&D pays a benefit if you are dismembered or die as a result of an accidental injury. If your annual benefits eligible pay is equal to or above $200,000, you are *not* eligible for company-paid Basic AD&D insurance.

The benefit is equal to your benefits eligible pay, rounded up to the nearest $1,000, to a maximum of $200,000. Benefits eligible pay is recalculated each year (June 30), and the new coverage amount is effective the following January 1.

Naming a beneficiary

Your beneficiary is the person or persons you choose to receive any benefit payable upon your death.

You may designate or change your beneficiary for Basic Life or Basic AD&D insurance at any time by visiting Your Benefits Resources™ through TotalComp@Citi at www.totalcomponline.com.

If there is no beneficiary designated or no surviving beneficiary at your death, the Claims Administrator will determine the beneficiary in the following order:

- Your spouse, if alive;
- Your child(ren), if there is no surviving spouse;
- Your parent(s), if there is no surviving child;
- Your sibling(s), if there is no surviving parent; or
- Your estate, if there is no surviving sibling.

If a beneficiary or payee is a minor or incompetent to receive payment, the Claims Administrator will pay his or her guardian.

Continuing Basic Life and Basic AD&D on an individual basis

You can convert your Basic Life coverage to an individual policy after the termination of employment from Citi. You'll receive a Health and Welfare Benefits Conversion/Portability Notice from the Citi Benefits Center once you lose eligibility. Once the notice is received, you may call MetLife directly at **1-877-275-6387.**

Regarding Basic AD&D insurance, once notified of your loss of eligibility, MetLife will send you information on how to continue coverage. Note that rates will be higher than the Citigroup rate. If you have any questions about continuing your AD&D on an individual basis, call MetLife directly at **1-888-252-3607**.

If you become ineligible for Basic Life or Basic AD&D coverage because your benefits eligible pay for the plan year equals or exceeds $200,000, you can also continue your coverage on an individual basis, without providing evidence of good health, by calling MetLife within 31 days after you become ineligible.

Group Universal Life (GUL) insurance

You can enroll in GUL insurance, provided by MetLife, from 1 to 10 times your benefits eligible pay, not to exceed $500,000 up to a maximum coverage amount of $5 million. If your benefits eligible pay is not an even multiple of $1,000, then your benefits eligible pay will be rounded up to the next $1,000.

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

If you are enrolling in GUL insurance outside your initial eligibility period (31 days from your date of hire/date you are eligible to enroll in Citi benefits), outside of a qualified change in status, or for an amount greater than three times your benefits eligible pay, not to exceed $500,000, or $1.5 million, you must provide evidence of good health and be actively at work before coverage will be effective. “Actively at work” means that you are regularly scheduled to work in the office or at home and you are not away from work due to a disability. You must be able to perform all the activities of your job.

Enrolling in GUL coverage

You will enroll in coverage directly with MetLife, not through Citi. Visit the MetLife MyBenefits website available through TotalComp@Citi at www.totalcomponline.com or submit an enrollment form, which you can obtain by calling MetLife at **1-888-830-7380**. Your spouse/civil union partner/domestic partner must complete a separate enrollment form.

If your benefits eligible pay is reduced, your GUL amount will continue to be based on the higher benefits eligible pay unless you call MetLife at **1-888-830-7380** to request that the GUL amount be reduced. Once you reduce coverage, you can increase it by reinstating the automatic benefits eligible pay or by purchasing additional multiples of your benefits eligible pay. You may be asked to provide satisfactory evidence of good health before the increased coverage will become effective. GUL coverage for an employee ends at age 95.

If you leave Citi, your GUL coverage may be continued under an individual policy. MetLife will send you information regarding the continuation of your GUL coverage once notified of your termination or retirement. If you continue your GUL coverage, MetLife will bill you at a higher rate than the Citigroup rate. The rate will become effective the first of the month following the date of your termination of employment. If you have any questions on continuing your coverage, call MetLife directly at **1-888-830-7380**.

Did you know?

If you’re enrolled in GUL coverage, you receive Will Preparation and Estate Resolution services at no cost. Call Hyatt Legal Plans at **1-800-821-6400** to work with an attorney. Provide the Citigroup number 1137000 when you call.

GUL Accelerated Benefits Option

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

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

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

- A completed Accelerated Benefit Claim form, available from MetLife by calling **1-888-830-7380**;
- A signed physician's certification that states you are terminally ill; and
- An exam by a physician of MetLife's choice, if requested, at no expense to you.

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

Accelerated benefits are not payable if:

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

Cash Accumulation Fund

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

The Puerto Rico Internal Revenue Code determines the annual maximum you can contribute to the CAF based on your GUL coverage amount, your age, and other factors.

If your contributions for GUL, including the CAF, exceed the actual limits of the coverage for which you are enrolled, MetLife will notify you about a refund. For the actual amount that applies to you under the applicable tax laws, call MetLife at **1-888-830-7380**.

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

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

For more information about the CAF, call MetLife at **1-888-830-7380**.

Taking a loan from your CAF

At any time, you can obtain cash through a loan of at least $200 from your CAF. You may take an unlimited number of loans each plan year, but only one loan can be in effect at any time. The most you can borrow at any time is the current cash value just prior to the loan and less the interest to the next plan anniversary date at the current loan interest rate.

Loan interest is charged at a rate set by MetLife. This rate will never be more than the maximum permitted by law and will not change more often than once a year on the plan anniversary date. Call MetLife at **1-888-830-7380** for the current interest rate.

You may repay all or part of a loan (but not less than $100) at any time while you are alive and enrolled in GUL coverage. If any payment is intended as a loan repayment, rather than a contribution to your CAF, you must notify MetLife when you make the payment. Loans are not payable through payroll deductions.

Failure to repay a loan or to pay loan interest will not terminate your GUL coverage unless the balance in your CAF, minus the loan and loan interest, is not sufficient to pay the monthly contribution for GUL coverage. If this occurs, you will be notified that you have a 60-day grace period to pay the amount due.

For more information about CAF loans, call MetLife at **1-888-830-7380**.

Assignment

You may assign your GUL insurance rights and benefits as a gift or as a viatical assignment. In this case, MetLife will recognize the assignee(s) under such assignment as owner(s) of your right, title, and interest if:

- You have completed a written form satisfactory to MetLife affirming this assignment;
- Both you and the assignee(s) have signed the written form;
- The written form has been delivered to MetLife; and
- MetLife acknowledges that the life insurance being assigned is in force on your life.

MetLife is not responsible for the validity of an assignment.

Naming a beneficiary

Your beneficiary is the person or persons you choose to receive any benefit payable upon your death. You may designate or change your beneficiary for GUL insurance at any time by calling MetLife at **1-888-830-7380**. You can also visit the MetLife MyBenefits website available through TotalComp@Citi at www.totalcomponline.com.

Your spouse/civil union partner/domestic partner must call MetLife at **1-888-830-7380**.

If there is no beneficiary designated or no surviving beneficiary at your death, MetLife will determine the beneficiary in the following order:

- Your spouse, if alive;
- Your child(ren), if there is no surviving spouse;
- Your parent(s), if there is no surviving child;
- Your sibling(s), if there is no surviving parent; or
- Your estate, if there is no surviving sibling.

If a beneficiary or payee is a minor or incompetent to receive payment, MetLife will pay his or her guardian.

Coverage for your spouse/civil union partner/domestic partner

You can enroll in GUL insurance coverage, provided by MetLife, for your spouse/civil union partner/domestic partner in increments of $10,000 to a maximum of $100,000. You do not need to buy GUL insurance for you to elect coverage for your spouse/civil union partner/domestic partner.

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

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

The cost is based on the amount of your spouse's/civil union partner's/domestic partner's coverage, his/her age, and whether he/she has used tobacco products in the past 12 months. You can also contribute to a Cash Accumulation Fund in his/her name.

If you leave Citi or terminate your marriage, civil union, or domestic partnership, your spouse/civil union partner/domestic partner can still continue coverage. MetLife will bill him or her directly at a higher rate than the Citigroup rate. The rate will become effective the month following your termination of employment, divorce, or termination of your civil union or domestic partnership.

Life insurance for your children

If you have enrolled in GUL insurance coverage for you or your spouse/civil union partner/domestic partner, you can enroll for life insurance from $5,000 to $20,000, in $5,000 increments, for your eligible dependent children. Life insurance coverage is provided by MetLife. To enroll in child life coverage, call MetLife at **1-888-830-7380** or visit the MetLife MyBenefits website through TotalComp@Citi at www.totalcomponline.com.

When you enroll in child life coverage, all your eligible children are covered. You may enroll your eligible children in GUL coverage at any time without evidence of insurability. Coverage for a child generally ends at the end of the month in which the child reaches the maximum age of 26, or earlier if you lose eligibility for coverage.

Separately, you must report the birth or adoption of each child to the Citi Benefits Center through ConnectOne at **1-800-881-3938** within 31 days of the birth or adoption. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Unless you have designated a beneficiary — other than you — to receive these benefits, benefits will be paid to:

> You, if you survive the dependent; or

> Your estate, if the dependent dies at the same time your death occurs or within 24 hours after your death

You may designate or change your beneficiary for life insurance for your child at any time by calling MetLife at **1-888-830-7380** or visit the MetLife MyBenefits website available through TotalComp@Citi at www.totalcomponline.com.

Supplemental AD&D insurance for you and your dependents

You may enroll in Supplemental AD&D coverage, provided by MetLife, without providing evidence of insurability. You may choose from 1 to 10 times your benefits eligible pay, not to exceed $500,000 up to a maximum coverage amount of $5 million. If your benefits eligible pay is not an even multiple of $1,000, then your benefits eligible pay will be rounded up to the next $1,000. Your cost is based on coverage you elect. If your benefits eligible pay is reduced, your Supplemental AD&D amount will continue to be based on the higher benefits eligible pay unless you call MetLife at **1-888-830-7380** to request that the Supplemental AD&D amount be reduced.

Enrolling in Supplemental AD&D coverage

You will enroll in coverage directly with MetLife, not through Citi. Visit the MetLife My Benefits site available through TotalComp@Citi at www.totalcomponline.com, or submit an enrollment form, which you can obtain by calling MetLife at **1-888-830-7380**.

Once you reduce coverage, you can increase it by reinstating the automatic benefits eligible pay increase or by purchasing additional multiples of your benefits eligible pay.

You can enroll in Supplemental AD&D insurance coverage, provided by MetLife, for your spouse/civil union partner/domestic partner in increments of $10,000 to a maximum of $100,000, without providing evidence of insurability at any time. You do not need to buy Supplemental AD&D insurance for you to elect coverage for your spouse/civil union partner/domestic partner. You may enroll your spouse/civil union partner/domestic partner for Supplemental AD&D coverage at any time without providing evidence of insurability.

You may enroll your eligible children in Supplemental AD&D coverage at any time without evidence of insurability. Coverage for a child generally ends at the end of the month in which the child reaches the maximum age of 26, or earlier if you lose eligibility for coverage.

If you leave Citi or terminate your marriage, civil union, or domestic partnership, you and your spouse/civil union partner/domestic partner and children may continue coverage by paying premiums directly to MetLife. If you continue coverage, MetLife will bill you at a higher rate than the Citigroup rate. The rate will become effective the month following the loss of eligibility. If you have any questions on coverage continuation, call MetLife directly at **1-888-252-3607**.

Details about AD&D insurance

Schedule of covered losses for employees

- Loss of life: 100% of the principal sum;
- Loss of any combination of hand, foot, or sight of one eye: 100% of the principal sum;
- Loss of an arm permanently severed at or above the elbow: 75% of the principal sum;
- Loss of a leg permanently severed at or above the knee: 75% of the principal sum;
- Loss of one hand or foot: 50% of the principal sum;
- Loss of all four fingers of the same hand: 25% of the principal sum;
- Loss of the thumb and index finger of same hand: 25% of the principal sum;
- Loss of all the toes of the same foot: 20% of the principal sum;
- Loss of sight of both eyes: 100% of the principal sum;
- Loss of sight in one eye: 50% of the principal sum;
- Loss of speech and hearing (in both ears): 100% of the principal sum;
- Loss of hearing (in both ears) or loss of speech: 50% of the principal sum;
- Quadriplegia: 100% of the principal sum;
- Paraplegia: 75% of the principal sum;
- Hemiplegia: 50% of the principal sum;
- Monoplegia: 25% of the principal sum;
- Brain Damage; 100% of the principal sum;
- Coma: 1% monthly beginning on the 7th day of the Coma for the duration of the Coma to a maximum of 60 months.

Age reduction schedule

A covered person's principal sum will be reduced to the percentage of his/her principal sum in effect on the date preceding the first reduction, as shown below:

Age	Percentage of Benefit Amount
70 but less than 75	70%
75 but less than 80	45%
80 but less than 85	30%
85 or over	15%

Additional Basic AD&D benefits

Seatbelt and airbag benefit

- Seatbelt benefit: 10% of the principal sum subject to a maximum benefit of $25,000;
- Airbag benefit: 5% of the principal sum subject to a maximum benefit of $15,000.

Additional Supplemental AD&D benefits

Child care center benefit

- 5% of the employee's principal sum subject to a maximum of $10,000 per year, for up to 10 years. The maximum benefit period is to age 13 for each surviving dependent child

Child education benefit

5% of the principal sum to a maximum benefit of $10,000 for each qualifying dependent child who is insured under the covered employee's benefits coverage on the date the employee dies. The covered employee's death must result directly and independently of all other causes from a covered accident for which an accidental death benefit is payable under this policy. This benefit is subject to the conditions and exclusions described below.

A qualifying dependent child must:

- Be enrolled as a full-time student in an accredited school of higher learning beyond the 12th-grade level on the date of the covered employee's covered accident or be at the 12th-grade level on the date of the covered employee's covered accident and then enroll as a full-time student at an accredited school of higher learning within 365 days from the date of the covered accident and continue his or her education as a full-time student.
- Continue his or her education as a full-time student in such accredited school of higher learning; and
- Incur expenses for tuition, fees, books, room and board, transportation and any other costs payable directly to, or approved and certified by, such school.

Up to four annual payments will be made at the end of each year to each qualifying dependent child or to the child's legal guardian, if the child is a minor. MetLife must receive satisfactory proof of the dependent child's enrollment and attendance within 31 days of the end of each year.

If no dependent child qualifies for a Special Education Benefit within 365 days of the covered employee's death, MetLife will pay a default benefit of $1,000 to the covered employee' beneficiary.

Spouse, civil union partner, or domestic partner education benefit

MetLife will pay expenses incurred, as described below, up to the maximum benefit of $10,000 to enable the covered employee's spouse/civil union partner/domestic partner to obtain occupational or educational training needed for employment if the covered employee dies directly and independently of all other causes from a covered accident.

A covered spouse/civil union partner/domestic partner must have been insured under this policy on the date of the covered employee's death to be eligible. This benefit will be payable if the covered employee dies within one year of a covered accident and is survived by his or her spouse/civil union partner/domestic partner who:

- Enrolls, within two years after the covered employee's death in any accredited school for the purpose of retraining or refreshing skills needed for employment; and
- Incurs expenses payable directly to, or approved and certified by, such school.

Exclusions

In addition to any benefit-specific exclusion, benefits will not be paid for any covered injury or covered loss that, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in this document:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- Infection, other than infection occurring in an external accidental wound;
- War, whether declared or undeclared; or act of war, participation in a felony, riot, or insurrection
- Suicide or attempted suicide;
- Intentionally self-inflicted injury;
- Service in the armed forces or unit Auxiliary thereto;
- Any incident related to:
  - Aviation, other than a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline;

- Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
- Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
- Travel in an aircraft or device used:
  - For testing or experimental purposes;
  - By or for any military authority; or
  - For travel or designed for travel beyond the earth's atmosphere;
- Committing or attempting to commit a felony;
- The voluntary intake or use by any means of:
  - Any drug, medication or sedative, unless it is taken or used as prescribed by a Physician or an "over the counter" drug, medication or sedative taken as directed;
  - Alcohol in combination with any drug, medication, or sedative; or
  - Poison, gas, or fumes;

We will not pay benefits under this section for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Common disaster

If you and your spouse are injured in the same accident and die within 365 days as a result of injuries in such accident, the full amount that we will pay for your spouse's loss of life will be increased to equal the full amount payable for your loss of life.

Continuing your coverage once you lose eligibility

When you are no longer eligible for group coverage, you or your dependents can continue your GUL and/or Supplemental AD&D insurance through the portability option by paying premiums directly to MetLife. GUL and Supplemental AD&D coverage continues through the last day of the month of your termination date.

After that, you'll receive a letter from MetLife describing your options for continuing your coverage. Your monthly premium may be significantly higher than the Citi employee rate.

If you continue GUL coverage, you also can continue to contribute to the Cash Accumulation Fund (CAF). If you have a balance in the CAF, your cost for GUL insurance will be deducted from your CAF to keep your coverage active until you notify MetLife that you don't wish to continue GUL insurance. If you don't have a CAF account, or your CAF becomes depleted and you don't pay the premiums to MetLife, your GUL coverage will end.

Business Travel Accident/Medical insurance

Business Travel Accident/Medical insurance (BTA/BTM) pays benefits for bodily injury and/or death when a covered accident is incurred while traveling on company business. In addition to the BTA, the Business Travel Medical program provides non-routine and emergency medical coverage while traveling on business for Citi.

Coverage is provided by ACE American Insurance Company. All regular full-time and part-time employees have BTA coverage equal to five times benefits eligible pay to a maximum benefit of $2 million. Your spouse (same or opposite sex)/civil union partner/domestic partner and/or dependent children are considered covered persons and have BTA coverage while accompanying you on a business or relocation trip paid for by the Company.

> An eligible spouse (same or opposite sex)/civil union partner/domestic partner has a coverage amount of $150,000.

> Each eligible dependent child (up to age 26) has a coverage amount of $25,000.

BTA benefits are paid in the event of death, dismemberment, paralysis, and loss of speech and/or hearing while traveling on an approved trip made on behalf of the Company. Certain covered losses are subject to limitations. Depending on the nature of your loss, you may be entitled to recover less than your total coverage amount.

If you suffer more than one loss in an accident, you will be paid only for the loss that provides the largest benefit. Each aircraft accident is subject to a maximum benefit limit, regardless of the number of covered persons who incur a loss or the severity of the loss.

Your BTA beneficiary, the person or persons designated to receive any benefit payable at your death, is the same beneficiary as for your Basic Life and Basic AD&D insurance. If you do not have Basic Life insurance, the beneficiary is your spouse/civil union partner/domestic partner, then your children, and then your estate.

Converting to an individual policy

You can convert your BTA coverage to an individual AD&D policy within 31 days of your termination of employment from Citi if you are under age 70 and you submit an application and appropriate premium. The coverage under the individual policy must be for at least $25,000 and cannot be more than the greater of the amount of your employee coverage or $500,000. Coverage for an employee ends when the employee is no longer considered to be benefits-eligible under the terms of the policy.

Filing a claim for Basic Life, Basic AD&D, GUL, Supplemental AD&D, and BTA/Medical insurance

You must provide notice, either written, authorized electronic (i.e. fax, email), or telephonic notice of your claim within 31 days after a covered loss occurs or begins or as soon as reasonably possible.

> For Basic Life, Basic AD&D, GUL, Supplemental AD&D and BTA/Medical insurance, you or your beneficiary may call the Citi Benefits Center. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “pension, retiree health and welfare and survivor support” option.

If proper notice, as indicated, is not given in that time, the claim will be invalidated or reduced if it is shown that proper notice was not given as soon as was reasonably possible.

Notice should include the insured’s name and policy number and the covered person’s name, address, policy and certificate number.

Survivor Support will send claim forms for filing proof of loss when it receives notice of a claim. The claimant must provide written or authorized electronic (i.e. fax) proof of loss, satisfactory to MetLife, within 90 days of the loss for which the claim is made. If Survivor Support does not send claim forms within 15 days (may be longer if additional documentation or information is required) after it receives notice of a potential claim, you or your beneficiary can submit, within 90 days, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Failure of a claimant to cooperate in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Claims and appeals

If you believe that you were incorrectly denied a benefit under the Insurance Benefit Plans, you can file a claim. For information on the claims and appeals procedures, see “Claims and appeals” on page 85.

Long-Term Care (LTC) insurance

Unless you enrolled in the Citigroup Long Term Care Plan prior to January 1, 2012, you will not be permitted to enroll. Participants who enrolled to that date may continue to be participants in the Citigroup Long Term Care Plan.

If you enrolled in the LTC coverage prior to January 1, 2012, premiums for you and your spouse/civil union partner/domestic partner will be deducted from your pay. You will pay for coverage with after-tax dollars; the cost is based on your age when you became insured. Family members who enrolled for LTC coverage, other than spouses/civil union partners/domestic partners, are billed directly.

Family members who call to obtain information should provide your name as the Citi employee.

When LTC benefits are payable

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

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

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

You become eligible for benefits only upon confirmation of your qualifying condition by a care coordinator from John Hancock. The insured or the insured's representative must call the toll-free number to notify John Hancock of a potential claim, as soon as possible.

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

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

Benefits and services covered

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

Choosing a level of coverage

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

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Nursing home DMB	$115	$175	$230	$290	$345	$405
Alternate care facility DMB	$115	$175	$230	$290	$345	$405
*Community-based professional care DMB**	$86.25	$131.25	$172.50	$217.50	$258.75	$303.75
Informal care DMB	$28.75	$43.75	$57.50	$72.50	$86.25	$101.25
Informal care calendar-year maximum	$862.50	$1,312.50	$1,725	$2,175	$2,587.50	$3,037.50
Lifetime maximum benefit (excluding stay-at-home benefit)	$209,875	$319,375	$419,750	$529,250	$629,625	$739,125
Stay-at-home lifetime maximum	$3,450	$5,250	$6,900	$8,700	$10,350	$12,150

* Community-based professional care includes adult day 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.

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

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

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

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

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 Citigroup Long Term Care Insurance Plan. The portion of the premium is based on your age at the time of death as shown below. Premiums are not returned if you are age 75 or older or if coverage is in reduced paid-up status.

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

Waiver of premium

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

Portability

If you retire or leave Citi, you may continue coverage at group rates. You will pay premiums directly to John Hancock. Your insured family members may also continue their coverage as long as premiums are paid when due and benefits have not been exhausted. If the group policy is terminated and coverage is replaced by other group coverage, LTC coverage may be continued under the replacement plan or continued through John Hancock.

Bed reservation benefit

The Citigroup Long Term Care Insurance 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 Citigroup Long Term Care Insurance 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 Citigroup Long Term Care Insurance 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 Citigroup Long Term Care Insurance Plan contains a coordination of benefits provision that may reduce or eliminate the benefits otherwise payable under the Citigroup Long Term Care Insurance Plan when benefits are payable under another plan. (This provision does not apply to residents of Connecticut.) John Hancock will not pay benefits for charges incurred in certain circumstances, such as intentional self-inflicted injury; charges that are reimbursable or would be reimbursable under Medicare except for coinsurance, copay, 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.

For more information

To obtain details of the coverage available and its cost, contact John Hancock by calling the John Hancock Long-Term Care Insurance Department at **1-800-222-6814**.

Your family members who call should provide your name as the Citi employee.

Claims and appeals

If you believe that you were incorrectly denied a benefit under the LTC Plan, you can file a claim. For information on the claims and appeals procedures, see “Claims and appeals” on page 85.

Legal and administrative information

When coverage ends

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

- The date the Plans are terminated;
- The last day for which the necessary contributions are made; or
- 11:59 P.M. on the day in which your employment ends (last day of notice period), you retire, die, or you otherwise cease to be eligible for coverage, unless you have attained age 65. If you attained age 65, your coverage will end at 11:59 P.M. of the last day of the month in which your employment terminated. Basic Life and Basic AD&D insurance and Citigroup Disability Plan coverage end on the date your employment is terminated. GUL and Supplemental AD&D insurance coverage ends on the last day of the month in which your employment is terminated.

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

- The day your coverage is terminated, except in the case of your death in which case coverage will continue for six months;
- The date you elect to terminate your eligible dependent's coverage due to a qualified change in status;
- The last day for which the necessary contributions are made;
- The date the eligible dependent ceases to be eligible for coverage; coverage will remain in effect through December 31 of the year in which the child reaches the maximum age;
- 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" on page 74.

Coverage when you retire

You could be eligible for retiree health care coverage if, on the date your employment with Citigroup ends, all the following apply:

- Your age plus completed years of service with Citi, as defined in the medical plans, totals at least 60;
- You have attained at least age 50 and have at least five years of Citi service; and
- You were eligible to participate in the Citi health plans immediately prior to your termination date.

For more information on eligibility for this coverage, contact the Citi Benefits Center. You will be required to pay for your coverage.

A note for employees who were involuntarily terminated

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

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

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

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

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

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

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

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

The Citi Benefits Center will send your surviving spouse (same or opposite sex)/civil union partner/domestic partner and/or dependent children a COBRA notification package. For your surviving spouse (same or opposite sex)/civil union partner/domestic partner and/or dependent children to have six months of free medical and/or dental coverage, they must elect COBRA continuation coverage by signing and returning the election form to the Citi Benefits Center within the election period. See "COBRA" on page 74.

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

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

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

Coverage if you become disabled

You and your eligible dependents may continue medical, dental, and vision coverage for up to 13 weeks as long as you make the active employee contributions. After a total of 52 weeks of disability, which includes both STD and LTD leave, generally, your employment will be terminated.

After the 13-week paid STD period, the Citi Benefits Center will bill you for your benefits, where applicable. The cost is not deducted from your Long-Term Disability (LTD) benefit.

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

<table>
<tr><th>Plan</th><th colspan="2">Coverage provisions</th></tr>
<tr><td rowspan="6">Medical</td><td colspan="2">Coverage will continue for 52 weeks, including the 13-week period of Short -Term Disability (STD), as long as you pay the active employee contributions.

If you became disabled prior to January 1, 2014:
If your disability extends beyond 52 weeks, you may continue medical coverage for the lesser of a length of your disability or the medical continuation period, based on your years of service (as shown below).
For the purposes of the Disability Plan, a year of service is each twelve (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 the rules similar to the Citigroup Pension Plan credited service such as not counting service prior to five consecutive one year breaks in service. In no event will the time between your period of Citi service be counted.</td></tr>
<tr><td>Years of Citi service (as of the LTD effective date)</td><td>Medical continuation period after week 52 (the termination of your employment)</td></tr>
<tr><td>Less than 2 years</td><td>6 months</td></tr>
<tr><td>2 years to less than 5 years</td><td>Equal to your length of service</td></tr>
<tr><td>5 years or more</td><td>As long as you are deemed disabled and eligible for LTD benefits under the Plan.</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td colspan="2">If you become disabled on or after January 1, 2014, and
(i) commence short-term disability benefits;
(ii) you receive disability benefits for 52 weeks (both STD and LTD); and
(iii) your employment is terminated,
you will be eligible to pay the same rate that active employees pay for medical coverage for up to thirty-six (36) months after your employment terminates, regardless of your years of service with Citi.
At the end of the medical continuation period, you may continue coverage through COBRA for up to 29 months, if applicable.
The disability administrator will medically manage your claim to determine your eligibility to continue in applicable health and welfare benefits at the active employee rate. If you are a totally disabled employee who has been denied LTD benefit due to a pre-existing condition, did not enroll in LTD coverage, or who has reached the maximum benefit under the two-year limitation rule, the disability administrator will medically manage your claim, as well.
Once you become disabled for more than 29 months and are approved for Social Security disability or if earlier, you become eligible for Medicare because you attained age 65, Medicare will become your primary medical coverage while benefits under the Citi plan become secondary. If you are receiving Social Security disability benefits due to your disability, you will be automatically enrolled in Medicare Part A and B when you satisfy the eligibility requirements. You should maintain your Medicare Part B coverage to receive the maximum benefit from the Citi medical coverage because Citi will pay benefits as if you are enrolled in Medicare Part A and B. In addition, you may incur penalties if you enroll in Medicare Part B after you are initially eligible.</td></tr>
<tr><td>Dental</td><td colspan="2">Coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. Then you may continue coverage under COBRA.</td></tr>
</table>

Plan	Coverage provisions
Vision	Coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. Then you may continue coverage under COBRA.
Basic Life and Basic AD&D insurance	Coverage stops after 52 weeks, but you can convert your Basic Life or Basic AD&D coverage to an individual policy by calling the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. For TDD and international assistance, please see the "For More Information" section.
GUL insurance	Coverage will continue at the active group rate for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. After that, you may continue GUL insurance by paying MetLife directly. MetLife will bill you at the active employee rate for a length of time based on your years of service as shown in the table above (the same time period that you pay active employee rates for medical coverage). Afterwards, MetLife will bill you at a higher rate than the Citigroup rate. The rate will become effective the month following the termination of your active rate. MetLife will send you information regarding the continuation of these coverages if you are no longer eligible.
Supplemental AD&D insurance	Your Supplemental AD&D coverage will continue until the last day of the month in which you have received your 52nd week of disability benefits. You can continue your Supplemental AD&D coverage by paying MetLife directly at the higher, portable rate. For additional information contact MetLife at **1-888-830-7380**.

Coverage if you take a leave of absence

If you are on an approved leave of absence, call the Citi Benefits Center about your rights to continue medical, dental, and/or vision coverage.

Continuing coverage during an FMLA leave

The Family and Medical Leave Act (FMLA) entitles eligible employees to take leave each year 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 FMLA, you may take up to a total of 13 weeks of leave each year, except where the law in Puerto Rico mandates differently.

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

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

Continuing coverage during a military leave of absence — Citi policy

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

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

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

You must contact the Citi Benefits Center to enroll in or stop coverage. If you do not contact the Citi Benefits Center, your benefit elections will continue in effect for the remainder of the year in which you are on a military leave with the exception of STD, LTD, and Business Travel Accident/Medical insurance, which are suspended automatically when your leave begins.

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

Continuing coverage during military leave — Federal policy applicable if no Citi policy

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

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

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

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

Important Notice from Citigroup about Your Prescription Drug Coverage and Medicare

Citigroup has determined that prescription drug coverage provided through the Medical Plan is "creditable" under Medicare.

Creditable Coverage Disclosure Notice

For employees and former employees enrolled in Citigroup medical plans.

This notice, required by Medicare to be delivered to Medicare-eligible individuals,[2] 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 speak to a Citi Benefits 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 if you so choose. You should compare your current coverage carefully — including which drugs are covered — with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.
- Your existing 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 October 15-December 7 for coverage effective the first day of the following year.

[2] Citigroup is required by law to distribute this notice to both current employees and former 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 because of your lost coverage. In addition, if you lose or decide to terminate your coverage under the Citigroup prescription drug plan; you will be eligible to join a Medicare prescription drug plan at that time under the SEP, as well. If, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will increase at least 1% for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay for the same coverage. You must pay this higher premium percentage as long as you have Medicare coverage. In addition, you may have to wait until the next annual enrollment period to enroll.

For more information about Medicare

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

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

Do you qualify for "extra help" from Medicare based on your income and resources? You can find Medicare's income level and asset guidelines at www.cms.hhs.gov/medicarereform/lir.asp or by calling 1-800-MEDICARE **(1-800-633-4227)**. If you qualify for assistance, visit the Social Security website 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 the "health care including COBRA" option and then speak to a Citi Benefits Center representative.

For TDD service, call the Telecommunications Relay Services at **1-866-280-2050**. Then call ConnectOne at **1-800-881-3938** as instructed above.

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

Your HIPAA rights

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

Your special enrollment rights

If you decline to enroll in Citi medical coverage for you and/or your eligible dependents, including your spouse, because you and/or your family members have other health coverage, you may in the future be able to enroll yourself or your dependents in Citi coverage provided that you request enrollment within 31 days after the date your coverage ends because you or a family member lost eligibility under another plan or because COBRA coverage has ended.

In addition, if you have a new dependent as a result of a marriage, birth, or adoption or placement for adoption of a child, you may also be able to enroll yourself and your eligible dependents provided you call within 31 days after the marriage, birth, or adoption.

If you miss the 31-day deadline, you must wait until the next annual enrollment period — or have another qualified status change or special enrollment right — to enroll. Visit the "Qualified Changes in Status" section for more information.

To meet IRS regulations and plan requirements, Citi reserves the right at any time to request written documentation of any dependent's eligibility for plan benefits and/or the effective date of the qualifying event.

Your right to privacy and information security

HIPAA requires employer health plans to maintain the privacy and security of your health information. HIPAA also requires the Citigroup Health Benefit Plan, Citigroup Dental Benefit Plan, Citigroup Vision Benefit Plan, Health Care Spending Account (HCSA), and Limited Purpose Health Care Spending Account (LPSA) (collectively, the Plans, individually the "Plan") to provide you with a notice of the Plans' legal duties and privacy practices with respect to your health information. The notice will describe how the Plans may use or disclose your health information and under what circumstances they may share your health information without your authorization (generally, to carry out treatment, payment or health care operations). In addition, the notice will describe your rights with respect to your health information. Please refer to the "Notice of HIPAA Privacy Practices" on page 4 for more information. You can obtain a copy of the notice by contacting the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. For TDD and international assistance, please see the "For More Information" section.

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

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

The Plans shall make available protected health information ("PHI") for purposes of providing access to individuals' PHI in accordance with 45 C.F.R. sec. 164.524. The Plans shall make available PHI to these Plans for purposes of amending the Plans and shall incorporate any amendments to protected health information in accordance with 45 C.F.R. sec. 164.526. The Plansshall make available PHI and any disclosures as required to provide an accounting of disclosures in accordance with 45 C.F.R. sec. 164.528.

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

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

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

Notice of HIPAA Privacy Practices

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

This notice also sets out Component Plans' legal obligations concerning your protected health information and describes your rights to access and control your protected health information. All Component Plans have agreed to abide by the terms of this notice. This notice has been drafted in accordance with the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule, contained in the Code of Federal Regulations at 45 CFR Parts 160 and 164, as amended by Title XIII, Subtitle D of the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5) and regulations promulgated thereunder. Terms that are not defined in this notice have the same meaning as they have in the HIPAA Privacy Rule, as amended and its related regulations.

For answers to your questions and for additional information

If you have any questions or want additional information about this notice, call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. To exercise any of the rights described in this notice, contact the third-party administrator for the relevant Component Plan as instructed under "Contact information" on page 72.

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, employer, 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. The Component Plans were required to limit the use, disclosure, or request for protected health information to the extent practicable to either limited data sets or, if needed, the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

Component Plans are obligated to provide to you a copy of this notice setting forth their legal duties and privacy practices regarding your protected health information. Component Plans must abide by the terms of this notice. If any of the Component Plans use or disclose personal health information for underwriting purposes, the Component Plan will not use or disclose personal health information that is your genetic information for such purposes.

Uses and disclosures of protected health information

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

Payment and health care operations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Research: Component Plans may disclose your protected health information to researchers when (1) their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information or (2) the research involves a limited data set that includes no unique identifiers, such as name, address, Social Security number, etc.

To prevent a serious threat to health or safety: Consistent with applicable laws, Component Plans may disclose your protected health information if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. Component Plans may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military: Under certain conditions, Component Plans may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, Component Plans may disclose, in certain circumstances, your information to the foreign military authority.

National security and protective services: Component Plans may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities and for the protection of the President, other authorized persons, or heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, Component Plans may disclose your protected health information to the correctional institution or to a law enforcement official for (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

Workers' Compensation: Component Plans may disclose your protected health information to comply with Workers' Compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Disclosures to the plan sponsor: Component Plans (or their respective health insurance issuers or HMOs) may disclose your protected health information to Citi and its employees and representatives in the capacity of the sponsor of the Component Plans.

Others involved in your health care: Component Plans may disclose your protected health information to a friend or family member involved in your health care, unless you object or request a restriction (in

accordance with the process described in “Right to request a restriction” under “Your rights” on page 71. Component Plans may also disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then, using professional judgment, Component Plans may determine whether the disclosure is in your best interest.

Disclosures to the Secretary of the U.S. Department of Health and Human Services: Each Component Plan is required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining a Component Plan’s compliance with the HIPAA Privacy Rule.

Disclosures to you: Each Component Plan is required to disclose to you or to your personal representative most of your protected health information when you request access to this information. Component Plans will disclose your protected health information to an individual who has been designated by you as your personal representative and who is qualified for such designation in accordance with relevant law.

Prior to such a disclosure, however, each Component Plan must be given written documentation that supports and establishes the basis for the personal representation. A Component Plan may elect not to treat the person as your personal representative if it has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; treating such person as your personal representative could endanger you; or such Component Plan determines, in the exercise of its professional judgment, that it is not in your best interest to treat the person as your personal representative.

Other uses and disclosures of your protected health information

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization as provided to each Component Plan. If you provide such authorization to a Component Plan, you may revoke the authorization in writing, and such revocation will be effective for future uses and disclosures of protected health information upon receipt. However, the revocation will not be effective for information that such Component Plan has used or disclosed in reliance on the authorization.

Contacting you

Each Component Plan (or its health insurance issuers, or third-party administrators) may contact you about treatment alternatives or other health benefits or services that might be of interest to you, as permitted as part of health care operations, as defined in the HIPAA privacy rules.

As required by law, in the event of an unauthorized disclosure, use, or access of your unsecured protected health information, you will receive written notification.

Your rights

The following is a description of your rights regarding your protected health information. If you wish to exercise any of these rights, you must contact the third-party administrator of the Component Plan that you wish to have comply with your request, using the contact information in “Contact information” on page 72.

Right to request a restriction: You have the right to request a restriction on the protected health information that a Component Plan uses or discloses about you for payment or health care operations. You also have a right to request a limit on disclosures of your protected health information to family members or friends involved in your care or the payment for your care. You may request such a restriction using the contact information as instructed under “Contact information” on page 72.

A Component Plan is not required to agree to any restriction that you request. If a Component Plan agrees to the restriction, it can stop complying with the restriction upon providing notice to you. Your request must include the protected health information you wish to limit; whether you want to limit such Component Plan’s use, disclosure, or both; and (if applicable) to whom you want the limitations to apply (for example, disclosures to your spouse).

A health care provider must comply with your request that protected health information regarding a specific health care item or service not be disclosed to the Component Plan for purposes of payment and health care operations if you have paid for the item or service in full out of pocket.

Right to request confidential communications: If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that a Component Plan communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. You may request a confidential communication using the contact information in “Contact information” on page 72.

Your request must specify the alternative means or location for communicating with you. It also must state that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger. A Component Plan will accommodate a request for confidential communications that is reasonable and states that the disclosure of all or part of your protected health information could endanger you.

Right to request access: You have the right to inspect and copy protected health information that may be used to make decisions about your benefits. You must submit your request in writing. If you request copies, the relevant Component Plan may charge you for photocopying your protected health information, and, if you request that copies be mailed to you, for postage. The third-party administrators of the Component Plans have indicated that they do not currently intend to charge for this service, although they reserve the right to do so.

You may request an electronic copy of your protected health information if it is maintained in an electronic health record. In addition, you may request a copy of all electronic protected health information maintained in a designated record set in the electronic form and format (e.g., web portal, e-mail or on portable electronic media) in which you and the Component Plan can reach an agreement that such information will be provided. You may also request that such electronic protected health information be sent to another entity or person. Any charge that is assessed, if any, must be reasonable and based on the Component Plan’s cost.

Note: Under federal law, you may not inspect or copy the following records: Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some, but not all, circumstances, you may have a right to have this decision reviewed.

Right to request an amendment: You have the right to request an amendment of your protected health information held by a Component Plan if you believe that information is incorrect or incomplete. If you request an amendment of your protected health information, your request must be submitted in writing, using the contact information in “Contact information” on page 72, and must set forth a reason(s) to support the proposed amendment. In certain cases, a Component Plan may deny your request for an amendment.

For example, a Component Plan may deny your request if the information you want to amend is accurate and complete or was not created by such Component Plan. If a Component Plan denies your request, you have the right to file a statement of disagreement. Your statement of disagreement will be linked with the disputed information, and all future disclosures of the disputed information by such Component Plan will include your statement.

Right to request an accounting: You have the right to request an accounting of certain disclosures Component Plans have made of your protected health information. You may request an accounting using the contact information in “Contact information” on page 72. You can request an accounting of disclosures made up to six years prior to the date of your request, except that Component Plans are not required to account for disclosures made prior to April 14, 2003.

You are entitled to one accounting from each Component Plan free of charge during a 12-month period. There may be a charge to cover a Component Plan’s costs for any additional requests within that 12-month period. Component Plans will notify you of the cost involved, and you may choose to withdraw or modify your request before any costs are incurred.

Right to a paper copy of this notice: You have the right to a paper copy of this notice, even if you have agreed to accept this notice electronically. To obtain such a copy, call the Citi Benefits Center. See “Contact information” on page 72.

Complaints

If you believe a Component Plan has violated your privacy rights or is not fulfilling its obligation under the breach notice rules, you may complain to such Component Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with such Component Plan using the contact information under "Contact information" on page 72. Component Plans will not penalize you for filing a complaint.

Changes to this notice

Component Plans reserve the right to change the provisions of this notice and to make the new provisions effective for all protected health information that they maintain. If a Component Plan makes a material change to this notice, it will provide a revised notice to you at the address that it has on record for the participant enrolled with such Component Plan (or, if you agreed to receive revised notices electronically, at the e-mail address you provided to such Component Plan).

Effective date

This Notice of HIPAA Privacy Practices became effective April 14, 2003 and was revised effective August 14, 2013.

Contact information

For more information about any of the rights in this notice, or to file a complaint, contact:

Citi Privacy Officer
c/o Corporate Benefits Department
1 Court Square, 21st Floor
Long Island City, NY 11120

To exercise any of the rights described in this notice, contact the third-party administrators for the Component Plans as follows:

If you are enrolled in any of these plans:	Call:
Citigroup Health Benefit Plan **Citigroup Dental Benefit Plan** **Citigroup Vision Benefit Plan**	The Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option and speak to a Citi Benefits Center representative. **From outside the United States and Puerto Rico:** Call HR Shared Services at **1-469-220-9600**. Press 1 when prompted. From the ConnectOne main menu, choose the "health and welfare benefits" option and speak to a Citi Benefits Center representative. **For TDD users** Call the Telecommunications Relay Service at 711. Then call ConnectOne as instructed above.

COBRA

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

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

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

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

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

Who is covered under COBRA

You have a right to choose this continuation coverage if:

- You are enrolled in Citigroup Health Benefit Plan, the Citigroup Dental Benefit Plan, or the Citigroup Vision Benefit Plan; and
- You lose your group health coverage because of a reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct on your part.

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

If you are the spouse (same or opposite sex)/civil union partner/domestic partner of an employee and are covered by Citigroup Health Benefit Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan and you lose coverage under a Citi-sponsored group health plan for any of the following four reasons on the day before the qualifying event, you are a qualified beneficiary and have the right to elect continuation coverage for yourself:

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

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

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

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 plans and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Citi of the birth or adoption.

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

Separate elections

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

Electing COBRA

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

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

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

Duration of COBRA

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

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

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

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

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

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 at any time during the first 60 days of continuation coverage.

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

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

Medicare

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

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

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

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

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

COBRA and FMLA

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

> When you definitively inform Citi that you are not returning to work at the end of the leave; or

> The end of the leave, and you do not return to work.

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

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

Your duties

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

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

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

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

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

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

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

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

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

Citi's duties

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

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

Cost of coverage

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

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

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

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

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

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

You may also call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “health and welfare benefits” option and then the “health care including COBRA” option and then speak to a Citi Benefits Center representative.

Recovery provisions

Recovery provisions apply to the Citigroup Plans and are described in this section.

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 person(s) receiving benefits under the Plan(s) (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 Citigroup Disability Plan reserves the right to recover funds related to disability benefits for any Overpayment when a Covered Person receives state benefits including Workers’ Compensation and Social Security benefits.

Reimbursement

This section applies when a Covered Person recovers damages — by settlement, verdict, or otherwise — for an injury, sickness, or other condition. If the Covered Person has made — or in the future may make — such a recovery, including a recovery from an insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an injury or illness or the treatment of such an injury or illness.

However, if the Plan does pay for or provide benefits for such an injury, sickness, or other condition, the Covered Person — or the legal representatives, estate, or heirs of the Covered Person — will promptly reimburse the Plan from all recovery amounts (whether or not characterized as related to medical expenses) from any settlement, verdict, or insurance proceeds received by the Covered Person (or by the legal representatives, estate, or heirs of the Covered Person) to the extent that medical benefits have been paid for or provided by the Plan to the Covered Person.

If the Covered Person receives payment from a third party or his or her insurance company as a result of an injury or harm due to the conduct of another party and the Covered Person has received benefits from the Plan, the Plan must be reimbursed first. In other words, the Covered Person's recovery from a third party may not compensate the Covered Person fully for all the financial expenses incurred because acceptance of benefits from the Plan constitutes an agreement to reimburse the Plan for any benefits the Covered Person receives.

The Covered Person also must take any reasonably necessary action to protect the Plan's subrogation and reimbursement right. That means by accepting benefits from the Plan, the Covered Person agrees to notify the Plan Administrator if and when the Covered Person institutes a lawsuit or other action or enters into settlement negotiations with another party (including his or her insurance company) in connection with or related to the conduct of another party.

The Covered Person also must cooperate with the Plan Administrator's reasonable requests concerning the Plan's subrogation and reimbursement rights and must keep the Plan Administrator informed of any important developments in his or her action. The Covered Person also agrees that the Plan Administrator may withhold any future benefits paid by this Plan or Citigroup Disability Plan or any other disability or health plan maintained by Citi or its participating companies to the extent necessary to reimburse this Plan under the Plan's subrogation or reimbursement rights.

To secure the rights of the Plan under this section, the Covered Person hereby:

- Grants to the Plan a first-priority lien against the proceeds of any such settlement, verdict, or other amounts received by the Covered Person to the extent of all benefits provided in an effort to make the Plan whole;
- Assigns to the Plan any benefits the Covered Person may have under any automobile policy or other coverage; the Covered Person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such lien or to effect such assignment of benefits; and
- Will cooperate with the Plan and its agents and will:
  - Sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement;
  - Provide any relevant information; and
  - Take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the value of the benefits provided.

If the Covered Person does not sign and deliver any such documents for any reason (including, but not limited to, the fact that the Covered Person was not given an agreement to sign or is unable or refuses to sign), the Plan Administrator, in its sole discretion, may or may not advance benefits to the Covered Person under the Plan.

If the Plan Administrator has advanced benefits, it has the right to subrogation and reimbursement whether or not the Covered Person has signed the agreement. The Covered Person shall not take any action that prejudices the Plan's right of reimbursement.

Subrogation

This section applies when another party is, or may be considered, liable for a Covered Person's injury, sickness, or other condition (including insurance carriers that are so liable) and the Plan has provided or paid for benefits.

The Plan is subrogated to all the rights of the Covered Person against any party, including any insurance carrier, liable for the Covered Person's injury or illness or for the payment for the medical treatment of such injury or occupational illness to the extent of the value of the medical benefits provided to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person.

The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages.

The Covered Person is obligated to cooperate with the Plan and its agents to protect the Plan's subrogation rights. Cooperation means complying with the terms of this section, providing the Plan or its agents with relevant information requested by them; signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim; responding to requests for information; appearing at requested medical examinations or depositions; and obtaining the consent of the Plan or its agents before releasing any party from liability for payment.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. Further, the Covered Person agrees to notify the Plan Administrator if and when the Covered Person institutes a lawsuit or other action or enters into settlement negotiations with another party (including his or her insurance company) in connection with or related to the conduct of another party.

Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of benefits the Plan has provided for a sickness or injury caused by a third party. The Plan may, at its own option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain. The Plan's rights will not be reduced due to your own negligence.

The costs of legal representation retained by the Plan in matters related to subrogation shall be borne solely by the Plan. If the Plan incurs attorney's fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. The costs of legal representation retained by the Covered Person shall be borne solely by the Covered Person.

The Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Claims and appeals

If you do not receive a benefit to which you believe you are entitled under any Citigroup Health and Welfare Plans subject to ERISA, 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 "Administrative Information" on page 89.

The Plan Administrator or Claims Administrator is generally required to evaluate your claim and notify you of its decision within a specified time period in accordance with ERISA. If your written claim is denied, you have a right to appeal the claim denied by the Plan Administrator or Claims Administrator by filing a request for review of your claim denial. If you wish to bring legal action against the Company or the Plan, you must first go through the Plan's appeals procedures.

ERISA provides for different timetables and claims procedures that may vary by type of benefit. Each of the medical benefits (including dental and vision benefits), disability benefits, and all other types of benefits has a different timetable and claims and appeals procedure. General information regarding the claims and appeals procedures is set forth below

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 timeframe within which claims and appeals must be determined.

1. **Preservice claim:** A claim is a preservice claim if the receipt of the benefit is conditioned, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined below. Benefits under any Plan that require approval in advance are specifically noted in this book or in the Plan document as being subject to preservice authorization.

2. **Urgent care claim:** An urgent care claim is a special type of preservice claim. A claim involving urgent care is any preservice claim for medical care or treatment with respect 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 make a determination of 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 claims:** A concurrent care decision occurs where 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 two years 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.

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.

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 timeframes 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. 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 timeframes, nothing prevents you from voluntarily agreeing to extend above timeframes. 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 timeframe, no less than 45 days, in which the necessary information must be provided. The timeframe 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

Written notification will be provided to you of an adverse decision on a claim, and 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; and
- 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 not later than three days after the oral notice.

Appeals procedure

First internal level of appeal

You or your authorized representative (refer to the requirements for appointing a representative, as described later in this document), must submit your appeal, in writing, within 180 days following the date you received the notification on adverse determination. When you submit your appeal, you may request assistance from the Patients' Advocate, the Ombudsman, or a lawyer of your preference (at your cost). For your appeal to be considered, it must include the following, if applicable:

- Name and contract number of the plan member that received the services being appealed;
- Date of service;
- Number of services and description of the services received;
- Original receipt for any amount paid by the appellant;
- Invoices from the provider;
- Name and address of the provider;
- Evidence of the precertification granted and/or the medical need certification, if any of these was required in order to receive the service;
- Forms CMS-1500 or UB-92, duly completed by the provider; and
- A written statement explaining why you believe Triple-S was mistaken in its decision on your reimbursement, precertification or benefit claim.

You must also submit any other written evidence or information regarding your appeal. You must send your appeal request to Triple-S, Customer Service Division, P.O. Box 363628, San Juan, PR 00936-3628.

If your case is considered to be urgent, Triple-S will notify you of its decision within a period that does not exceed 72 hours, from the date the completed application for appeal was received. Incomplete applications will not be considered until they meet the requirements thereof. Urgent appeals means those appeal requests that correspond to services or medical treatment in which the timeframe to complete the regular appeal process (a) may jeopardize the life or the health of the plan member or the ability of a vital organ of the body to function at its maximum capacity, or (b) by physician's opinion that the patient may be under severe pain that cannot be handled without medical care or treatment, subject to the appeal.

In case of appeals to a precertification, Triple-S must notify you of it decision within 15 days from the receipt of your appeal request. In other instances, Triple-S must give an answer within 30 days from the receipt of your appeal request. If Triple-S requests additional information, you must provide it within 45 days from the date of the notification. If you do not submit the information requested within this period, Triple-S will make its decision based on the documents that were first submitted.

Triple-S may also notify you that your appeal is being considered but that additional time is needed. In this case, Triple-S will have 15 additional days to give you its determination on your appeal. Once Triple-S notifies you its decision, you have the right to request that Triple-S disclose the names and positions of the officers or consultants who participated in the evaluation of your appeal, as well as an explanation of the criteria on which they based their decision.

Second internal level of appeal

If you do not agree with Triple-S' decision on your first appeal, you have the right to request a second appeal within 60 days from the date Triple-S notified you of its decision on your first appeal.

With this second request for appeal, you must include a copy of all the documents related to your first appeal, a statement explaining why you believe Triple-S' decision on your first appeal was incorrect, and any additional evidence to support your allegations.

Your second appeal will be evaluated by persons who were not involved in deciding the first appeal and are not subordinates of the persons who decided your first appeal. Triple-S' previous decision will not be considered. You have the right to request that Triple-S disclose the names and positions of the officers or consultants who evaluated your second appeal as well as an explanation of the criteria on which they based their decision.

In case of urgent appeals (as defined earlier), Triple-S must respond to your request within 72 hours. In cases of precertification appeals, Triple-S must respond to your second appeal within 15 days from the date it received your appeal. In other cases, Triple-S must respond within 30 days from the date it received your appeal.

Right to be assisted

You have the right to be assisted by the Health Advocate in the appeals processes previously described. The Office of the Health Advocate is located at 1215 Ponce de León, Stop 18, Santurce, PR, and you may contact the Health Advocate at **1-787-977-0909** (Metro area) or **1-800-981-0031** (outside Metro area).

Right to appoint a representative

You have the right to appoint a representative to act on your behalf in submitting any request for appeal to Triple-S. The designation of a representative must meet the following criteria:

- Name and contact number of the participant;
- Name, address, and telephone number of the person designated as an authorized representative as well as his or her relationship to the participant;
- Process for which the representative has been designated;
- Signature and date on which the designation is granted; and
- Expiration date for the designation.

The participant or beneficiary is responsible of notifying Triple-S, in writing, if the designation has been revoked before the expiration date.

The participant/ member will be entitled to the benefits determined, as they are determined as a result of the appeal process.

Notice of benefit determination on appeal

You will receive written or electronic notice of the benefit determination upon review. In the event your claim is denied on appeal, the notice will provide:

- The specific reason or reasons for the denial of the appeal;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- A statement describing any voluntary appeal procedures offered by the Plan, and a statement of your right to bring an action under Section 502(a) of ERISA;
- If an internal rule or guideline was relied upon in making the adverse determination, either the specific rule or guideline, or a statement that such a rule or guideline was relied upon in making the adverse determination and that a copy of such rule or guideline will be provided free of charge upon request, and
- If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

External Appeal Process

If you do not agree with the determination made in the second internal level of appeal, you have the right to request an evaluation to the Office of Personnel Management (OPM), within four months from the date you received the notice on adverse determination. You or your authorized representative may submit the request for external evaluation if:

Your case determination involves medical judgment (for example: medical need, effectiveness of the treatment received or to be received, level of care, among others). Determinations based on coverage exclusions will not be evaluated by OPM, or

Rescission of Coverage, as previously defined.

For your appeal to be considered for evaluation it must include the following: Name and contact information (including address, telephone number and e-mail address, if applicable); Copy of the adverse determination notice; An explanation of why you do not agree with Triple-S' decision; and, must specify if you are requesting an expedite evaluation. You must also include any other document, evidence or additional information to support your claim (for example, letters from the attending physician, invoices, and medical records, among others). If you appoint a representative to act on your behalf (refer to the requirements detailed later in this document) you must include a signed authorization. It is important that you keep copies of all the documents regarding your claim.

You may submit your claim in writing and mail it to the Office of Personnel Management (OPM) at PO Box 791 Washington DC, 20044; by fax to **1-202-606-0036** or via e-mail to Disputedclaim@opm.gov.

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.

Eligibility and Enrollment Claims

If you believe your application to enroll in or change any of the health and welfare Plans subject to ERISA is denied, you may file a claim with the Plans Administration Committee of Citigroup Inc. (the "Committee"). You may also file an appeal if the Committee denies your claim.

To file an eligibility or enrollment-related claim and for information on the claim review process, follow the instructions included on the Citgroup Employee Benefits Eligibility Claims and Appeals Form available to you at no cost by calling the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. Follow the instructions on the form and return the form to the Plans Administration Committee at the fax number or address below:

Plans Administration Committee of Citigroup Inc.
c/o Claims and Appeals Management Team
P.O. Box 1407
Lincolnshire, IL 60069-1407

Fax: **1-847-554-1653**

In addition, if you file a claim for benefits under the Citigroup Disability, Citigroup Life Insurance Benefits, the Citigroup Business Travel Accident/Medical, or the Long-Term Care Insurance Plans, generally your claim will be administered in accordance with the timetable outlined in "Notice of adverse benefit determinations."

Other benefit claims

If your claim is denied, you will receive a written or an electronic notice within 90 days after receipt of your claim (180 days if special circumstances apply and you are notified of the extension in writing within the initial 90-day period and informed of the anticipated benefit determination date). If your claim is for disability benefits, you will receive a written or an electronic notice within 45 days after receipt of your claim (105 days if special circumstances apply and you are notified of the extension in writing within the initial 45-day period and informed of the anticipated benefit determination date). The explanation will include the following:

- The specific reasons for the denial;
- The specific reference to the Plan documentation that supports these reasons;
- The additional information you must provide to perfect your claim and the reasons why that information is necessary;
- The procedure available for a further review of your claim, including a statement regarding your right to bring action under Section 502(a) of ERISA if your claim is denied on review; and
- A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request).

Appeals

You have 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 must be filed within 30 days of your receipt of the notification of the decision to reduce or terminate.

Failure to comply with this important deadline may cause you to forfeit any rights to any further review of an adverse decision under these procedures or in a court of law.

The appeal shall be decided within a reasonable time appropriate to the medical circumstances but no later than 30 days after receipt of the appeal.

The appeal of an urgent care claim shall be decided as soon as possible, taking into account the medical urgency but no later than 72 hours after receipt of the appeal.

The appeal of a post-service claim shall be decided within a reasonable period but no later than 60 days after receipt of the appeal.

The appeal of a decision to reduce or terminate an initially approved course of treatment shall be decided before the proposed reduction or termination takes place. The appeal of a denied request to extend a concurrent care decision shall be decided in the appeal time frame for a preservice, urgent care, or post-service claim described above, as appropriate to the request.

Notice of benefit determination on appeal

You will receive written or electronic notice of the benefit determination upon review. In the event your claim is denied on appeal, the notice will provide:

- The specific reason or reasons for the denial of the appeal;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- A statement describing any voluntary appeal procedures offered by the Plan, and a statement of your right to bring an action under Section 502(a) of ERISA; and
- If an internal rule or guideline was relied on in making the adverse determination, either the specific rule or guideline, or a statement that such a rule or guideline was relied on in making the adverse determination and that a copy of such rule or guideline will be provided free of charge upon request.

In the event that your appeal is denied, you have the right to bring a legal action under Section 502(a) of ERISA, provided that you file any lawsuit or similar enforcement proceeding, commenced in any forum, regarding the Plans within 12 consecutive months after the date of receiving a final determination on review of your claim or, if earlier, within two years from the date on which you were aware, or should have been aware, of the claim at issue in the suit.

The two-year limitation shall be increased by any time a claim or appeal on the issue is under consideration by the appropriate fiduciary. If any different period to begin suit is specified in an insurance contract forming part of the Plans or any shorter period is specified in the rules of the Claims Administrator, that period will apply to proceedings against the insurer or with regard to the ruling of that Claims Administrator, respectively.

You and the Plans may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency, as applicable. Generally, the determination reached by the Plans is final.

Regarding appeals

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- The Claims Administrator is required to give the participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination;
- You cannot file suit in federal court until you have exhausted these appeals procedures. However, you have the right to file suit under ERISA Section 502 following an adverse appeal decision;
- Each participant has the right to request and obtain documents, records and other information as it pertains to the Plans. Notwithstanding any provision of the Plan to the contrary, you must file any lawsuit related to your adverse benefit determination within 12 consecutive months after the date of receiving such a determination or, if earlier, within two years from the date on which you were aware, or should have been aware, of the claim at issue in the suit. The two year limitation shall be increased by any time a claim or appeal on the issue is under consideration by the appropriate fiduciary. If any different period to commence suit is specified in an insurance contract forming part of the Plan, that period will apply to suits against the insurer.

ERISA information

As a participant in Citigroup Health and Welfare Plans that are subject to ERISA, 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 locations.

Upon written request to the Plan Administrator, you may obtain copies of documents governing the operations of the Plans, including insurance contracts, a copy of the latest annual report (Form 5500) and the current Summary Plan Description. The Plan Administrator will mail these documents to your home free of charge.

You may also receive a copy of the Plan's annual financial reports. The Plan Administrator will furnish each participant with a copy of the Summary Annual Report.

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

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” on page 44.

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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications’ hotline of the Employee Benefits Security Administration or by visiting its website at **www.dol.gov/ebsa/**.

Administrative Information

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

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 affiliates, if appropriate) has the right to amend, modify, suspend, or terminate any Plan, policy or program in whole or in part, at any time, for any reason, without prior notice, including the Plans described in this SPD.

In the event of the dissolution, merger, consolidation, or reorganization of Citigroup, the Plan will terminate unless the Plan is continued by a successor to Citigroup. If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Citigroup to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document.

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 and such determinations shall be binding on all parties.

The Plan Administrator has designated other organizations or persons to act out specific fiduciary responsibilities in administering the 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

Item	Details
Plan sponsor	Citigroup Inc. 750 Washington Boulevard, 9th Floor Stamford, CT 06901
Employer Identification Number	52-1568099
Plan Administrator	Plans Administration Committee of Citigroup c/o Claims and Appeals Management Team P.O. Box 1407 Lincolnshire, IL 60069-1407 Fax: 1-847-554-1653 **1-800-881-3938** (ConnectOne). From the ConnectOne main menu, choose the "health and welfare benefits" option and then speak to a Citi Benefits Center representative From outside the United States, call HR Shared Services at **1-469-220-9600**. Press 1 when prompted. From the ConnectOne main menu, choose the "health and welfare benefits" option. If you are hearing-impaired, call the National Relay Services at **1-866-280-2050**. Then call ConnectOne at **1-800-881-3938**
Type of Administration	The Plans are administered by the Plans Administration Committee of Citigroup Inc. However, the final decision on the payment of claims under certain Plans rest with the Claim Administrators.
Agent for Service of Legal Process	General Counsel Citigroup Inc. 399 Park Ave., 2nd Floor New York, NY 10043
Plan Year	January 1 - December 31
Plan Names and Numbers	
Medical Plans (self-insured Triple-S plan) including the Prescription Drug Program	Citigroup Health Benefit Plan Group # SP0003726 Group # 6569 Plan # 508
Dental Plans (self-insured Triple-S plan)	Citigroup Dental Benefit Plan Group # SP0003726 Plan number 505
Vision Plan	Citigroup Vision Benefit Plan Plan number 533
Employee Assistance Program	Citigroup Employee Assistance Program Plan number 521
Basic Life Insurance, Basic AD&D, Group Universal Life and Supplemental AD&D	Citigroup Life Insurance Benefits Plan Plan number 506
Business Travel Accident/Medical	Citigroup Business Travel Accident/Medical Plan Plan number 510
Long-Term Care insurance (closed to new participants)	Citigroup Long-Term Care Insurance Plan Plan number 535
Short-Term Disability and Long-Term Disability	Citigroup Disability Plan Plan number 530

Item	Details
Funding	
Medical Plan *Dental Plan*	The Medical and Dental Plans are funded from the general assets of Citigroup and may be funded from a trust qualified under section 501(c)(9) of the Code on behalf of the Plans in accordance with the terms of their Plan documents. The Employee Assistance Program is funded from the general assets of Citigroup. The medical and dental plans are self-insured. The cost of Medical and Dental coverage is shared by Citigroup and the participant.
Vision Plan *Employee Assistance Program*	The Vision Plan is fully-insured, funded through an insurance contract. The cost of the Vision Plan is provided by employee contributions. The Employee Assistance Program is provided by employer contributions.
Basic Life Insurance *Basic AD&D Insurance* *Group Universal Life Insurance* *Supplemental AD&D Insurance* *Business Travel Accident/Medical Insurance*	The Basic Life and Basic AD&D, GUL and Supplemental AD&D, 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 and Basic AD&D coverage is provided through employer contributions; GUL and Supplemental AD&D is provided through employee contributions. The BTA is funded by an insurance contract. BTA/Medical coverage is provided through employer contributions.
Disability Plan	STD benefits are paid from the general assets of the Company. STD coverage is provided by Citigroup, and no employee contributions are required. A portion of the LTD benefits are fully insured and a portion of the benefits are paid from the general assets of the Company. 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.

Note: Any refund, rebate, dividend adjustment, or other similar payment under any insurance contract entered into between Citigroup and any insurance provider shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse Citigroup for premiums it has paid or to reduce Plan expenses.

Claims Administrators

Each of the Claims Administrators below has the discretion and authority to render benefit determinations in a manner consistent with the terms and conditions of its respective benefit Plan, namely, those provisions of the Plan Document that apply to the participant and administered by that particular Claims Administrator.

MEDICAL PLAN	
Preferred Provider Organization (PPO)	**Triple-S** P.O. Box 363628 San Juan PR 00936-3628 (mailing address) **1-787-774-6098** or **1-787-749-4777**
Prescription Drug Program	**Triple-S** P.O. Box 363628 San Juan PR 00936-3628 **1-866-881-6221** (Regarding mail order prescriptions) **1-787-774-6098** (For Retail Pharmacy questions)
DENTAL PLAN	
Triple-S	**Triple-S** P.O. Box 363628 San Juan PR 00936-3628 **1-787-774-6098** or **1-787-749-4777**
VISION	
Aetna Vision Plan	Aetna Vision Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111 **1-877-787-5354** www.AetnaVisionOE.com/avp1 Members: www.aetnavision.com
OTHER INSURANCE	
Short-Term Disability *Long-Term Disability*	Metropolitan Life Insurance Co. P.O. Box 14590 Lexington, KY 40511-4590 **1-800-826-0547**
Basic Life	Metropolitan Life Insurance Co. 200 Park Avenue New York, NY 10166 **1-888-638-6420**
Group Universal Life	Metropolitan Life Insurance Co. 200 Park Avenue New York, NY 10166 **1-888-638-6420**
Basic Accidental Death and Dismemberment (AD&D)	Metropolitan Life Insurance Co. 200 Park Avenue New York, NY 10166 **1-888-638-6420**
Supplemental AD&D	Metropolitan Life Insurance Co. 200 Park Avenue New York, NY 10166 **1-888-638-6420**

MEDICAL PLAN	
Business Travel Accident/Medical	ACE American Insurance Company Accident & Health Claims 1 Beaver Valley Road P.O. Box 15417 Wilmington, DE 19850 **1-800-336-0627**
Long-Term Care	John Hancock Life Insurance Company (U.S.A.) Group Long-Term Care, B-6 200 Berkeley St. Boston, MA 02117 **1-800-222-6814**

Telephone and website directory

You can contact many of the vendors through the "health and welfare benefits" option of ConnectOne.

Telephone

ConnectOne: **1-800-881-3938**

- From outside the United States and Puerto Rico: Call the HR Shared Services at **1-469-220-9600**. Press 1 when prompted.
- If you use a TDD: Call the Telecommunications Relay Service at 1-866-280-2050. 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 on Your Benefits Resources™ (YBR™) through the TotalComp@Citi website at www.totalcomponline.com, available from the Citi intranet and the Internet.

For information about these topics, plans, or programs	Contact	Telephone number/website
COBRA coverage (Consolidated Omnibus Budget Reconciliation Act)	Citi Benefits Center	Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option and then the "health care including COBRA" option and then speak to a Citi Benefits Center representative.
Medical	Triple-S	**1-787-774-6098** or **1-787-749-4777** www.ssspr.com
Dental	Triple-S	**1-787-774-6098** or **1-787-749-4777** www.ssspr.com
Insurance Basic Life insurance Basic Accidental Death and Dismemberment (AD&D) insurance	Citi Benefits Center	Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option and then speak to a Citi Benefits Center representative.
Group Universal Life (GUL) insurance	MetLife	**1-888-830-7380**
Supplemental AD&D insurance	MetLife	**1-888-830-7380**
Long-Term Care insurance	John Hancock Life Insurance Company (U.S.A)	For current participants only; new enrollment is not permitted. **1-800-222-6814**

For information about these topics, plans, or programs	Contact	Telephone number/website
Disability/FMLA	MetLife	For Short-Term Disability (STD), Long-Term Disability (LTD), and Family and Medical Leave Act (FMLA) information To report a disability or FMLA leave, choose the "disability" option of ConnectOne. You also can report a disability by calling MetLife directly. **1-800-826-0547**
Prescription Drug Program	Triple-S	**1-866-881-6221** regarding mail order **1-787-774-6098** regarding retail scripts
Total Compensation website	TotalComp@Citi	www.totalcomponline.com
Vision Care Plan	Aetna	**1-877-787-5354** www.AetnaVisionOE.com/avp1 Members: www.aetnavision.com
Employee Assistance Program	Harris Rothenberg	**1-866-723-7223** TTY: **1-800-256-1604** https://www.hriworld.com/loginc.html User ID: resources, password: for_you
Work/Life	Health Advocate	**1-866-449-9933**, select option #2 for Work/Life program www.HealthAdvocate.com/citiworklife

This document is intended to provide a brief overview of your benefits. Citigroup reserves the right to change or to discontinue any or all of the benefits coverage or programs described here at any time. No statement in this or any other document and no oral representation shall be construed as waiving this right. The Plan Administrator, except to the extent not delegated to the Claims Administrator, has the sole discretion to interpret all of the provisions contained here, including the discretion to interpret the terms of eligibility for any of the benefits provided. Any such interpretation may only be relied upon if in writing from the Plan Administrator. Nothing in this or any other benefits documents or any oral representation should be construed as a guarantee of employment for any period of time.

Glossary

Definitions of certain terms used in this Handbook are included in this section.

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

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

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

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

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

In-network provider: A health care provider on a list of providers preselected by the insurer. The insurer will offer discounted coinsurance or co-payments, to a plan member to utilize in-network providers and facilities.

Maximum allowed amount (MAA): Any charge that, for services rendered by or on behalf of an out-of-network physician, does not exceed the amount determined by the Claims Administrator in accordance with the applicable fee schedule. This amount is determined by taking into account all pertinent factors including:

- The complexity of the service;
- The range of services provided; and
- The geographic area where the provider is located.

How MAA is calculated varies depending on which plan option you are enrolled in and which carrier you have. Contact your plan for more details.

Medically necessary or medical necessity: Health care services and supplies that are determined by the Claims Administrator to be medically appropriate and:

- Necessary to meet the basic health needs of the covered person;
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply;
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Plan;
- Consistent with the diagnosis of the condition;
- Required for reasons other than the convenience of the covered person or his or her physician;
- Must be provided by a physician, hospital, or other covered provider under the Plan;
- With regard to an inpatient, it must mean the patient’s illness or injury requires that the service or supply cannot be safely provided to that person on an outpatient basis;
- It must not be primarily scholastic, vocational training, educational or developmental in nature or experimental or investigational;

- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy:
    - For treating a life-threatening sickness or condition;
    - In a clinically controlled research setting; and
    - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, mental illness, or pregnancy does not mean that it is medically necessary as defined above. The definition of medically necessary used in this document relates only to coverage and differs from the way in which a physician engaged in the practice of medicine may define medically necessary. The Plans Administration Committee may delegate the discretionary authority to determine medical necessity under the Plans. No benefit will be paid for services that are not considered medically necessary.

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

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

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

Precertification: A requirement that a participant calls his or her health plan option before seeking certain treatment. The Claims Administrator will:

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

Obtaining an authorization means that the insurer is obligated to pay for the service, assuming it matches what was authorized.

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

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

Preventive care: Routine care exams based on guidelines from the American Medical Association, the United States Preventive Care Task Force, the Advisory Committee on Immunization Practices that has been adopted by Director of the Centers for Disease Control and Prevention, the Comprehensive Guidelines Supported by the Health Resources and Services Administration and doctor recommendations. Covered expenses include routine physical exams (including well-woman and well-child exams), routine cancer screenings, and immunizations. See "Preventive care" on page 19.

Provider: A health care provider is an individual or an institution that provides preventive, curative, promotional or rehabilitative health care services in a systematic way to individuals, families or communities. An individual health care provider may include, but is not limited to, a health care professional, physician assistant, nurse practitioner, chiropractor an institution, facility, primary care center, patient-centered medical home, clinic, ambulatory surgical center, outpatient center, urgent care center, or pharmacy.

Wellness services: See “Preventive care” on page 19.

Additional medical coverage definitions

The following definitions apply to benefits provided under the Citigroup Health and Benefit Plan, unless clearly indicated otherwise.

Accredited school or college: An accredited secondary school, junior college, college, or university or a state or federally accredited trade or vocational school.

Ambulatory surgical center: A specialized facility established, equipped, operated, and staffed primarily to perform surgical procedures and that fully meets one of the following two tests:

- It is licensed as an ambulatory surgical center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all of the following requirements:
  - It is operated under the supervision of a licensed doctor of medicine (MD) or doctor of osteopathy (DO) who devotes full time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area;
  - In all cases, except those requiring only local infiltration anesthetics, it requires that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure;
  - It provides at least one operating room and at least one post-anesthesia recovery room;
  - It is equipped to perform diagnostic X-ray and laboratory exams or has arranged to obtain these services;
  - It has trained personnel and necessary equipment to handle emergency situations;
  - It has immediate access to a blood bank or blood supplies;
  - It provides the full-time services of one or more registered nurses (RN) for patient care in the operating rooms and in the post-anesthesia recovery room; and
  - It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative exam report, medical history and laboratory tests and/or X-rays, an operative report, and a discharge summary.

An ambulatory surgical center that is part of a hospital, as defined herein, will be considered an ambulatory surgical center for the purposes of the Plan.

Birth center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and that fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- It meets all of the following requirements:
  - It is operated and equipped in accordance with any applicable state law;
  - It is equipped to perform routine diagnostic and laboratory exam, such as hematocrit and urinalysis, for glucose, protein, bacteria, and specific gravity;

- It has available, to handle foreseeable emergencies, trained personnel and necessary equipment, including, but not limited to, oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders;
- It is operated under the full-time supervision of a licensed doctor of medicine (MD), doctor of osteopathy (DO), or registered nurse (RN);
- It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications;
- It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal exam, any laboratory or diagnostic tests, and a postpartum summary; and
- It is expected to discharge or transfer patients within 24 hours following delivery unless medically necessary.

A birth center that is part of a hospital, as defined herein, will be considered a birth center for the purposes of the Plan.

Brand-name drug: A drug that is under patent by its original innovator or marketer.

Calendar year: January 1 through December 31 of the same year. For new enrollees, the calendar year is the effective date of their enrollment through December 31 of the same year, unless otherwise provided in the annual enrollment materials.

Center of Excellence (COE): A health care facility that is identified as providing the most efficient and best quality of care. COEs often produce the best health outcomes.

Chiropractic care: Skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a physician to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column. The following are not considered to be chiropractic care: Chiropractic appliances, services related to the diagnosis and treatment of jaw joint problems such as temporomandibular joint (TMJ) syndrome or craniomandibular disorders or services for treatment of strictly non-neuromusculoskeletal disorders.

Claims Administrator: Triple-S and any other party designated as a claims fiduciary pursuant to a contractual relationship and as authorized by the Plans Administration Committee of Citigroup Inc. The Claims Administrator does not insure the benefits described in this document.

Comprehensive outpatient rehabilitation facility: A facility that is primarily engaged in providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured or sick persons and that fully meets one of the following two tests:

> It is approved by Medicare as a comprehensive outpatient rehabilitation facility; or

> It meets all of the following tests:

- It provides at least the following comprehensive outpatient rehabilitation services:
  - Services of physicians who are available at the facility on a full- or part-time basis;
  - Physical therapy; and
  - Social or psychological services;
- It has policies established by a group of professional personnel (associated with the facility), including one or more physicians to govern the comprehensive outpatient rehabilitation services it furnishes and provides for the carrying out of such policies by a full- or part-time physician;
- It has a requirement that every patient must be under the care of a physician; and
- It is established and operates in accordance with the applicable licensing and other laws.

Cosmetic surgery: Medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns, or disfigurements.

Covered family members or covered person: The employee and the employee's legal spouse (same or opposite sex) and/or dependent children, or qualified domestic partner/civil union partner who are covered under the Plan.

Designated transplant facility: A facility designated by the Claims Administrator to render medically necessary covered services and supplies for qualified procedures under the Plan.

Emergency care: An "Emergency Condition" is a medical or behavioral condition of sudden onset that manifests itself by symptoms of sufficient severity (including severe pain), that a prudent lay person, possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy; or in the case of a behavioral condition placing the health of such a person or others in serious jeopardy;
- Serious impairment to such person's bodily function;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

ERISA: The Employee Retirement Income Security Act of 1974, as amended.

Experimental, investigational, or unproven services: This includes any medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by any institutional review board for the proposed use;
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in FDA regulations, regardless of whether the trial is actually subject to FDA oversight; and
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Claims Administrator, in its judgment, may deem an experimental, investigational, or unproven service covered under the Plan for treating a life-threatening sickness or condition if it is determined by the Claims Administrator that the experimental, investigational, or unproven service at the time of the determination:

- Is proven to be safe with promising efficacy;
- Is provided in a clinically controlled research setting; and
- Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For purposes of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

Fiduciary: A person who exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan. The "named fiduciary" for the Plan is the Plans Administration Committee of Citigroup Inc., except to the extent fiduciary authority has been delegated by this document or otherwise to Claims Administrators or others.

Generic drug: Equivalent medications that contains the same active ingredient and are subject to the same rigid FDA standards for quality, strength, and purity as their brand-name equivalents. Generic drugs are less expensive than brand-name drugs.

Home health care agency: An agency or organization that provides a program of home health care and meets one of the following three tests:

- It is approved under Medicare;
- It is established and operated in accordance with the applicable licensing and other laws; or
- It meets all of the following tests:
  - Its primary purpose is to provide a home health care delivery system bringing supportive services to the home;
  - It has a full-time administrator;
  - It maintains written records of services provided to the patient;
  - Its staff includes at least one registered nurse (RN) or it has nursing care by a RN available; and
  - Its employees are bonded, and it maintains malpractice insurance.

Hospice: An agency that provides counseling and incidental medical services for a terminally ill individual. Room and board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a hospice;
- It is licensed in accordance with any applicable state laws; or
- It meets the following criteria:
  - It provides 24/7 service;
  - It is under the direct supervision of a duly qualified physician;
  - It has a nurse coordinator who is a RN with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients;
  - The main purpose of the agency is to provide hospice services;
  - It has a full-time administrator;
  - It maintains written records of services given to the patient; and
  - It maintains malpractice insurance coverage.

A hospice that is part of a hospital will be considered a hospice for purposes of the Plan.

Hospital: An institution engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and fully meets one of the following three tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations;
- It is approved by Medicare as a hospital; or
- It meets all of the following tests:
  - It maintains, on the premises, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians;
  - It continuously provides, on the premises, 24/7 nursing service by or under the supervision of registered graduate nurses; and
  - It is operated continuously with organized facilities for operative surgery on the premises.
  - **In-network pharmacy:** A registered and licensed pharmacy, including a mail-order pharmacy that participates in the network.

In-network provider: A provider that participates in the health plan network in which you enrolled.

Infertile or Infertility: The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- For a woman who is under 35 years of age: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- For a woman who is 35 years of age or older: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Injury: An accidental physical injury to the body caused by unexpected external means.

Intensive care unit: A separate, clearly designated service area maintained within a hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has facilities for special nursing care not available in regular rooms and wards of the hospital, special life-saving equipment that is immediately available at all times, at least two beds for the accommodation of the critically ill, and at least one RN in continuous and constant attendance 24/7.

Licensed counselor: A person who specializes in mental health and chemical dependency treatment and is licensed as a Licensed Clinical Social Worker (LCSW) by the appropriate authority.

Lifetime: A word appearing in the Plan in reference to benefit maximums and limitations. Lifetime is understood to mean the period of time in which a participant and his or her eligible dependents are covered under the Plan. Under no circumstances does lifetime mean during the entire lifetime of the covered individual, unless covered by the plan at date of death.

Medicare: The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act.

Mental health and chemical dependency treatment: Treatment for both of the following:

- Any sickness identified in the current edition of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM), including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause; and
- Any sickness for which the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

All inpatient services, including room and board, given by a mental health facility or area of a hospital that provides mental health or substance abuse treatment for a sickness identified in the DSM, are considered mental health and chemical dependency treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the sickness that is identified in the DSM is considered mental health and chemical dependency treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered mental health and chemical dependency treatment.

Prescription drugs are not considered mental health and chemical dependency treatment.

Morbid obesity: A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent body mass index (BMI) tables for a person of the same height, age, and mobility as the covered person.

Non-preferred brand-name drug: A brand-name drug that is not a formulary drug. See the definition of preferred brand-name drug.

Nurse-midwife: A person licensed or certified to practice as a nurse-midwife and who fulfills both of these requirements:

- Licensed by a board of nursing as a RN; and
- Has completed a program approved by the state for the preparation of nurse-midwives.

Nurse-practitioner: A person who is licensed or certified to practice as a nurse-practitioner and fulfills both of these requirements:

- Licensed by a board of nursing as a RN; and
- Has completed a program approved by the state for the preparation of nurse-practitioners.

Occupational therapy: Services that improve the patient's ability to perform tasks required for independent functioning when the function has been temporarily lost and can be restored.

Other services and supplies: Services and supplies furnished to the individual and required for treatment, other than the professional services of any physician and any private-duty or special nursing services (including intensive nursing care by whatever name called).

Out-of-network hospital: A hospital (as defined) that does not participate in the Plan's network in which you enrolled.

Out-of-network pharmacy: A pharmacy other than an Express Scripts network pharmacy.

Out-of-network provider: A provider that does not participate in the Plan's network in which you enrolled.

Outpatient care: Treatment including services, supplies, and medicines provided and used at a hospital under the direction of a physician to a person not admitted as a registered bed patient or services rendered in a physician's office, laboratory or X-ray facility, an ambulatory surgical center, or the patient's home.

Physical therapy: Services that are designed to restore an individual to a level of function present prior to an illness or accidental injury.

Physician: A legally qualified and licensed:

- Doctor of Medicine (MD);
- Doctor of Chiropody (DPM; DSC);
- Doctor of Chiropractic (DC);
- Doctor of Dental Surgery (DDS);
- Doctor of Medical Dentistry (DMD);
- Doctor of Osteopathy (DO); or
- Doctor of Podiatry (DPM).

Plan Administrator: The Plans Administration Committee of Citigroup Inc.

Plan year: January 1 - December 31.

Preadmission tests: Tests performed on a covered person in a hospital before confinement as a resident inpatient provided the tests meet all of the following requirements:

- The tests are related to the performance of scheduled surgery;
- The tests have been ordered by a physician after a condition requiring surgery has been diagnosed and hospital admission for surgery has been requested by the physician and confirmed by the hospital; and
- The covered person is subsequently admitted to the hospital, or the confinement is canceled or postponed because a hospital bed is unavailable or because there is a change in the covered person's condition that precludes the surgery.

Preferred brand-name drug: A drug that is prescribed from a list of medications preferred for its clinical effectiveness and opportunity to help contain health care costs. Preferred drugs are part of an incentive program to help control the costs of care and are frequently called formulary drugs.

Prescription drugs: Any drugs that cannot be dispensed without a doctor's prescription. The following will be considered prescription drugs:

- Federal legend drugs. This is any medicinal substance that the federal Food, Drug, and Cosmetic Act requires to be labeled "Caution - federal law prohibits dispensing without prescription";

- Drugs that require a prescription under state law but not under federal law;
- Compound drugs having more than one ingredient; at least one of the ingredients has to be a federal legend drug or a drug that requires a prescription under state law;
- Injectable insulin; and
- Needles and syringes.

Primary care physician (PCP): A physician in general practice or who specializes in pediatrics, family practice, or internal medicine who has agreed with the Claims Administrator to act as the entry point to the health care delivery system and may coordinate the member's care. The PCP is not an agent or employee of the Claims Administrator or Citigroup Inc.

Psychiatrist: A physician who specializes in mental, emotional, or behavioral disorders.

Psychologist: A person who specializes in clinical psychology and fulfills one of these requirements:

- Licensed or certified as a psychologist or
- A member or fellow of the American Psychological Association, if there is no government licensure or certification required.

Rehabilitation facility: A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

Room and board: Room, board, general-duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the hospital as a condition of occupancy of the class of accommodations occupied but not including professional services of physicians or special nursing services rendered outside of an intensive care unit by whatever name called.

Self-insured or self-funded plan: A plan in which no insurance company or service plan collects premiums and assumes risk.

Sickness: Bodily disorder or disease. The term "sickness" used in connection with newborn children will include congenital defects and birth abnormalities, including premature births.

Skilled nursing facility: A facility, if approved by Medicare as a skilled nursing facility, is covered by this Plan. If not approved by Medicare, the facility may be covered if it meets the following tests:

- It is operated under the applicable licensing and other laws;
- It is under the supervision of a licensed physician or RN who is devoting full time to supervision;
- It is regularly engaged in providing room and board and continuously provides 24/7 skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or sickness;
- It maintains a daily medical record of each patient who is under the care of a licensed physician;
- It is authorized to administer medication to patients on the order of a licensed physician; and
- It is not, other than incidentally, a home for the aged, the blind or the deaf; a hotel; a domiciliary care home, a maternity home; or a home for alcoholics or drug addicts or the mentally ill.

A skilled nursing facility that is part of a hospital will be considered a skilled nursing facility for the purposes of the Plan.

Specialty drug: A drug for the treatment of complex chronic diseases, such as, but not limited to, multiple sclerosis, hemophilia, cancer and rheumatoid arthritis.

Treatment center: A facility that provides a program of effective mental health and chemical dependency treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law;
- It provides a program of treatment approved by a physician and the Claims Administrator;

- It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient;
- It provides at least the following basic services:
  - Room and board (to the extent that this Plan provides inpatient benefits at a Treatment Center);
  - Evaluation and diagnosis;
  - Counseling by a licensed provider; and
  - Referral and orientation to specialized community resources.

Treatment centers that qualify as a hospital are covered as a hospital and not as a treatment center.

Urgent care: Conditions or services that are non-preventive or non-routine and are needed to prevent the serious deterioration of a member's health following an unforeseen illness, injury, or condition. Urgent care includes conditions that could not be adequately managed without immediate care or treatment, but do not require the level of care provided in the emergency room.

Urgent care facility/center: A facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.