Health and Insurance **Benefits Handbook**

For coverage effective
January 1, 2015

Live Well at Citi

citi®

Benefits Handbook for health, disability, insurance, and welfare plans

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 it provides general information to help you make the right decisions for you and your family.

In the Benefits Handbook

The information in this Benefits Handbook is broken up into sections, including:

- About this Benefits Handbook;
- Eligibility and participation;
- Health care benefits;
- Spending accounts;
- Disability coverage;
- Life & Accident;
- Administrative information;
- Glossary; and
- For more information.

The Benefits Handbook describes the health and insurance benefits available effective January 1, 2015. Visit the "Archives" section for health and insurance benefits available prior to January 1, 2015.

Health Advocate

The Live Well at Citi Program offers you free health care support from Health Advocate. Health Advocate isn't affiliated with insurance carriers or health care providers and doesn't share your information with Citi. You and your entire family can use Health Advocate, regardless of health coverage. Health Advocate can help you take control of your health care issues, including resolving insurance claims and billing issues, making appointments with a hard-to-reach specialist, and understanding issues related to prescription drugs, such as comparisons between generic and brand-name medications.

To contact Health Advocate, call **1-866-449-9933**.

Puerto Rico

See the English and Spanish versions of the 2015 annual enrollment guide for information about changes to the plans for 2015 and the 2015 Summary Plan Description.

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About this Benefits Handbook

The Benefits Handbook serves as the plan document and Summary Plan Description ("SPD") for health and insurance benefits for specified U.S. employees of Citigroup Inc. ("Citigroup" or "Citi") and its participating companies (collectively, the "Company"), for the 2015 plan year (January 1 – December 31, 2015).

If there is a conflict between any information on Citi Benefits Online and the descriptions of benefits in the Benefits Handbook, the Handbook will govern.

Citi reserves the right to change or discontinue, at any time, any or all of the benefits coverage or programs described here.

No right to employment

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

Eligibility and participation

Your Citi health and welfare benefits are a valuable part of the rewards of working at Citi. To make the most of your benefits, you need to understand how they work. This section describes the eligibility and participation rules for the following Citigroup Health and Insurance Plans (collectively, the “Plans”; and individually, a “Plan”):

- Medical (including the ChoicePlan 500, High Deductible Health Plan, Oxford PPO, and HMOs);
- Prescription drug;
- Dental (including MetLife Dental PDP and Cigna Dental);
- Vision;
- Wellness benefits;
- Spending accounts;
- Employee Assistance Program;
- Disability coverage; and
- Insurance benefits (including Basic Life, Basic Accidental Death and Dismemberment (AD&D) Group Universal Life (GUL), Supplemental AD&D, and Business Travel Accident/Medical).

Contents

Benefits overview

Citi provides a basic level of benefits coverage, called core benefits, as well as the opportunity to enroll in additional coverage for yourself and your family. Coverage is effective on your date of hire or the date you become eligible for benefits. Other than the core and non-core LTD (you are automatically enrolled upon initial eligibility with an option to decline the LTD coverage) benefits, you must enroll to have coverage.

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

- **Short-Term Disability (STD) coverage**, administered by MetLife; coverage to replace generally up to 100% of your annual base salary for an approved disability leave of up to 13 weeks; the number of weeks at 100% pay will depend on your length of service with Citi; see "Short-Term Disability (STD)" in the Disability section for the STD schedule of benefits that applies to you; and
- **Long-Term Disability (LTD) coverage**, administered by MetLife, equal to 60% of your benefits eligible pay, provided your benefits eligible pay is less than or equal to $50,000.99.
- **Basic Life insurance**, equal to your benefits eligible pay, if less than $200,000, on your date of eligibility. Basic Life insurance is insured by MetLife; if your benefits eligible pay is equal to or exceeds $200,000, you are not eligible for Basic Life insurance;
- **Basic Accidental Death and Dismemberment (AD&D) insurance**, equal to your benefits eligible pay, if less than $200,000, on your date of eligibility. Basic AD&D insurance is insured by MetLife; if your benefits eligible pay is equal to or exceeds $200,000, you are not eligible for Basic AD&D insurance;
- **Business Travel Accident/Medical (BTA) insurance**, administered by ACE American Insurance Company, of up to five times your benefits eligible pay to a maximum benefit of $2 million; and medical coverage related to covered accidents and/or sickness while traveling on behalf of Citi;
- **Employee Assistance Program (EAP)**, administered by Harris Rothenberg International LLC; a confidential, professional counseling service designed to help you and your household members resolve issues that affect your personal lives or may interfere with job performance;
- **Live Well at Citi Program**, administered by Health Advocate, RedBrick Health and Citi's self-insured medical carriers (Anthem BlueCross BlueShield, Aetna and Oxford), Citi's comprehensive health and wellness program provides you and your family with the tools and resources designed to assist you in managing your health care and help you achieve your health goals;
- **Work/Life Program**, administered by Health Advocate; provides assistance and helps employees save time as they face common everyday challenges, such as finding child care, free legal assistance, help with identity theft, and more;
- **Additional benefits** to consider that require enrollment:
- Benefits paid with before-tax dollars (as long as you are receiving a paycheck):
  - Medical (including the Health Savings Account [HSA] if you are enrolled in the High Deductible Health Plan [HDHP]);
  - Dental;
  - Vision;

- Health Care Spending Account (HCSA);
- Limited Purpose Health Care Spending Account (LPSA);
- Dependent Day Care Spending Account (DCSA); and
- Transportation Reimbursement Incentive Program (TRIP).

> Benefits paid with after-tax dollars:

- LTD, if your benefits eligible pay is $50,001 and above; if your benefits eligible pay is below this amount, LTD is a core benefit provided at no cost to you;
- Group Universal Life (GUL) insurance;
- Supplemental AD&D insurance; and
- Long-Term Care insurance (if enrolled prior to January 1, 2012).

Eligibility

Citi provides benefits coverage for you, your spouse (same- or opposite-gender), civil union partner or qualified domestic partner, and/or eligible dependents.

For employees

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

> You work in any U.S. entity in which Citigroup Inc. owns at least an 80% interest. U.S. employees of Global Consumer Banking, Institutional Clients Group, Corporate Center or one of their participating employers participate in the Plan as well as certain other employees of affiliated companies as described in the Plan. For a complete list of all the participating employers, please contact the Citi Benefits Center.

> You are an active:

- Full-time employee (regularly scheduled to work 40 or more hours a week); **or**
- Part-time employee (regularly scheduled to work at least 20 or more hours a week); **and**

> You receive regular biweekly or monthly pay; 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 have been employed 90 days without regard for the temporary classification.

If both you and your spouse (same- or opposite-gender)/civil union partner/domestic partner are Citi employees

If both you and your spouse (same- or opposite-gender)/civil union partner/domestic partner are employed by Citi and are benefits-eligible, each of you can enroll individually or one of you can enroll and claim the other as a dependent. You cannot enroll in Citi's Plan as an individual and be claimed as your spouse's/civil union partner's/domestic partner's dependent.

Plan	Applicable rules
Medical, dental, and vision	Each of you may be covered under the medical and dental plans as either an employee or a dependent but not as both. Either of you may cover your children, but they cannot be covered by both of you.
Health Care Spending Account (HCSA)	Each of you, as a Citi employee, may contribute to an HCSA but you may not file more than once for reimbursement of the same eligible expense. However, your civil union partner or qualified domestic partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of Section 152 of the Internal Revenue Code (the "Code") as determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.
Limited Purpose Health Care Spending Account (LPSA)	If either of you enrolls in the Citi High Deductible Health Plan (HDHP), either of you may contribute to a LPSA but you may not file more than once for reimbursement of the same eligible expense. You may be reimbursed only for dental, vision, or preventive care expenses under this account. Neither of you can enroll in the HCSA. Your civil union partner or qualified domestic partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.
Health Savings Account (HSA)	The maximum amount that can be contributed to an HSA for the 2015 calendar year is $3,350 for single and $6,650 for family coverage. This does not mean that both family members can contribute $6,650 each, it is a combined contribution amount. Citi makes up to a $1,000 annual contribution for employees with family coverage and up to $500 for individual coverage. Citi's contribution to your HSA counts toward your annual contribution maximum.
Dependent Day Care Spending Account (DCSA)	Either of you may contribute to a DCSA but you may not file more than once for reimbursement of the same eligible expense. Your civil union partner or qualified domestic partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of Section 152 of the Code as determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof. If your civil union partner's children or domestic partner's children are not your tax dependents, as noted above, your partner, as a Citi employee, can contribute to his/her own DCSA.
Transportation Reimbursement Incentive Program (TRIP)	Spouses (same- or opposite-gender)/civil union partner/domestic partner, as Citi employees, are eligible to enroll in TRIP on their own behalf.
Group Universal Life (GUL)	Each of you may be covered under the GUL plan as either an employee or a dependent, but not as both. Either of you may cover your children, but they cannot be covered by both of you.
Supplemental Accidental Death and Dismemberment (AD&D)	Each of you may be covered under the Supplemental AD&D plan as either an employee or a dependent, but not as both. Either of you may cover your children, but they cannot be covered by both of you.

Plan	Applicable rules
Live Well at Citi Program	**Health Assessment Reward:** Rewards for you and your spouse (same- or opposite-gender)/domestic partner/civil union partner will be applied to the employee that has medical coverage for the couple. If neither of the couple has medical coverage, then dental or vision will be used to determine appropriate assignment of this Reward. If you as a couple do not elect medical, dental, or vision coverage, an HCSA will be established for the Rewards. However, if due to a subsequent qualified change in status, either of you elect to enroll in a HDHP, you would be ineligible to make contributions to an HSA. **Tobacco Penalty:** The tobacco penalty is applied per covered adult per year, regardless of whether both adults work for Citi or not.
Employee Assistance Program (EAP)	Both you and your household members are covered under this program.

When you are not eligible to enroll

You are not eligible to enroll in the Plans if:

- Your compensation is not reported on a Form W-2 Wage and Tax Statement issued by a participating employer;
- You are employed by a Citi subsidiary or affiliate that is not a participating employer;
- You are engaged under an agreement that states you are not eligible to participate in the applicable plan or program;
- You are a non-resident alien performing services outside the United States; or
- You are classified by Citi as an independent contractor or consultant, or you are employed on a temporary basis hired with the intent to work fewer than six months, or you are not classified as an active full-time or part-time employee, as described above. However, 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 you are not eligible for benefits pursuant to the above and are subsequently reclassified as, or determined to be, an employee by the Internal Revenue Service, any other governmental agency or authority, or a court, or any other individual or entity, or if Citi is required to reclassify you as an employee as a result of such reclassification or determination (including any reclassification in settlement of any claim or action relating to your employment status), you will not become eligible to participate in the Plans by reason of such reclassification or determination retroactively. If a person who is not classified by Citi as an eligible employee otherwise satisfies these eligibility rules and is subsequently reclassified by Citi as an eligible employee, such person, for purposes of these Plans, shall be deemed an eligible employee from the later of the actual or the effective date of such reclassification.

If you are a U.S. citizen or legal resident employed outside the United States or if you are otherwise unsure whether you are eligible to participate in the Plans, call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “health and welfare benefits” option. For TDD and international assistance, please see the “For More Information” section. You can also contact your HR representative for more information.

No pre-existing condition limitations

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

For dependents

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

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

- Regardless of gender, your lawfully married spouse, or your common-law spouse if you live in a state that recognizes common-law marriages or your civil union partner, if you live in a state that recognizes such partnerships; if you are legally separated or divorced, your spouse is *not* an eligible dependent unless mandated by state law; at any time, you 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. However, under federal law, civil union partnerships are subject to the same tax treatment as domestic partnerships. Alternatively, if your domestic partnership is registered in any state or under any local government authority authorized to provide such registration, documentation of such registration will be accepted as proof of your domestic partnership, without satisfying the listed requirements for nonregistered domestic partners.
- Your domestic partner;
- Your domestic partner's eligible dependents;
- Your children under the age of 26* (dependent children are covered through the end of the plan year in which they turn 26, regardless of whether they are full-time students) 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
  - Any other child for whom you are the legal guardian in accordance with the laws of the state in which you reside.

You can cover your disabled child beyond age 26 if he or she was covered under the Plans before age 26 and became incapable of self-sustaining employment due to a disability while covered, in which case the eligible dependent may be eligible for coverage beyond such age.

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

Please note that not all HMOs cover civil union partner's/domestic partner's and/or their children. For more specific information, contact your HMO directly.

***Note:** Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age of 26. However, for some HMOs, coverage ends on the last day of the month in which the child reaches the maximum age. For specific information, contact your HMO directly. For more information on when coverage ends, see "When coverage ends" beginning on page 33.

State laws apply only to fully insured plans. See the list of fully insured plans in the Medical subsection of the Health care benefits section of this Benefits Handbook.

No dependent can be covered under these Plans as both an employee and as an eligible dependent or as an eligible dependent of more than one employee.

Note about disabled children: 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 the applicable maximum age as described above, or (b) you enroll this dependent within the first 31 days of your eligibility under the Plans, this child may continue to be considered an eligible dependent under the Plans beyond the date his 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.

For domestic partners

You are eligible to enroll your domestic partner who is a U.S. citizen or legal resident in Citi coverage if you are a U.S. employee who is active or on an approved leave of absence. For GUL insurance to be effective for your domestic partner, you must be actively at work.

To be eligible for coverage, you and your partner may be of the same- or opposite-gender 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; if you are married, legally separated or getting a divorce, the six months is counted beginning with the date your divorce is final or the date you report your divorce to the Citi Benefits Center, whichever is later;
- You are financially interdependent, or your partner is dependent on you for financial support;
- Neither you nor your domestic partner is legally married to another person; if you are married, legally separated, or getting divorced, you cannot add a domestic partner to your coverage until the later of six months from the date your divorce is final or the date you report your divorce to the Citi Benefits Center;
- Both of you are at least 18 years old and mentally competent to consent to contract;
- You are not related by blood to a degree of closeness that would prohibit marriage were you of the opposite gender; **you cannot enroll your parents or siblings even though all other criteria may apply to your relationship**;
- Neither you nor your domestic partner is in a domestic partnership, marriage, 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 permanent and one in which each is the sole domestic partner of the other.

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

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

To cover a domestic partner, you and your domestic partner must first complete forms attesting to your domestic partnership. 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 previously listed requirements or completing a certification form. 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 to certify your domestic partnership 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. **You must wait six months from the time your termination attestation form is received before you can add a new domestic partner.**

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

- Biological children;
- Legally adopted children;
- Stepchildren; and
- Any other child for whom your domestic partner is the legal guardian in accordance with the laws of the state in which he or she resides.

You can cover your domestic partner's disabled child beyond age 26 if he or she was covered under the Plans before age 26 and became incapable of self-sustaining employment due to a disability while covered, in which case the eligible dependent may be eligible for coverage beyond such age.

You can also cover your domestic partner's disabled adult child when you begin employment with Citi and you enroll him or her when you are first eligible to do so. You must have a letter from the Social Security Administration declaring your domestic partner's child as disabled; if you do not have such a letter, your Citi health plan will evaluate the child before adding him or her to your benefits.

Note: Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age. However, for some HMOs, coverage ends on the last day of the month in which the child reaches the maximum age. For more specific information, contact your HMO directly. For more information on when coverage ends, see "When coverage ends" beginning on page 33.

HMO eligibility

Please note that insured HMOs made available through the Citigroup Health Benefit Plan comply with state laws that require less restrictive age and/or income requirements for dependents. These laws apply only to insured health programs and do not apply to ChoicePlan 500 or other non-insured (self-funded) programs. This applies to the following plans:

1. Coventry Health Care of Iowa;
2. Geisinger Health Plan (Pennsylvania);
3. Health Plan Hawaii Plus (HMSA);
4. SelectHealth (Utah and part of Idaho);
5. Independent Health (upstate New York);
6. Kaiser FHP of California - Northern;
7. Kaiser FHP of California - Southern;
8. Kaiser FHP of Colorado;
9. Kaiser FHP of Georgia;
10. Kaiser FHP of Hawaii;
11. Kaiser FHP of the Mid-Atlantic States; and
12. Sanford Health Plan (South Dakota, and parts of North Dakota, Minnesota, and Iowa).

For more information, contact the insured HMO provider in your state. Coverage may be available only on an after-tax basis if your covered children are not your tax dependents, and other costs may apply.

Other coverage

If you are eligible to enroll in coverage elsewhere, for example, through a spouse's, civil union partner's/domestic partner's, or other employer's plan, you can compare the Citi coverage and costs with the other coverage. You may decide to enroll in some plans offered through Citi and some from the other source.

However, if you are enrolling in coverage from two sources, be sure you understand how benefits are paid when you are covered by two group medical plans or group dental plans. In many instances, you may pay for coverage from two group plans but you will not receive double benefits or even be reimbursed for 100% of your costs as a result of what is called "coordination of benefits." See "Coordination of benefits" on page 46 for the guidelines on whose plan pays first.

Health Advocate

Health Advocate can help you understand your benefits and compare the costs and benefits of different plans. Call **1-866-449-9933** and select option #1 to speak with your Personal Health Advocate.

Enrollment

You can enroll in Citi coverage within 31 days of the time you first become eligible, during the annual enrollment period, or as a result of a qualified change in status. Your enrollment materials will contain the coverage available to you, the enrollment deadline, and how to enroll. You can enroll in any or all types of benefits offered to you.

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-gender)/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-gender)/civil union partner/domestic partner, your eligible children, and your civil union partner's/domestic partner's eligible children.

You can choose a different coverage category for medical and dental. For example, you might enroll in "Employee Only" coverage for medical if your spouse has medical coverage from his or her employer and "Employee Plus Spouse/Partner" for dental coverage if your spouse's employer does not offer dental coverage.

Each category has a different cost. In addition, your cost for medical coverage will depend on your benefits eligible pay band as defined in "Your contributions" on page 21. 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.

Changing your coverage category

You can change your coverage category during the annual enrollment period and within 31 days of a qualified change in status. See "Changing your coverage" beginning on page 26 for more information.

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 benefits. *Enrolling in Citi health and welfare benefits is not mandatory.* Remember, however, that the Affordable Care Act requires almost all individuals to have health insurance or incur a penalty. If you don't enroll in coverage, you may have to pay this penalty.

You must enroll during your initial enrollment period for benefits (except core benefits), including medical, dental and vision coverage. You must also enroll to participate in a Health Care Spending Account (HCSA), Limited Purpose Health Care Spending Account (LPSA), Dependent Day Care Spending Account (DCSA) or the Transportation Reimbursement Incentive Program (TRIP). You are not required to enroll in TRIP during annual enrollment. You can enroll at any time. If you do not enroll, you will have the core coverage, described in "Benefits overview" on page 10.

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 over age 26, 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 "For dependents" on page 14, under "Eligibility" beginning on page 11.

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.

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.

If you do not enroll

If you do not enroll in coverage within your initial 31 day enrollment period, you can enroll during a subsequent annual enrollment period or as the result of a qualified change in status.

If you do not enroll and do not have health coverage as of January 1, 2015, you may incur a penalty from the U.S. government (due to health care reform requirements).

During annual enrollment

If you want to enroll in Citi coverage, drop Citi coverage, change to a different medical, dental, or vision option, enroll in a spending account, or change your coverage category — for example from single to family or vice versa — you must do so during your annual enrollment period. Outside of annual enrollment, generally you can only make changes to your coverage if you have a qualified change in status, such as getting married.

Medical, dental, and/or vision coverage

If you previously enrolled in coverage and do not enroll during a subsequent annual enrollment period you will be assigned the same coverage for the following year, or, if that coverage is no longer available, to comparable medical, dental, and/or vision coverage.

If you do not complete the Tobacco Free Attestation on YBR™**,** available through TotalComp@Citi at **http://www.totalcomponline.com**, before your enrollment deadline**,** you will pay a $600 penalty on your Citi medical plan coverage.

Health Care Spending Account (HCSA)/Limited Purpose Health Care Spending Account (LPHCSA), and/or Dependent Day Care Spending Account (DCSA)

You must enroll each year to have coverage.

Health Savings Account (HSA)

You must enroll in the High Deductible Health Plan (HDHP) option under the medical plan to be potentially eligible to establish an HSA. If you satisfy all the requirements to be eligible to establish an HSA, you must accept the Terms and Conditions of the program and satisfy Citi's policies and procedures required to establish an HSA to complete your enrollment. If you do not elect an annual contribution amount, you will only receive Citi's contribution, no additional contributions will be made to your HSA.

Basic Life and Basic Accidental Death & Dismemberment (AD&D) Coverage

If your benefits eligible pay, for benefits purposes, increases to $200,000 or above in connection with benefits coverage that will be effective on January 1 of any subsequent plan year, you'll be ineligible for company-paid Basic Life/Basic AD&D coverage. However, if you have not previously elected the maximum coverage under GUL insurance, during annual enrollment you'll have the opportunity to enroll in GUL insurance equal to one times your benefits eligible pay, not to exceed $500,000, without providing evidence of insurability.

If you become ineligible for Basic Life and Basic AD&D coverage due to an increase in your benefits eligible pay, you may convert your Basic Life and AD&D coverage to an individual insurance policy without providing evidence of insurability within 31 days of receipt of the loss of coverage notice.

Long-Term Disability (LTD) coverage

If, as a newly hired employee, your benefits eligible pay exceeds $50,000.99, you may be automatically enrolled in LTD coverage with an option to decline coverage, described below. If your benefits eligible pay, for benefits purposes, increases above $50,000.99 in any plan year, you may be automatically enrolled in LTD coverage for the following year during annual enrollment with payroll deductions beginning January 1. (Evidence of insurability will *not* be required at this time.)

If you do not want LTD coverage, you may choose "no coverage" when you make your elections during annual enrollment (or enroll as a new hire). However, if you do not make an election, you will be automatically enrolled in LTD coverage. You may elect to retroactively decline coverage for up to 90 days after January 1 (or 90 days after enrollment as a new hire), and receive a refund of premiums paid. You may elect to decline coverage after the initial 90-day period passes; however, you will not receive a premium refund for the coverage beyond the initial 90-day period.

Company-paid LTD coverage is available only to eligible employees whose benefits eligible pay is less than or equal to $50,000.99.

After you enroll or default

Confirmation of enrollment

- **If you enroll by telephone by speaking with a representative:** A confirmation statement will be mailed to your permanent address on file after your enrollment period ends. It will list your benefits elections and their costs. Review this confirmation statement carefully for accuracy, and retain it as proof of your enrollment. If you find an error, immediately call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. For TDD and international assistance, please see the "For More Information" section.
- **If you enroll online:** A confirmation statement will appear after you enroll and before you log out. Print and retain a copy as proof of your enrollment. A confirmation statement will be mailed to your permanent address on file after your enrollment period ends. If you find an error, immediately call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. For TDD and international assistance, please see the "For More Information" section.

Confirmation of default

If you do not enroll, you will have the "default" coverage shown on the Your Benefits Resources™ website, available through TotalComp@Citi at **http://www.totalcomponline.com**. If you are a new hire, default coverage will also be shown on your Personal Enrollment Worksheet, which would reflect the core benefits that are provided at no cost to you.

A confirmation statement will be mailed to your home after your enrollment period ends. The confirmation statement will list your default coverage.

Naming a beneficiary

Your beneficiary information should be on file with Citi. If you have not designated a beneficiary, visit the Your Benefits Resources™ website through TotalComp@Citi at **http://www.totalcomponline.com**, available from the Citi intranet and the Internet.

If you do not have intranet or Internet access, call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "pension, retiree health and welfare, and survivor support" option. For TDD and international assistance, please see the "For More Information" section. Speak with a Citi Benefits Center representative to name a beneficiary for Basic Life and Basic AD&D insurance, Business Travel Accident/Medical (BTA) insurance, Citigroup 401(k) Plan, and/or Citigroup Pension Plan.

If you enroll in GUL or Supplemental AD&D insurance, you must complete a MetLife Beneficiary Designation form available on Citi Benefits Online 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 **http://www.totalcomponline.com**, available from the Citi intranet and the Internet.

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

Your contributions

Your contributions for medical, dental, and vision coverage are based on the plan and the coverage category you elect. Your medical contribution also depends on the benefits eligible pay band that applies to you. The employee contributions for the medical plan increase as benefits eligible pay increases. The benefits eligible pay bands for 2015 are shown below.

Benefits eligible pay bands on which employee contributions for medical coverage are based:

- $30,000 or less
- $30,001 – $50,000
- $50,001 – $100,000
- $100,001 – $200,000
- $200,001 +

For purposes of calculating your medical contributions and coverage amounts, benefits eligible pay is determined each year and will apply for the entire calendar year.

Before-tax contributions

Contributions for medical (including the Health Savings Account [HSA]), dental, vision care, and spending accounts are made with before-tax dollars as long as you are receiving a paycheck. This means your contributions are deducted from your pay before federal income and employment taxes are deducted. Before-tax contributions reduce your gross salary, which lowers your taxable income and, therefore, the amount of income tax you must pay. However, these before-tax contributions may be subject to state or local income taxes in certain jurisdictions.

Citi reports the total value of the health coverage we provide on your Form W-2. This is only a reporting requirement and *does not change how your benefits are taxed*.

Social Security taxes

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

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 and Dismemberment (AD&D) insurance benefits;
- Group Universal Life (GUL) insurance and costs;
- Supplemental AD&D insurance and costs;
- Eligibility for the Dependent Day Care Spending Account (DCSA) subsidy;
- Short-Term Disability (STD) benefits for Financial Advisors in the Institutional Clients Group; and
- Business Travel Accident/Medical (BTA) insurance benefits.

Definition of benefits eligible pay

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

Your benefits eligible pay at the time you are hired (if after June 30, 2014) is equal to your annual base salary. If you are to be paid commissions only, your benefits eligible pay is calculated differently and is based either on a default amount or an amount established as appropriate for your position. Ask your HR representative for details.

For future years, your benefits eligible pay will be based on a formula that includes your actual base pay plus commissions, performance-based bonuses, and annual incentive bonus. Your benefits eligible pay for subsequent years will be determined under the Plan rules for annual enrollment as noted below. **Note:** Your benefits eligible pay does not necessarily equal the amount reported as salaries and wages on your Form W-2 Wage and Tax Statement.

For new hires in the Institutional Clients Group

Any guaranteed bonus will be considered in the calculation of your benefits eligible pay for benefits purposes.

For Financial Advisors

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

If you decide to provide a copy of the form, your Basic Life and Basic AD&D insurance amount, if applicable, will be set at the higher amount 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 coverage, and LTD coverage and contributions will also be based on the higher amount.

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

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.

If you are enrolling during the annual enrollment period

If you are enrolling during the annual enrollment period for coverage effective January 1, 2015, your benefits eligible pay for purposes of benefits enrollment is made up of the following:

1. Annual base pay as of June 30, 2014;
2. Commissions paid from January 1 - December 31 in the year prior to enrollment to capture an entire year of commissions paid; commissions paid from January 1 - December 31, 2013, will be used for the 2015 annual enrollment calculation;
3. 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;
4. 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;
5. Guaranteed bonus effective in current year 2014; and
6. Short-Term Disability benefits paid from January 1 - December 31, 2013, for employees paid commissions only.

Domestic partner/civil union partner benefits

Citi offers benefit coverage to your certified or registered unmarried domestic partner of the same or opposite gender. (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-gender spouse.

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

- Medical;
- Dental;
- Vision;

- Health Care Spending Account (HCSA), provided your domestic partner/civil union partner and his or her eligible children are considered tax dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; (**Note:** Civil union partners/domestic partners who are not considered tax dependents under Section 152 cannot have their claims reimbursed under the Health Care Spending Account);
- Limited Purpose Health Care Spending Account (LPSA), provided your domestic partner/civil union partner and his or her eligible children are considered tax dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof;
- Dependent Day Care Spending Account (DCSA), provided your domestic partner/civil union partner and his or her eligible children are considered tax dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof; and
- Group Universal Life (GUL) and Supplemental Accidental Death & Dismemberment (AD&D) insurance for domestic partners/civil union partners and life insurance for children.

You may enroll your domestic partner/civil union partner and his or her eligible children in the medical and/or dental plan in which you enroll. You may enroll your domestic partner/civil union partner in spouse GUL and Supplemental AD&D insurance, and/or the vision plan even if you do not enroll in those Plans.

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

When you can enroll your domestic partner

You can enroll your domestic partner and his or her eligible children in Citi medical, dental, vision, and spending account 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 during the plan year are:

- Submitting your registration or certifying your domestic partnership by submitting the Domestic Partner Coverage Forms;
- The birth or adoption of a child; and
- Your domestic partner's loss of benefits coverage in another employer's plan.

You must speak with a Citi Benefits Center representative to request the Domestic Partner Coverage Forms. Call 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.

For information on domestic partner eligibility, see "For Domestic Partners" under "Eligibility."

Cost of civil union partner/domestic partner benefits

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

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

Tax implications

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

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

Employees who have a same-gender domestic partner or a civil union partner enrolled in these benefits will be issued a payment at the end of the year to help cover the extra tax-related costs they incur under the Code. This payment will be an approximation for taxes owed.

Note: Employees must be working at Citi, and have a covered same-gender domestic partner/civil union partner at the time of this payment.

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

If your civil union partner/domestic partner and his or her children qualify as dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2), and d(1)(B) thereof, your contributions for their medical, dental, and/or vision coverage will be deducted from your pay before taxes are withheld, and there are no tax implications for you. Since the requirements are complex, consult your tax adviser for information on how civil union partnership/domestic partnership benefits will affect your taxes and those of your civil union partner/domestic partner.

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

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

You may, but are not required, to certify whether your civil union partner/domestic partner and his or her dependent children qualify as dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2), and d(1)(B) thereof. If no certification is on file with Citi, the benefits are considered taxable.

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

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

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

Example: Total Citi cost for Employee Only coverage is $450 per month. Total Citi cost for Employee Plus Spouse/Partner coverage is $900.

The $450 cost for Employee Plus Spouse/Partner coverage (known as imputed income) will be treated as taxable income to you.

You will see a line item on your pay statement that shows $450 in imputed income. The taxable amount of that benefit (as determined by Citi's payroll department) will be deducted from your pay. In this example, $100 in taxes may be deducted from your pay for the $450 in imputed income.

If you terminate domestic partner coverage

To terminate domestic partner coverage, you must complete a form attesting that your domestic partnership has ended, or submit a document showing the termination of your domestic partner registration, as applicable. To request the form, call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. For TDD and international assistance, please see the "For More Information" section. Taxes paid on the imputed income are not refundable.

Your domestic partner and his or her children will be eligible to continue medical, dental, vision, and/or HCSA coverage, if applicable, at his or her expense for a period of 36 months.

This coverage will be similar to Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) coverage offered to spouses, domestic partners, civil union partners, and other covered dependents. See "COBRA" beginning on page 41 for more information.

If you and your domestic partner marry

Report your qualified change in status to the Citi Benefits Center as soon as possible after your marriage and request that the assessment of imputed income be stopped. You will be required to provide proof of the marriage in order to stop the assessment of imputed income permanently. Otherwise, imputed income will continue to be calculated. Call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. For TDD and international assistance, please see the "For More Information" section.

Note: Changing your marital status and/or number of withholding allowances for payroll purposes will not stop imputed income from being calculated and taxes being withheld. You must call the Citi Benefits Center, as instructed above, to report your marriage.

Changing your coverage

Qualified changes in status

The rules regarding qualified changes in status apply to coverage elections you make for medical, dental, vision, Health Care Spending Account (HCSA), Limited Purpose Health Care Spending Account (LPSA), Dependent Day Care Spending Account (DCSA), Long-Term Disability (LTD), and Group Universal Life (GUL) insurance. In general, the benefit plans and coverage levels you choose during annual enrollment remain in effect for the remainder of 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 event" on page 30.

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 carrier. Your medical plan carrier 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, vision, HCSA, LPSA, or DCSA coverage;
- Increase or decrease the amount of your HCSA, LPSA, or DCSA coverage;

- Enroll in LTD without having to provide evidence of good health; 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, respectively, is available if you marry, establish an eligible domestic partnership/civil union 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;
5. The loss of coverage under your spouse's (same- or opposite-gender)/civil union partner's/domestic partner's or other employer's plan;
6. The death of a spouse (same- or opposite-gender)/civil union partner/domestic partner or dependent child;
7. The issuance of a Qualified Medical Child Support Order (QMCSO);
8. Relocation outside your medical and/or Cigna Dental HMO's network area;
9. The start of a military leave of absence;
10. The loss of group Basic Life insurance;
    - If your 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 CHIP coverage; and
12. The start of eligibility for state premium assistance.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, Citi will permit you and your dependents to enroll in the Plan, as long as you and your dependents are eligible but not already enrolled in the Plan. This is called a "special enrollment"

opportunity, and you must 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;
- **Domestic/civil union partnership status**: You enter into or terminate a domestic/civil union 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;
- **Residence**: A change in the place of residence for you, your spouse, or another dependent if outside your medical or Cigna Dental HMO'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, vision, and spending account 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-gender)/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. Additionally, you may increase or start contributions to an HCSA or an LPSA if you add a dependent. The Plan Administrator will determine whether a requested change is due to a qualified status change and is consistent with the qualified status change.

Coverage 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. However, in no event will any cost or coverage event allow you to make a change to your HCSA or your LPSA election.

Coverage events

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

For example, if there is an overall reduction under a plan option that reduces coverage to participants in general, participants enrolled in that plan option may elect coverage under another option providing similar coverage (if the other plan option permits). Additionally, if Citi adds an HMO or other plan option midyear, participants can drop their 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 in accordance with IRS regulations, 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 annual enrollment period or when you have a qualified status change, 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-gender)/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 coverage only for the person who becomes entitled to Medicare or Medicaid, and you are limited to adding medical coverage only for the person who loses eligibility for Medicare or Medicaid.

Family and Medical Leave Act (FMLA): You may drop medical (including the HCSA and the LPSA), 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 note regarding civil union partner/domestic partner coverage: The events qualifying you to make a midyear election change described in this section also apply to events related to a civil union partner/domestic partner. However, IRS rules generally do not permit you to make a midyear change "on a before-tax basis" for such events unless they involve a tax dependent. Thus, if you make a midyear change due to an event involving your civil union partner/domestic partner, generally that

change must be made on an after-tax basis, unless your civil union partner/domestic partner can be claimed as your dependent for federal income tax purposes. See *IRS Publication 17, Your Federal Income Tax,* for a discussion of the definition of a tax dependent. The publication is available at **www.irs.gov/formspubs/index.html.**

Special enrollment rights: If you or your dependents become eligible for premium assistance or lose eligibility for Medicaid or a state's 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 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, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, Citi will permit you and your dependents to enroll in the Plan, as long as you and your dependents are eligible but not already enrolled in the Plan.

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.

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.

To report a 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. For TDD and international assistance, please see the "For More Information" section.
- Visit Your Benefits Resources™, available through TotalComp@Citi at **http://www.totalcomponline.com**.
- To enroll in GUL insurance or Supplemental AD&D insurance, call MetLife at **1-888-830-7380** or access the MetLife MyBenefits website available through TotalComp@Citi at **http://www.totalcomponline.com**.

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 change 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. (**Note:** This eligibility provision does not apply to all insured plans; therefore, you should contact your plan for details.) However, if you have coverage under any of the Plan options, you must report this qualified status change 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.

Coverage changes you can make at any time

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

Long-Term Disability (LTD)

You may enroll in LTD coverage at any time. However, you must provide evidence of insurability except when you enroll as a result of certain qualified changes in status.

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 insurability except when you enroll as a result of certain qualified changes in status.

The Disability Plan will not cover any total disability caused by, contributed to, or resulting from a pre-existing condition until you have been enrolled in the Disability 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) insurance

You may enroll in GUL coverage at any time. GUL coverage is administered by MetLife. MetLife does not require evidence of insurability 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;
- For one times your benefits eligible pay, not to exceed $500,000, as a result of losing Basic Life coverage because your benefits eligible pay has increased to $200,000 or above and certain other qualified changes in status.

However, MetLife will require evidence of insurability 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.

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

Supplemental Accidental Death and Dismemberment (AD&D) insurance

You may enroll for Supplemental AD&D coverage 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)

Effective January 1, 2012, no new participants were permitted to enroll into the LTC plan. Participants who enrolled on or before December 31, 2011 may continue to be participants under the LTC Plan. See the ‘Long-Term Care insurance’ subsection of the ‘Insurance’ section for more information.

Health Savings Account (HSA)

You must be enrolled in the High Deductible Health Plan (HDHP) option under the medical plan to be eligible to establish an HSA. You can stop or change your HSA contributions (within the contribution limits) at any time.

Transportation Reimbursement Incentive Program

You can enroll to purchase a transit and/or parking pass online at any time. Enrollments/changes are effective as soon as administratively possible.

When coverage begins

This table describes when coverage begins for your medical, dental, vision, and spending account coverage.

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

When coverage ends

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

- The date the Plans are terminated;
- The last day for which the necessary contributions are made;
- 11:59 P.M. of the day in which your employment ends (last day of notice period), 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 is terminated, or you otherwise cease to be eligible for coverage;
- The day you die;
- To the extent applicable, the date benefits paid on your behalf equal the lifetime maximum benefit under the Plans for such category of benefits, if applicable; or
- Upon a finding of fraud or intentional misrepresentation related to a claim for eligibility or benefits under the Citigroup Health Benefit Plan; in such an event, coverage may be terminated retroactively.

Basic Life and Basic Accidental Death & Dismemberment (AD&D) insurance coverage, Short-Term Disability (STD), Long-Term Disability (LTD), and coverage under the Dependent Day Care Spending Account (DCSA), Health Care Spending Account, (HCSA), Limited Purpose Health Care Spending Account (LPSA), and Transportation Reimbursement Incentive Program (TRIP) end on the date your employment is terminated.

You can continue Group Universal Life (GUL) and Supplemental AD&D coverage by paying MetLife directly. However, your coverage on a group basis will end on the last day of the month your employment is terminated; as such, your premiums will be higher.

Long-Term Care (LTC) coverage ends on the last day of the month in which you fail to make a required premium payment when due, or the date you exhaust your benefits under your certificate, or the date that the group policy is terminated if your coverage is replaced within 31 days by other group coverage providing substantially equivalent benefits.

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

- 11:59 P.M. of the day in which your employment is terminated 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; an exception is your death, in which case coverage will continue for six months if covered survivors elect COBRA;
- The date you elect to end your eligible dependent's coverage as a result of a qualified change in status;
- The date you become legally separated, divorced, submit a domestic partnership termination form, or submit other legal documents showing your termination of the relationship to your spouse (same- or opposite-gender)/civil union partner/domestic partner;
- The last day for which the necessary contributions are made;
- The date your eligible dependent ceases to be eligible for coverage; coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age (although coverage under some HMOs may end at the end of the month in which the child reaches the maximum age);
- The date the eligible dependent is covered as an employee under the Citigroup Health and Welfare Plans;
- The date the eligible dependent is covered as the dependent of another employee under the Citigroup Health and Welfare Plans;
- The date the eligible dependent enters the armed forces of any country or international organization;
- The date the dependent is no longer eligible for coverage under a Qualified Medical Child Support Order (QMCSO);
- The date defined in the dependent verification package if proof of eligibility is not received by the deadline; or
- Upon a finding of fraud or intentional misrepresentation related to a claim for eligibility or benefits under the Citigroup Health Benefit Plan; in such an event, coverage may be terminated retroactively.

You and your eligible covered dependents may be able to continue coverage under COBRA. See "COBRA" beginning on page 41.

Coverage when you retire

You could be eligible for retiree health care coverage if:

- Your age plus completed years of service with Citi totals at least 60; and
- You have attained age 50 and have at least five years of Citi service.

Please note: If you are eligible for access only retiree health coverage (the retiree pays all the premiums) and you have attained age 65, you are no longer eligible to enroll in the Citi retiree health coverage. You will be assisted by OneExchange (formerly Extend Health), a Towers Watson Company to enroll in Medicare exchange health care coverage. For information on OneExchange, health plan and premium options call One Exchange at **1-888-427-8835**.

For more information about eligibility for retiree health plan coverage and the cost of coverage, call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "pension and retiree health and welfare benefits" option. For TDD and international assistance, please see the "For More Information" section.

A note for employees who were involuntarily terminated

If (a) you are eligible for coverage under the U.S. 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 plan, as currently available, at any of the following times:

1. The date you would have met the age and service requirements for retiree health plan 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 Citi's retiree health plan coverage.*

Alternatively, if (a) you are eligible for coverage under the U.S. 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 plans, as currently available, at the time you meet the age and service requirements for Citi's retiree health plans, 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 U.S. 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 plans; the 12-month rule described above is not available.

The Citi retiree health plan, as currently available, permits an eligible retiring employee to enroll in the retiree health plans. However, eligible retiring employees who have attained age 65 and are only eligible to enroll in "access only" coverage under the retiree health plans may not enroll in the retiree health plans. If a retired employee who is eligible for retiree health coverage has attained age 65 and is eligible for access only coverage (the retiree pays all premiums), he/she is assisted by OneExchange to enroll in Medicare health coverage.

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

Coverage if you become disabled

You and your eligible dependents may continue medical, dental, and vision coverage for up to 13 weeks as long as you make the active employee contributions. You may also continue to participate in the HCSA or LPSA for 13 weeks or if a COBRA election is made, until the end of the calendar year in which your employment ends. 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 LTD benefit.

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

<table>
<tr><th>Plan</th><th>Coverage provisions</th></tr>
<tr><td>Medical</td><td>
Coverage will continue for 52 weeks, including the 13-week period of 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.
<table>
<tr><th>Years of Citi service (as of the LTD effective date)</th><th>Medical continuation period after week 52 (the termination of your employment)</th></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>
</table>
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.

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 (including LTD benefits); 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, unless you decline Medicare Part B coverage. There is typically a fee associated with Medicare Part B coverage. 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>
</table>

Plan	Coverage provisions
Dental	Coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. Then you may continue coverage under COBRA.
Vision	Coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. Then you may continue coverage under COBRA.
Basic Life 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 coverage. 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**.
Health Savings Account (HSA)	If you establish an HSA in connection with your High Deductible Health Plan (HDHP) coverage, participation will continue for the 13-week period of STD as long as you pay the active employee contributions. Then you may choose to make additional contributions, on an after-tax basis, directly to your HSA by contacting ConnectYourCare. Such contributions up to the permissible limit are tax deductible. Any remaining balance is yours to take with you when you leave Citi. Note: you are no longer eligible to make contributions to an HSA once you enroll in Medicare. You must remain in the HDHP to continue to be eligible to make HSA contributions.
Health Care Spending Account (HCSA)	Participation will continue for the 13-week period of STD as long as you pay the active employee contributions. Then you may continue coverage on an after-tax basis under COBRA for the remainder of the calendar year in which your employment terminates. You will have until June 30 of the following calendar year to submit and resolve your claims.
Limited Purpose Health Care Spending Account (LPSA)	Participation will continue for the 13-week period of STD as long as you pay the active employee contributions. Then you may continue coverage on an after-tax basis under COBRA for the remainder of the calendar year in which your employment was terminated. You will have until June 30 of the following calendar year to submit and resolve your claims.
Dependent Day Care Spending Account (DCSA)	Participation ends on your first day of STD. When you return to work from your approved disability, if you want coverage through the end of the year, you must re-enroll within 31 days of your return. Once re-enrolled, you can incur expenses through the end of the calendar year and will have until June 30 of the following calendar year to submit claims. You cannot be reimbursed for claims incurred while you were on a leave. With the exception of a military leave of absence, you cannot continue DCSA during a leave of absence.
Transportation Reimbursement Incentive Program (TRIP)	Coverage ends on your first day of STD. Your payroll deductions will stop. When you return to work from your approved disability, you can re-enroll, and the TRIP rules apply.

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

When an active employee dies, the surviving spouse (same- or opposite-gender)/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 plan coverage at the time of death

The Citi Benefits Center will send your surviving spouse (same- or opposite-gender)/civil union partner/domestic partner and/or dependent children a COBRA notification package. For your surviving spouse (same- or opposite-gender)/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" beginning on page 41.

If the employee was eligible for retiree health plan 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 plan coverage, as currently available. Retiree health plan 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 plan coverage, as currently available, but not COBRA coverage.

Continuing coverage

During a Family and Medical Leave Act (FMLA) leave

FMLA entitles an eligible employee to take a job-protected leave for specified family and medical reasons such as for your own serious health condition, to care for a spouse (same- or opposite-gender)/civil union partner/domestic partner, child, or parent who has a serious health condition, or the birth, adoption or foster care placement of your child.

Consult the Citi Employee Handbook for details of the FMLA policy, including eligibility, duration, and compensation related to your leave.

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

If you take an unpaid leave of absence that qualifies under the FMLA, you may continue medical, dental, and vision coverage for yourself and your spouse (same- or opposite-gender)/civil union partner/domestic partner and/or dependent children and continue participating in the Health Care Spending Account (HCSA) or Limited Purpose Health Care Spending Account (LPSA) as long as you continue to contribute your share of the cost of coverage during the leave. Your monthly contributions during a leave are made on an after-tax basis. You will be billed directly for them and failure to pay the billed amount will result in a loss of coverage.

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

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

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

If your HCSA or LPSA participation is terminated during a paid leave and you return to work during the same year in which your leave began, your contributions will resume. You can choose to resume contributions at the same level in effect before your paid FMLA leave or elect to increase your contribution level to make up for the contributions you did not make during your leave. If your HCSA or LPSA participation is terminated during an unpaid leave, your contributions will not resume when you return to work. However, you may elect to begin contributing to the HCSA or LPSA, providing you are eligible, when you return to work following an unpaid leave. You must re-enroll within 31 days of your return.

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

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

Coverage if you take an unpaid leave of absence

If you go on an approved leave of absence, you may continue coverage under the medical, dental, vision, and HCSA or LPSA. Your reduction in hours (less than 20 hours per week) constitutes a COBRA-qualifying event under the plans. See “COBRA” on page 41 regarding continuation of coverage.

Call the Citi Benefits Center through ConnectOne about your rights to continue medical, dental, vision, and HCSA or LPSA coverage. You will be billed directly for them and failure to pay the billed amount will result in a loss of coverage. Call 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.

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, vision, DCSA, and HCSA or LPSA coverage at active employee rates for the length of your leave. Employee contributions will be deducted automatically from your pay.

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

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:

- Transportation Reimbursement Incentive Program (TRIP) participation, which stops automatically when your leave begins and
- Short-Term Disability (STD), Long-Term Disability (LTD), and Business Travel Accident/Medical (BTA) insurance, which are suspended automatically when your leave begins.

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

Under the Heroes Earnings Assistance Relief Tax Act of 2008, if you are a reservist called to active military duty for more than 179 days, you are entitled to receive a taxable distribution of your HCSA or LPSA balance (contributions less the amount reimbursed) if you request a distribution by the last day of the calendar year in which you made such contributions.

Call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “health and welfare benefits” option. For TDD and international assistance, please see the “For More Information” section. You can also contact your HR representative for more information about a military leave of absence.

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 Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan, and the HCSA or LPSA under the Citigroup Spending Account 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 Plans 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 Plans. 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. For TDD and international assistance, please see the “For More Information” section.

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-gender) 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, the Citigroup Vision Benefit Plan and the health care spending accounts (HCSA/LPSA) under the Citigroup Spending Account Plan (collectively the "Health Plans"). Federal law does not require it, but Citi provides COBRA coverage to civil union partners and domestic partners of employees as well.

Eligibility to elect COBRA coverage is contingent upon the Health Plan in which you were enrolled as an active employee prior to the qualifying event.

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

If you terminate employment following a leave of absence qualifying under 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-gender)/civil union partner/domestic partner of an employee and are covered by the Citigroup Health Benefit Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan (or your claims can be reimbursed through your spouse's (same- or opposite-gender)/civil union partner's/domestic partner's HCSA or LPSA) and you lose coverage under a Citi-sponsored group health plan for any of the following four reasons on the day before the qualifying event, you are a qualified beneficiary and have the right to elect continuation coverage for yourself:

1. The death of your spouse (same- or opposite-gender)/civil union partner/domestic partner;
2. The termination of your spouse's (same- or opposite-gender)/civil union partner's/domestic partner's employment (for reasons other than your spouse's (same- or opposite-gender)/civil union partner's/domestic partner's gross misconduct) or a reduction in your spouse's (same- or opposite-gender)/civil union partner's/domestic partner's hours of employment;

3. Divorce or legal separation from your spouse (same- or opposite-gender) or the termination of your civil union partnership/domestic partnership; or
4. Your spouse's (same- or opposite-gender)/civil union partner's/domestic partner's entitlement to Medicare.

If you are a covered dependent child of an employee who is covered by the Citigroup Health Benefit Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan or HCSA or LPSA on the day before the qualifying event and you lose coverage under a Citi-sponsored group health plan for any of the following five reasons, you 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 or HCSA or LPSA.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption, or placement for adoption) during that period of continuation coverage the new child 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 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/civil union partner/domestic partner or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. A spouse/civil union partner/domestic partner 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. For TDD and international assistance, please see the "For More Information" section.

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 up to 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-gender)/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 after an initial qualifying event, such as loss of employment. 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.

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-gender)/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. For TDD and international assistance, please see the “For More Information” section.

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

Special rule for HCSA and LPSA

Generally, unless required by law, continuation coverage for HCSA and LPSA will not be available beyond the end of the year in which the qualifying event occurs. For more information, please see the “Spending Accounts” section.

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 the Citi Benefits Center 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 the Citi Benefits Center 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 Health Plan coverage due to your termination of employment or reduction in hours, your eligible dependents' COBRA coverage will not end before 36 months from the date you became entitled to Medicare. However, your eligible dependents' COBRA coverage will not extend beyond 36 months.

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 SSA makes a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996, as amended (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-gender)/civil union partner/domestic partner and/or dependent child is covered by the applicable Health Plans 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 applicable Health Plans;
- 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, you and your family members may be required to reimburse the applicable Health 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 COBRA 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 applicable Health Plan(s) 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 Health Plan(s), you may notify the COBRA administrator in writing immediately at the address below.

All notices and other communications regarding COBRA and Citi-sponsored Health Plans should 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. For TDD and international assistance, please see the "For More Information" section.

Coordination of benefits

All payments under these plans will be coordinated with benefits payable under any other group benefit plans that provide coverage for you or your dependent(s). Coordination of benefits prevents duplication of payments when a covered employee or a covered dependent has health coverage under a Citi Plan and one or more other plans, such as a spouse's or other employer's plan.

The Citigroup Health Benefit Plan (which includes prescription drug coverage), the Citigroup Dental Benefit Plan, and the Citigroup Vision Benefit Plan ("Citi 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 other sections of this Benefits Handbook.

The following definitions apply to terms used in this section:

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

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

How coordination of benefits works

- **When the Citi Plan is primary:** The Citi Plan considers benefits as if a secondary plan does not exist, and it will pay benefits first. Benefits will be calculated according to the terms of the applicable plan and will not be reduced due to benefits payable under other plans.
- **When the Citi Plan is secondary:** The Citi Plan will pay the difference, if any, between what you would have received from Citi if it were the only coverage and what you are eligible to receive from the other plan. Total benefits will never equal more than what the Citi Plan would have paid alone. Benefits under the Citi Plan may be reduced. The Claim Administrator will determine the amount the Citi Plan normally would pay. Then the amount payable under the primary plan for the same expenses will be subtracted from the amount the Citi Plan would have normally paid. The Citi Plan will pay you the difference. If the Citi Plan is secondary, you will never be paid more for the same expenses under both the Citi Plan and the primary plan than the Citi Plan would have paid alone.

  When the Citi Plan is secondary and the patient is covered under an HMO, benefits under the Citi Plan will be limited to the coinsurance, if any, for which you would have been responsible under the HMO, whether or not the services provided are rendered by the HMO. If a service is not covered or coverage is denied, you will be responsible for payment.

Aetna, Anthem BlueCross BlueShield, and Oxford: with regard to automobile accidents, this plan **always** pays secondary to:

- Any motor vehicle policy available to you including any medical payments, Personal Injury Protection (PIP), and No Fault; and
- Any plan or program which is required by law.

All covered persons should review their automobile insurance policy and ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

The Citi Plan will be the primary plan for claims:

- For you, if you are not covered as an employee by another plan;
- For your spouse, if your spouse is not covered as an employee by another plan; and
- For your dependent children, if they are not covered by another plan through their employment or through military service.

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

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

In case of divorce or legal separation

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

1. The plan of the parent with custody of the child;

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

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

Coordination with Medicare

When you or your eligible dependents are entitled to Medicare and you are covered under the Citi Plan as an active employee, the Citi Plan continues to be the primary plan. The Citi Plan is primary for the following situations:

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

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

If you or your dependent are eligible for Medicare, and you are no longer an active employee, enrollment in Medicare cannot be deferred based on enrollment in COBRA. Delaying enrollment in Medicare beyond initial eligibility may result in the assessment of penalties or late fees.

No-fault automobile insurance

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

Facility of payment

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

Right of recovery

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

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

Aetna, Anthem BlueCross and BlueShield and Oxford: with regard to automobile accidents, this Plan **always** pays secondary to:

> Any motor vehicle policy available to you including any medical payments, PIP, and No Fault; and

> Any plan or program which is required by law.

All Covered persons should review their automobile insurance policy and ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer. For more information, please see "Recovery Provisions" in the Administrative Information section.

Release of information

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

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

How to file a claim

Claims must be submitted in order to receive reimbursement for charges incurred under the Plans. Many times, the claim is submitted electronically to the claims administrator without your intervention needed. However, you may be required to manually submit a claim for expenses to be paid or approved for reimbursement. Listed below are the forms needed to claim benefits that may not be reimbursed automatically or paid directly. Claims should be sent to the Claims Administrators as detailed under "Claims Administrators" in the Administrative Information section. If you do not receive benefits to which you believe you are entitled, see the applicable "Claims and appeals" subsection in the section that describes each plan at **www.citibenefitsonline.com**, available from the Citi intranet and the Internet. No password is required.

Name of Plan	Name/form number and when to use the form	How to obtain a form
Aetna > ChoicePlan 500 (CP500) > High Deductible Health Plan (HDHP)	Aetna Medical Benefits Request form Use the form to file a claim for covered out-of-network expenses.	Visit the Claim Forms section of at Citi Benefits Online at **www.citibenefitsonline.com** Or Visit Your Benefits Resources™ through TotalComp@Citi at **www.totalcomponline.com**
Anthem BlueCross BlueShield > CP500 > HDHP	Anthem BlueCross BlueShield Claim form Use the form to file a claim for covered out-of-network expenses.	
Oxford Freedom Direct Plan	Oxford Health Plans Claim form Use the form to file a claim for covered out-of-network expenses.	
HMOs	Call your HMO for any claim-filing information. Use the contact information on the back of your ID card or visit "For more information" at **www.citibenefitsonline.com/.**	

Name of Plan	Name/form number and when to use the form	How to obtain a form
Express Scripts (Prescription drug coverage for CP500, HDHP, and Oxford PPO)	Express Scripts Prescription Drug Claim form Use the form to file a claim for covered out-of-network expenses.	Visit the Claim Forms section of at Citi Benefits Online at **www.citibenefitsonline.com** Or Visit Your Benefits Resources™ through TotalComp@Citi at **www.totalcomponline.com** Or Call Express Scripts at **1-800-227-8338** or visit **www.express-scripts.com**
MetLife Dental PDP	MetLife Dental Claim form Use the form to file a claim for covered dental expenses.	Visit the Claim Forms section of at Citi Benefits Online at **www.citibenefitsonline.com**
Cigna DHMO	There are no claim forms required with the Cigna Dental HMO plan. When your Dental Patient Charge Schedule lists a copay, pay that amount to the dentist directly after you receive care.	
Vision Plan	Aetna Vision Claim form Use the form to file a claim for covered out-of-network expenses.	Visit the Claim Forms section of at Citi Benefits Online at **www.citibenefitsonline.com** Or Visit **www.aetnavision.com**
Health Care Spending Account (HCSA)	HCSA/LPSA Claim form Use the form to submit eligible health care claims for reimbursement if you do not use the Your Spending Accounts™ Card	Visit the Claim Forms section of at Citi Benefits Online at **www.citibenefitsonline.com** Or Visit Your Benefits Resources™ through TotalComp@Citi at **www.totalcomponline.com**
Limited Purpose Health Care Spending Account (LPSA)	HCSA/LPSA Claim form Use the form to submit eligible vision, dental, and/or preventive care health care claims for reimbursement.	
Dependent Day Care Spending Account (DCSA)	DCSA Claim form Use the form to submit eligible dependent care claims for reimbursement.	
Transportation Reimbursement Incentive Program (TRIP)	TRIP Claim form **Note:** With the exception of the Parking Cash Reimbursement Option (CRO). CRO claims must be filed within 12 months from the date of service.	

All claims for benefits and pertinent supporting documents must be filed by these deadlines:

- Medical, dental, and vision claims must be filed within two years of the date of service. If you participate in an HMO, call your HMO for its claim-filing deadlines.
- Prescription drug claims must be filed within one year of the date of service.
- HCSA, LPSA, and DCSA claims must be filed and resolved by June 30 following the year in which the expense was incurred.
- TRIP Parking Cash Reimbursement Option (CRO) claims must be filed within 12 months from the date of service.

Health care benefits

Your Citi health care benefits are composed of:

- Medical coverage (including the Citigroup Prescription Drug Program);
- Dental coverage;

Vision coverage;

- Wellness benefits;
- Be Well Program; and
- Work/Life Program.

Medical

The Citigroup Health Benefits Plan offers several medical options to protect you and your eligible dependents against the high cost of treating major illness and injury.

The following information applies to all Citi medical options. Your Benefits Resources™ (YBR™), available through TotalComp@Citi, lists the medical options available to you based on your home zip code.

Depending on your location, you may choose from one of the following medical options or an HMO:

- ChoicePlan 500 (CP500) administrated by Aetna (Choice POS II Open Access) and Anthem BlueCross BlueShield (PPO Preferred Provider Organization plan);
- High Deductible Health Plan (HDHP) administrated by Aetna (Choice POS II Open Access) and Anthem BlueCross BlueShield (PPO Preferred Provider Organization plan); or
- Oxford Health Plans PPO (available in the Connecticut, New Jersey, and New York tri-state area only). Citi members have access to the UnitedHealthcare Choice Plus Network nationwide. (This is also known as the Direct Freedom Plan.)

HMOs:

1. Coventry Health Care of Iowa;
2. Geisinger Health Plan (Pennsylvania);
3. Health Plan Hawaii Plus (HMSA);
4. SelectHealth (Utah and part of Idaho);
5. Independent Health (upstate New York);
6. Kaiser FHP of California - Northern;
7. Kaiser FHP of California - Southern;
8. Kaiser FHP of Colorado;
9. Kaiser FHP of Georgia;
10. Kaiser FHP of Hawaii;
11. Kaiser FHP of the Mid-Atlantic States; and
12. Sanford Health Plan (South Dakota, and parts of North Dakota, Iowa, and Minnesota).

Contents

Administrators of the High Deductible Health Plan (HDHP), ChoicePlan 500 (CP500) and Preferred Provider Organization (PPO)

The HDHP and CP500 are administered by Aetna and Anthem BlueCross BlueShield throughout the United States. The plan designs for the HDHP and the CP500 are essentially the same no matter which vendor administers the plan. The PPO is administered by Oxford Health Plans (a United HealthCare company) and is offered in CT, NJ, and NY only. The HDHP, CP500, and Oxford Health Plans PPO are self-insured, meaning these plans are not subject to state laws and Citi pays the claims incurred.

Medical options at a glance

Although each of the Citi medical plans offers comprehensive coverage, there are differences between the plans. Some high-level information is available in the table below. For HMO information, visit "2015 insured HMOs" on page 120 or see the Health Plan Comparison Charts on Your Benefits Resources™ (YBR™). To access YBR™, visit TotalComp@Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet.

Note: Precertification is required for certain procedures and services both in-network and out-of-network. Penalties may apply. Call your plan at the number listed on the back of your ID card for details.

For in-network covered expenses, the plans pay a percentage of discounted rates while for out-of-network charges, the plans pay a percentage of the maximum allowed amount (MAA). See the Glossary for a definition of MAA, which is sometimes referred to as "Recognized Charges." For out-of-network services, providers may balance bill you for the charges above MAA, and you are responsible for those charges.

Remember: You can save on out-of-pocket costs by using providers who participate in the plan's network. If you use an out-of-network doctor, you'll pay more when you need care.

	ChoicePlan 500 Administered by Aetna and Anthem BlueCross BlueShield		Oxford Health Plans PPO (Available in CT, NJ, and NY only)	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Annual deductible				
Individual	$500[1]	$1,500[1]	$500	$1,500
Maximum per family	$1,000[1]	$3,000[1]	$1,000	$3,000
Annual medical out-of-pocket maximum (includes medical deductible, medical coinsurance, and medical copayments) **Note: There is a separate out-of-pocket maximum for prescription drug expenses.**				
Individual	$3,000[1]	$6,000[1]	$3,000	$6,000
Maximum per family	$6,000[1]	$12,000[1]	$6,000	$12,000

	ChoicePlan 500 Administered by Aetna and Anthem BlueCross BlueShield		Oxford Health Plans PPO (Available in CT, NJ, and NY only)	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Lifetime maximum	None	None	None	None
Professional care (in office)				
Doctor/primary care physician (PCP) visits	80% after deductible[2]	60% of MAA after deductible[2]	80% after deductible[2]	60% of MAA after deductible[2]
Specialist visits	80% after deductible; **Aetna:** 90% after deductible[2] for Aexcel specialists	60% of MAA after deductible[2]	80% after deductible[2]	60% of MAA after deductible[2]
Preventive care (subject to frequency limits)				
Well-adult visits	100%, not subject to deductible	100% of MAA, not subject to deductible up to $250 combined maximum[3], then covered at 60% of MAA, not subject to deductible	100%, not subject to deductible	100% of MAA, not subject to deductible up to $250 combined maximum[3], then covered at 60% of MAA, not subject to deductible
Well-child visits	100%, not subject to deductible	100% of MAA, not subject to deductible up to $250 combined maximum[3], then covered at 60% of MAA, not subject to deductible	100%, not subject to deductible	100% of MAA, not subject to deductible up to $250 combined maximum[3], then covered at 60% of MAA, not subject to deductible
Adult and child routine immunizations	100%, not subject to deductible	60% of MAA, not subject to deductible	100%, not subject to deductible	60% of MAA, not subject to deductible
Routine cancer screenings (PAP test, mammogram, sigmoidoscopy, colonoscopy, PSA screening)	100%, not subject to deductible	100% of MAA, not subject to deductible up to $250 combined maximum[3], then covered at 60% of MAA, not subject to deductible	100%, not subject to deductible	100% of MAA, not subject to deductible up to $250 combined maximum[3], then covered at 60% of MAA, not subject to deductible

	ChoicePlan 500 Administered by Aetna and Anthem BlueCross BlueShield		Oxford Health Plans PPO (Available in CT, NJ, and NY only)	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Contraceptive devices	100%, not subject to deductible, for diaphragms and Mirena, an implantable device. All other implantable devices will be covered at 80% after deductible[2]	60% of MAA after deductible[2]	100%, not subject to deductible, for diaphragms and Mirena, an implantable device. All other implantable devices will be covered at 80% after deductible[2]	60% of MAA after deductible[2]
Voluntary sterilization (tubal ligation, sterilization implants and surgical sterilizations)	100%, not subject to deductible. Male sterilization services (e.g., vasectomies) are covered at 80% after deductible[2]	60% of MAA after deductible[2]	100%, not subject to deductible. Male sterilization services (e.g., vasectomies) are covered at 80% after deductible[2]	60% of MAA after deductible[2]
Hospital emergency room (no coverage in any medical option if not a true emergency)				
	100% after $100 copayment (waived if admitted within 24 hours of emergency room use; precertification required for hospitalization; not subject to annual deductible)		100% after $100 copayment (waived if admitted within 24 hours of emergency room use; precertification required for hospitalization; not subject to annual deductible)	
Emergency Transportation Services (no coverage when used as routine transportation to receive inpatient or outpatient services)				
	100%, not subject to the deductible; for transport to and from the nearest medical facility qualified to give the required treatment **Anthem:** Precertification required for air transport		100%, not subject to the deductible; for transport to and from the nearest medical facility qualified to give the required treatment; pre-certification required for inter-facility transfers	
Urgent care center				
	80% after deductible[2]	80% of MAA after deductible[2]	80% after deductible[2]	80% of MAA after deductible[2]

	ChoicePlan 500 Administered by Aetna and Anthem BlueCross BlueShield		Oxford Health Plans PPO (Available in CT, NJ, and NY only)	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Hospital (inpatient and outpatient services)				
Semiprivate room and board, doctor's charges, lab, radiology, and X-ray	80% after deductible[2]; precertification required for hospitalization and certain outpatient procedures	60% of MAA after deductible[2]; precertification required for certain outpatient procedures	80% after deductible[2]; precertification required for hospitalization and certain outpatient procedures	60% of MAA after deductible[2]; precertification required for hospitalization and certain outpatient procedures
Anesthesia	80% after deductible[2]	60% of MAA after deductible[2]	80% after deductible[2]	60% of MAA after deductible[2]
Non-routine outpatient				
Lab, radiology, and X-ray	80% after deductible[2]; precertification required for certain outpatient procedures	60% of MAA after deductible[2]; precertification required for certain outpatient procedures	80% after deductible[2]; precertification required for certain outpatient procedures	60% of MAA after deductible[2] precertification required for certain outpatient procedures
Mental health and substance abuse				
Inpatient	80% after deductible[2]; precertification required	60% of MAA after deductible[2]; precertification required	80% after deductible[2]; precertification required	60% of MAA after deductible[2]; precertification required
Outpatient	80% after deductible[2]	60% of MAA after deductible[2]	80% after deductible[2]; precertification required for certain outpatient procedures	60% of MAA after deductible[2] precertification required for certain outpatient procedures

	ChoicePlan 500 Administered by Aetna and Anthem BlueCross BlueShield		Oxford Health Plans PPO (Available in CT, NJ, and NY only)	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Therapies				
Physical/occupational therapy (combined): Limited to 60 visits a year for in-network and out-of-network combined **Aetna and Anthem:** You may be eligible for additional visits at a lower benefit level with plan approval after a medical necessity review **Oxford:** Limited to 90 visits a year for physical/speech/occupational therapy in-network and out-of-network combined.	80% after deductible[2]; 70% after deductible[2] for approved visits over plan limits	60% of MAA after deductible[2]; 50% of MAA after deductible[2] for approved visits over plan limits	80% after deductible[2]; 60% after deductible[2] for approved visits over plan limits	60% of MAA after deductible [2], 50% of MAA after deductible[2] for approved visits over plan limits
Speech therapy: Limited to 90 visits a year for in-network and out-of-network combined **Aetna and Anthem:** You may be eligible for additional visits at a lower benefit level with plan approval after a medical necessity review **Oxford:** Limited to 90 visits a year for physical/speech/occupational therapy in-network and out-of-network combined.	80% after deductible[2]; 70% after deductible[2] for additional visits over plan limits	60% of MAA after deductible[2]; 50% of MAA after deductible[2] for additional visits over plan limits	80% after deductible[2]; 60% after deductible[2] for approved visits over plan limits	60% of MAA after deductible[2]; 50% of MAA after deductible[2] for approved visits over plan limits
Chiropractic therapy: Limited to 20 visits per calendar year for in-network and out-of-network combined	80% after deductible[2]	60% of MAA after deductible[2]	80% after deductible[2]; precertification required	60% of MAA after deductible[2]; precertification required
Acupuncture Must be administered by a medical doctor or a licensed acupuncturist	80% after deductible[2]	60% of MAA after deductible[2]	80% after deductible[2]	60% of MAA after deductible[2]
Applied behavioral analysis therapy	Not covered	Not covered	Not covered	Not covered

1 The annual deductible combines in-network and out-of-network expenses.

2 The plan will pay this percentage of the cost after you first pay the full deductible of the plan. The deductible can be paid with after-tax dollars, such as cash or check, or with before-tax dollars if you have available funds in a Health Care Spending Account (HCSA).

3 Combined maximum benefit applies to well-adult visits, well-child visits, routine cancer screenings, routine hearing, and routine vision. The maximum is measured on a calendar year basis.

	High Deductible Health Plan (HDHP) Administered by Aetna and Anthem BlueCross BlueShield	
	In-network	**Out-of-network**
Annual deductible (in-network and out-of-network combined)		
Individual	$1,800[1] Includes prescription drug expenses	$2,800[1] Includes prescription drug expenses
Maximum per family (no benefits will be paid to an individual until the family deductible has been met)	$3,600[1] Includes prescription drug expenses	$5,600[1] Includes prescription drug expenses
Annual out-of-pocket maximum (includes deductible, medical and prescription drug coinsurance and medical and prescription drug copayments; in-network and out-of-network combined)		
Individual	$5,000 Includes prescription drug expenses	$7,500 Includes prescription drug expenses
Maximum per family[2]	$10,000 Includes prescription drug expenses	$15,000 Includes prescription drug expenses
Lifetime maximum	None	None
Professional care (in office)		
Doctor/primary care physician (PCP) visits	80% after deductible[3]	60% of MAA after deductible[3]
Specialist visits	80% after deductible[3] **Aetna:** 90% after deductible for Aexcel specialists	60% of MAA after deductible[3]
Preventive care (subject to frequency limits)		
Well-adult visits	100%, not subject to deductible	100% of MAA, not subject to deductible
Well-child visits	100%, not subject to deductible	100% of MAA, not subject to deductible
Adult and child immunizations	100%, not subject to deductible	100% of MAA, not subject to deductible

	High Deductible Health Plan (HDHP) Administered by Aetna and Anthem BlueCross BlueShield	
	In-network	**Out-of-network**
Routine cancer screenings (PAP test, mammogram, sigmoidoscopy, colonoscopy, PSA screening)	100%, not subject to deductible	100% of MAA, not subject to deductible
Contraceptive devices	100%, not subject to deductible, for diaphragms and Mirena, an implantable device. All other implantable devices will be covered at 90% after deductible[3]	60% of MAA after deductible[3]
Voluntary sterilization (including tubal ligation, sterilization implants and surgical sterilizations)	100%, not subject to deductible. Male sterilization services (e.g., vasectomies) are covered at 90% after deductible[3]	60% of MAA after deductible[3]
Hospital emergency room (no coverage in any medical option if not a true emergency)		
	80% after deductible[3]; precertification required if admitted	80% after deductible[3]; precertification required if admitted
Emergency Transportation Services (no coverage when used as routine transportation to receive inpatient or outpatient services)		
	80% after deductible[3] **Anthem:** Pre-certification required for air transport	80% of MAA after deductible; pre-certification required for inter-facility transfers
Urgent care center		
	80% after deductible[3]	80% of MAA after deductible
Hospital (inpatient and outpatient services)		
Semiprivate room and board, doctor's charges, lab, radiology, and X-ray	80% after deductible[3]; precertification required for hospitalization and certain outpatient procedures	60% of MAA after deductible[3]; precertification required for hospitalization and certain outpatient procedures
Anesthesia	80% after deductible[3]	60% of MAA after deductible[3]

	High Deductible Health Plan (HDHP) Administered by Aetna and Anthem BlueCross BlueShield	
	In-network	**Out-of-network**
Non-routine outpatient		
Lab, radiology, and X-ray	80% after deductible[3]; precertification required for certain outpatient procedures	60% of MAA after deductible[3]; precertification required for certain outpatient procedures
Mental health and substance abuse		
Inpatient	80% after deductible[3], precertification required	60% of MAA after deductible[3]; precertification required
Outpatient	80% after deductible[3]	60% of MAA after deductible[3]
Therapies		
Physical/occupational therapy (combined): Limited to 60 visits a year in-network and out-of-network combined; you may be eligible for additional visits with plan approval after a medical necessity review	80% after deductible[3]; 70% after deductible[3] for approved visits over plan limits	60% of MAA after deductible[3]; 50% of MAA after deductible[3] for approved visits over plan limits
Speech therapy: Limited to 90 visits a year in-network and out-of-network combined; you may be eligible for additional visits with plan approval after a medical necessity review	80% after deductible[3]; 70% after deductible[3] for additional visits over plan limits	60% of MAA after deductible[3]; 50% of MAA after deductible[3] for additional visits over plan limits
Chiropractic therapy: Limited to 20 visits a year in-network and out-of-network combined	80% after deductible[3]	60% of MAA after deductible[3]
Acupuncture Must be administered by a medical doctor or a licensed acupuncturist	80% after deductible[3]	60% of MAA after deductible[3]
Applied behavioral analysis therapy	Not covered	Not covered

1 The annual deductible combines in-network and out-of-network expenses.

2 In the HDHP, the family out-of-pocket maximum can be satisfied as a family or by an individual within the family.

3 The plan will pay this percentage of the cost after you first pay the full deductible of the plan. The deductible can be paid with after-tax dollars, such as cash or check, or with before-tax dollars if you have available funds in a Health Savings Account (HSA).

Preventive care

Preventive care services are available in all plans. Both exams and immunizations are covered by network providers at 100% with no deductible to meet.

Preventive care services include but are not limited to:

- Routine physical exams and diagnostic tests, for example, CBC (complete blood count), cholesterol blood test, and urinalysis and immunizations;
- Well-child 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 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 implantable devices, sterilization procedures, and patient education and counseling for women with reproductive capacity. See the Prescription Drug section of the Plan/SPD for information about covered contraceptive drugs. Contact your plan for details;
- 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 (at least every three years);
- 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.

Contact your plan for details.

Patient Protection and Affordable Care Act (PPACA) Guidelines

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. (See the current guidelines at www.uspreventiveservicetaskforce.org.)

All of the Citi medical options follow these guidelines — or provide more generous benefits than what is required — however each of the plans may be administered differently. Contact your medical plan to confirm how these screenings are covered.

Screening recommendations include:

- ***Colorectal Cancer*** – covered for adults 50-75, using fecal occult blood testing, flexible sigmoidoscopy, or colonoscopy
- ***High Blood Pressure*** – covered every two years if below 120 systolic/80 diastolic, or every year if between 120-139 systolic/80-90 diastolic
- ***Lipid Disorders*** – covered for men 20-35, women 20-45 if at high risk, or men over 35, women over 45 if normal risk
- ***Type 2 Diabetes*** – covered for asymptomatic adults with blood pressure higher than $^{135}/_{80}$
- ***HIV*** – covered for adolescents and adults at increased risk and all pregnant women
- ***Syphilis*** – covered for adults at increased risk and all pregnant women
- ***Abdominal Aorta Aneurysm*** – covered one time for men 65-75 who have ever smoked
- ***Breast Cancer*** – covered every 1 to 2 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
- ***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 medical for all newborns
- ***Asymptomatic Bacteriuria*** – covered during 12-16 weeks gestation
- ***Hepatitis B*** – covered during first prenatal visit
- ***Iron Deficiency Anemia*** – covered for asymptomatic women during first prenatal visit
- ***Rh (D) Incompatibility*** – covered during prenatal visit
- ***Congenital Hypothyroidism*** – covered for newborns
- ***Phenylketonuria (PKU)*** – covered for newborns
- ***Sickle Cell Anemia (SSA)*** – covered for newborns
- ***Hearing Loss*** – covered for newborns
- ***Visual Impairment under age 5*** – covered to detect amblyopia, strabismus, and visual acuity defects
- ***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
- ***Alcohol misuse*** – covered for adults, including pregnant women, in primary care setting
- ***Obesity*** – covered for adults and children age 6 and older, including intensive counseling and behavioral interventions

Preventive care guidelines for plans administered by Aetna

This section on Preventive Care describes the covered expenses for services and supplies provided when you are well.

Routine physical exams

Covered expenses include charges made by your physician for routine physical exams, including routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (a panel of health care experts that evaluate the latest scientific evidence on clinical preventive services);
- For women, additional preventive care and screenings, not included in the above, as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- Radiological services, x-rays, lab and other tests given in connection with the exam;
- Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Testing for Tuberculosis;
- For covered newborns, an initial hospital check up;
- Well visits (including routine oral screenings), for covered persons in accordance with the evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Limitations:

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during your stay for medical care;
- Services not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams

Important Note:

For details on the frequency and age limits that apply to Routine Cancer Screenings, contact your physician, log onto the carrier's web site (Aetna: **www.aetna.com,** Anthem BlueCross BlueShield: **www.anthem.com** or Oxford: **www.oxhp.com**), or call the number on the back of your ID card.

Screening and counseling services

Covered expenses include charges made by your physician in an individual or group setting for the following:

Obesity

Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- Preventive counseling visits and/or risk factor reduction intervention;
- Medical nutrition therapy;
- Nutrition counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits, available from Aetna or Anthem BCBS. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Misuse of alcohol and/or drugs

Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Use of tobacco products

Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, cigars; smoking tobacco; snuff; smokeless tobacco and candy-like products that contain tobacco. Coverage includes the following to aid in the cessation of the use of tobacco products:

- Preventive counseling visits;
- Treatment visits; and
- Class visits.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during your inpatient stay for medical care;
- Services not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

Family planning services

Covered expenses include charges for certain contraceptive and family planning services, even though not provided to treat an illness or injury.

Contraception services

Covered expenses include charges for certain contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive devices, including diaphragms and implantable devices, prescribed by a physician provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Other family planning

- Covered expenses include charges for family planning services, including:
  - Voluntary sterilization; and
  - Voluntary termination of pregnancy.

The plan does *not* cover the reversal of voluntary sterilization procedures, including related follow-up care.

Contraception services not covered

- Charges for services which are covered to any extent under any other part of the plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Vision care services

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- ***Routine*** eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam per calendar year.

Limitations

Coverage is subject to any applicable Calendar Year deductibles, copays and payment percentages.

Hearing exam

Covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A physician certified as an otolaryngologist or otologist; or
- An audiologist who:
- Is legally qualified in audiology; or
- Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
- Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam per calendar year.

All covered expenses for the hearing exam are subject to any applicable deductible, copay and payment percentage.

Routine cancer screenings

In the ChoicePlan 500 (CP500), Oxford Health Plans PPO, and High Deductible Health Plan (HDHP), cancer-screening tests are covered 100% with no deductible to meet when performed by network providers. For frequency limits, please contact your plan at the number on the back of your ID card.

Cancer screening tests are:

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

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- mammograms;
- pap smears;
- gynecological exams;
- fecal occult blood tests;
- digital rectal exams;
- prostate specific antigen (PSA) tests;
- sigmoidoscopies;
- double contrast barium enemas (DCBE); and
- colonoscopies.

These benefits will be subject to any age; family history; and frequency guidelines as set forth in the most current:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and
- The comprehensive guidelines supported by the Health Resources and Services Administration.

Unless specified above, not covered under this benefit are charges incurred for:

- Services which are covered to any extent under any other part of this plan.

Important Note:

For details on the frequency and age limits that apply to Routine Cancer Screenings, contact your physician, log onto the medical carrier's website (Aetna: **www.aetna.com** , Anthem BlueCross BlueShield: **www.anthem.com** or Oxford: **www.oxhp.com**), or call the number on the back of your ID card.

Using an emergency room

If you have a true medical emergency, you should go to the nearest emergency facility. If you are admitted, you must notify your plan within 48 hours. If you are not able to do this, have a representative contact your plan.

The Citi plans do not cover non-emergency services provided in an emergency room.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed. Generally, urgent care centers have evening and weekend hours and do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, or the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, or seizures).

Genetic Information Nondiscrimination Act of 2008

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

Newborns' and Mothers' Health Protection Act notice

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

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

Women's Health and Cancer Rights Act notice

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

If you receive benefits for a medically necessary mastectomy, and if you elect breast reconstruction after the mastectomy, you will also 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 that if group health plans and health insurance issuers decide to provide mental health or substance use disorder (MH/SUD) benefits, to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to MH/SUD benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Precertification/ notification

Precertification/notification helps ensure that you obtain the most appropriate care for your condition in the most appropriate setting, and that your health care costs and Citi's costs are kept under control. If you do not precertify, your claim may be denied in whole or in part. The following sections describe the precertification/notification features of each plan. Be sure to read the sections that apply to the plan in which you enroll.

Precertification requirements for Aetna plans

If you are enrolled in Aetna ChoicePlan 500 (CP500) or the High Deductible Health Plan (HDHP), you must call Aetna to precertify any inpatient surgery or hospitalization and certain outpatient diagnostic/surgical procedures. Scheduled inpatient services and non-emergency outpatient procedures must be precertified at least 14 days in advance. Aetna must be notified of emergency admissions within 48 hours of the admission.

You are not required to notify Aetna of emergency hospitalization or other emergency services occurring outside the United States.

Infertility services

Treatment of infertility must be pre-authorized by Aetna. Penalties apply if the treatment is received without pre-certification. Contact the plan for details.

Inpatient confinements

For inpatient confinement, you must call Aetna for precertification at least 14 days prior to the scheduled admission date. An admission date may not have been set when the confinement was planned. You must call Aetna again as soon as the admission date is set.

You must obtain precertification for:

- A scheduled hospital admission;
- A scheduled admission to a skilled-nursing hospice care or rehabilitation facility;
- Home health care, including psychiatric home care services;
- Private-duty nursing;
- Outpatient hospice care;
- Amytal interview (used with medical procedures as part of testing for prediction of memory dysfunction that may be a result of brain surgery);
- Biofeedback;
- Psychological testing;

- Electroconvulsive therapy;
- Neurophsychological testing;
- Bariatric services;
- Cardiovascular services; and
- Musculoskeletal services.

In case of an unscheduled or emergency admission, you or your doctor must call Aetna within 48 hours after the admission.

Mental health/substance abuse

You must call Aetna for precertification before you obtain covered inpatient mental health and/or substance abuse treatment, including stays in a residential treatment facility or a partial hospitalization program, outpatient detoxification, intensive outpatient programs, or psychiatric home care services.

Organ/tissue transplants

You must notify Aetna before the scheduled date of any of the following:

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant.

See Organ/tissue transplants in “Covered services and supplies” on page 129 for information about precertification requirements. Aetna will then complete the utilization review. You, the physician, and the facility will receive a letter confirming the results of the utilization review.

Pregnancy

Pregnancy is subject to the following notification time periods:

- Aetna should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in a prenatal program;
- You must notify the plan to certify inpatient confinement for delivery of a child. This is to certify a length of stay that exceeds:
  - 48 hours following a normal vaginal delivery; or
  - 96 hours following a cesarean section.
- For inpatient care (for either the mother or child) that continues beyond the 48/96-hour limits stated above, Aetna must be notified before the end of these time periods; and
- Non-emergency inpatient confinement during pregnancy but before the admission for delivery requires notification as a scheduled confinement.

If you or your physician does not agree with Aetna’s determination, you may appeal the decision. For information about the claims appeal process, see “Claims and appeals for Aetna medical plans” on page 160.

Precertification requirements for Anthem BlueCross BlueShield plans

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

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

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

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

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

You are required to obtain precertification for the following services:

- Inpatient admission;
- Maternity admission precertification only needed if inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery;
- Acute inpatient rehabilitation;
- Home health care (includes home infusion billed by Home Health Care agency);
- Visiting nurses;
- Private duty nursing (home);
- Skilled nursing facility (SNF);
- Hospice (inpatient and outpatient);
- Organ and tissue transplant (inpatient and outpatient);
- Bone marrow and stem cell transplant (inpatient and outpatient);
- Air ambulance (air ambulance only suspends for medical review, there is no penalty applied);
- Inpatient mental health/substance abuse (in-network/out-of-network);
- Residential mental health/substance abuse (if covered, precertification required in-network/out-of-network);
- Partial hospitalization mental health/substance abuse (in-network/out-of-network); and
- Some surgical procedures. Contact the Anthem Health Guide Service Team to determine whether or not your scheduled surgery requires precertification.

If you or your physician does not agree with Anthem BlueCross BlueShield's determination, you may appeal the decision. For more information about the claims appeal process, see "Claims and appeals for Anthem BlueCross BlueShield medical plans" on page 166 or call **1-855-593-8123**.

Precertification for Oxford Health Plans PPO

The following are examples of services that require precertification. Be sure to contact Oxford Health for a complete list.

- Non-emergency ambulance services for inter-facility transfers;
- Chiropractic services;
- Dental services (accident only);
- Durable medical equipment with a retail cost of more than $500 whether for purchase or rental;
- Hospital and other facility admissions;
- Home health care services, including private-duty nursing;
- Infertility services;
- Reconstructive procedures;
- Hospice care;
- Maternity admissions exceeding 48 hours for normal delivery/96 hours for cesarean section;
- Outpatient hospital, outpatient rehabilitation and ambulatory surgical centers;
- Short-term rehabilitation (PT, OT & ST); and
- Transplant services.

In-network services: Your PCP or other in-network provider will handle the precertification process for you when you receive any in-network services.

Out-of-network services: When you receive care from an out-of-network provider, you must obtain precertification before receiving any of the listed services (your out-of-network provider does not obtain precertification for you).

Inpatient confinements

For inpatient confinement in a hospital or other facility, you must precertify the scheduled admission date at least five days before the start of the confinement. An admission date may not have been set when the confinement was planned. You must call Oxford again as soon as the admission date is set. You must receive precertification for:

- A scheduled hospital admission, including to a mental health or substance abuse treatment facility;
- A scheduled admission to a skilled-nursing facility or hospice care facility;
- Home health care; and
- Private-duty nursing.

Outpatient surgery/diagnostic testing/other services

When you receive care from an out-of-network provider, you must obtain precertification before receiving the following services:

- Diagnostic tests for organ or tissue transplants;
- Reconstructive procedures;
- Home health care;

- Infertility services, including diagnosis and treatment;
- Private-duty nursing;
- Hospice;
- Dental services (accident only); and
- Durable medical equipment with a purchase or cumulative rental cost of $500 or more.

For outpatient services that require precertification, you must receive precertification as soon as reasonably possible.

Mental health/substance abuse

You must obtain precertification before you obtain covered inpatient mental health and/or substance abuse treatment.

Organ/tissue transplants

You must obtain precertification before the scheduled date of any of the following, or as soon as reasonably possible:

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant.

Pregnancy

Pregnancy is subject to the following precertification time periods:

- Precertification should be requested through Oxford during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in a prenatal program;
- For inpatient care (for either the mother or child) that continues beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, Oxford must receive a precertification request before the end of these time periods; and
- Non-emergency inpatient confinement during pregnancy but before the admission for delivery requires precertification as a scheduled confinement.

If you or your physician does not agree with Oxford's determination, you may appeal the decision. For information about the claims appeal process, see "Claims and appeals for Oxford Health Plans medical plans" on page 170.

ChoicePlan 500 (CP500)

CP500 at a glance

Note: For in-network covered expenses, the plan pays a percentage of discounted rates while for out-of-network charges, the plan pays a percentage of the maximum allowed amount (MAA). See the Glossary for a definition of MAA, which is sometimes referred to as "Recognized Charges."

Type of service	In-network	Out-of-network
Annual deductible (in-network and out-of-network combined)		
> Individual	> $500	> $1,500
> Maximum per family	> $1,000	> $3,000
Annual medical out-of-pocket maximum (includes medical deductible, medical coinsurance, and medical copayments; in-network and out-of-network combined) **Note: There is a separate annual out-of-pocket maximum for prescription drugs.**		
> Individual	> $3,000	> $6,000
> Maximum per family	> $6,000	> $12,000
Lifetime maximum	> None	> None
Professional care (in office)		
> PCP visits	> 80% after deductible[2]	> 60% of MAA after deductible[2]
> Specialist visits	> 80% after deductible[2] > Aetna: 90% after deductible[2] for Aexcel specialists	> 60% of MAA after deductible[2]
> Allergy treatment	> 80% after deductible[2] for the first office visit; 100% for each additional injection if office visit fee is not charged	> 60% of MAA after deductible[2]
Preventive care (subject to frequency limits)		
> Well-adult visits	> 100%, not subject to deductible	> 100% of MAA, not subject to deductible up to $250 combined maximum[1], then covered at 60% of MAA, not subject to deductible
> Well-child visits	> 100%, not subject to deductible	> 100% of MAA, not subject to deductible up to $250 combined maximum[1], then covered at 60% of MAA, not subject to deductible
> Routine cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening)	> 100%, not subject to deductible	> 100% of MAA, not subject to deductible up to $250 combined maximum[1], then covered at 60% of MAA, not subject to deductible

Type of service	In-network	Out-of-network
> Adult and Child Routine Immunizations	> 100%, not subject to deductible	> 60% of MAA, not subject to deductible
> Contraceptive devices	> 100%, not subject to deductible, for diaphragms and Mirena, an implantable device. All other implantable devices will be covered at 80% after deductible[2]	> 60% of MAA after deductible[2]
> Voluntary sterilization – including tubal ligation, sterilization implants and surgical sterilizations	> 100%, not subject to deductible. Male sterilization services (e.g., vasectomies) are covered at 80% after deductible[2]	> 60% of MAA after deductible[2]
Routine care (subject to frequency limits)		
> Routine vision exams	> 100%, not subject to deductible, limited to one exam per calendar year	> 100% of MAA, not subject to deductible, up to $250 combined maximum[1], then covered at 60% of MAA, not subject to deductible. Limited to one exam per calendar year
> Routine hearing exams	> 100%, not subject to deductible, limited to one exam per calendar year	> 100% of MAA, not subject to deductible, up to $250 combined maximum[1], then covered at 60% of MAA, not subject to deductible. Limited to one exam per calendar year
Hospital (inpatient and outpatient services)		
> Semiprivate room and board, doctor's charges, lab, X-ray, radiology, and surgical care	> 80% after deductible[2]; precertification is required for hospitalization and certain outpatient procedures	> 60% of MAA after deductible[2]; precertification required for hospitalization and certain outpatient procedures
> Anesthesia	> 80% after deductible[2]	> 60% of MAA after deductible[2]
Non-routine outpatient		
> Lab, X-ray, and radiology	> 80% after deductible[2]; precertification is required for certain outpatient procedures	> 60% of MAA after deductible[2]; precertification is required for certain outpatient procedures
Maternity care		
> Physician office visit	> 80% after deductible[2]	> 60% of MAA after deductible[2]
> Hospital delivery	> 80% after deductible[2] > Precertification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery	> 60% of MAA after deductible[2] > Pre-notification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery

Type of service	In-network	Out-of-network
Emergency care (no coverage if not a true emergency)		
> Hospital emergency room (includes emergency room facility and professional services provided in the emergency room)	> 100% after $100 copayment (waived if admitted within 24 hours, precertification required for hospitalization, not subject to annual deductible)	> 100% after $100 copayment (waived if admitted within 24 hours, precertification required for hospitalization, not subject to annual deductible)
Emergency Transportation Services (no coverage when used as routine transportation to receive inpatient or outpatient services)		
	100%, not subject to the deductible; for transport to and from the nearest medical facility qualified to give the required treatment **Anthem:** Precertification required for air transport	100%, not subject to the deductible; for transport to and from the nearest medical facility qualified to give the required treatment; pre-certification required for inter-facility transfers
Urgent Care Center		
> Urgent care facility	> 80% after deductible[2]	> 80% of MAA after deductible
Outpatient short-term rehabilitation		
> Physical or occupational therapy. (All therapy visits are reviewed for medical necessity. PT/OT therapy visits are combined with a 60-visit per year maximum. Additional visits may be approved.) This limit applies to in-network and out-of-network services combined	> 80% after deductible[2] > 70% after deductible[2] for visits approved for medical necessity over plan limit	> 60% of MAA after deductible[2] > 50% of MAA after deductible[2] for visits approved for medical necessity over plan limit
> Speech therapy. (90-visit per year maximum. Additional visits may be approved.) This limit applies to in-network and out-of-network services combined	> 80% after deductible[2] > 70% after deductible[2] for visits approved for medical necessity over plan limit	> 60% of MAA after deductible[2] > 50% after deductible[2] for visits approved from medical necessity over plan limit
> Chiropractic therapy (medically necessary), up to 20 visits per year for in-network and out-of-network services combined	> 80% after deductible[2]	> 60% of MAA after deductible[2]
Other services		
> Durable medical equipment (includes orthotics/ prosthetics and appliances)	> 80% after deductible[2]	> 60% of MAA after deductible[2]
> Private-duty nursing and home health care	> 80% after deductible[2], limited to 200 visits annually for in-network and out-of-network services combined; precertification required	> 60% of MAA after deductible[2], limited to 200 visits annually for in-network and out-of-network services combined; precertification required
> Hospice	> 80% after deductible[2]; precertification required	> 60% of MAA after deductible[2]; precertification required

Type of service	In-network	Out-of-network
> Skilled nursing facility	> 80% after deductible[2] (limited to 120 days annually for in-network and out-of-network services combined); precertification required	> 60% of MAA after deductible[2] (limited to 120 days annually for in-network and out-of-network services combined); precertification required
> Infertility treatment	> Covered up to a $24,000 family lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. > 80% after deductible[2] up to the family lifetime maximum; precertification required > Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum per family	> Covered up to a $24,000 family lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. > 60% after deductible[2] up to the family lifetime maximum; precertification required > Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum per family
Prescription drugs (see the Prescription Drugs section)		
Mental health and substance abuse (see "Mental health/substance abuse in and out-of-network" on page 91)		

1 Combined maximum benefit applies to well-adult visits, well-child visits, routine cancer screenings, routine hearing, and routine vision. The maximum is measured on a calendar year basis.

2 The plan will pay this percentage of the cost after you first pay the full deductible of the plan. The deductible can be paid with after-tax dollars, such as cash or check, or with before-tax dollars if you have available funds in a Health Care Spending Account (HCSA).

These tables are intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see "Covered services and supplies" on page 129 and "Exclusions and limitations" on page 152.

The CP500 is self-insured; therefore, Citi pays the claims incurred. The CP500 is not subject to state laws.

You have the freedom to choose your doctor or health care facility when you need health care. How that care is covered and how much you pay for your care out of your own pocket depends on whether the expense is covered by the plan and whether you choose a preferred provider or a non-preferred provider. Using preferred providers (in-network) saves you money in two ways. First, preferred providers charge special, negotiated rates, which are generally lower than the maximum allowed amounts (MAA). Second, the level of reimbursement for many services is higher when using preferred providers. *Citi plans only cover services that are deemed medically necessary.*

You must meet a deductible before the plan will pay benefits. Both in-network and out-of-network services will apply to meeting the deductible. Precertification is required before any inpatient hospital stay and certain outpatient procedures.

CP500 network features

Deductible

If you elect to use physicians or other providers in the network, you will need to meet an annual in-network deductible of $500 individual/$1,000 family before any benefit will be paid. Once you meet your deductible, the plan will pay 80% of covered in-network expenses.

The individual deductibles apply to all covered expenses, except preventive care, and must be met each calendar year before any benefits will be paid.

The family deductible represents the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible can be applied toward the family deductible. The family deductible can be met as follows:

> **Two in a family:** Each member must meet the $500 individual deductible; or

> **Three or more in a family:** Expenses can be combined to meet the $1,000 family deductible, but no one person can apply more than the individual deductible ($500) toward the family deductible amounts.

Deductible expenses cross-apply between in-network and out-of-network limits.

Coinsurance

Coinsurance refers to the portion of a covered expense that you pay after you have met the deductible. For example, if the plan pays 80% of certain covered expenses, your coinsurance for these expenses is 20%.

Medical out-of-pocket maximum

The out-of-pocket maximum for medical services rendered in the network is $3,000 (individual)/$6,000 (family). This amount represents the most you will have to pay out of your own pocket in a calendar year for in-network services. This amount does not include penalties, charges above the MAA, prescription drug expenses, or services not covered under CP500. Once this out-of-pocket maximum is met, covered medical expenses are payable at 100% of the negotiated rate contracted with the Claims Administrator for the remainder of the calendar year. In-network copayments for medical services also apply to the out-of-pocket maximums; once the out-of-pocket maximum has been satisfied, no additional in-network medical copayments will apply for the remainder of the plan year. Prescription drug copays are subject to a separate out-of-pocket maximum.

Eligible medical expenses within a family can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount ($3,000) to the family out-of-pocket maximum ($6,000).

Not all expenses count toward your medical out-of-pocket maximum. Among those that do *not* count are:

> Charges above MAA;

> Penalties;

> Prescription drug expenses (which count toward the separate prescription drug out-of-pocket maximum); and

> Charges for services not covered under CP500.

To help you manage the high cost of prescription drugs, there is also a separate annual prescription drug out-of-pocket maximum. Once you reach the prescription drug out-of-pocket maximum $1,500 (individual)/$3,000 (family), the plan pays the full cost of prescription drug expenses for the remainder of the year.

Out-of-pocket maximum expenses cross-accumulate between in-network and out-of-network limits.

Primary care physician (PCP)

When seeking primary care services, you should choose a provider from the PCPs in the directory of network providers. You may choose a pediatrician as the PCP for your covered child. Women may also select an OB/GYN without referral from their PCP. A directory of the providers who participate in the CP500 network is available from the Claims Administrator. You may call or visit the Claims Administrator's website:

> Aetna: **www.aetna.com**; select the Aetna Open Access, Choice POSII Open Access Plan or call **1-800-545-5862**

- Anthem BlueCross BlueShield: **www.anthem.com**; to access a network provider through the BlueCross BlueShield Association BlueCard® PPO Program, select "Find a Doctor," and then choose "Across the Country (National Provider Search)." Enter your search details (provider name, provider specialty, search location,). Enter your identification prefix (which is the first three letters of your member ID located on your ID card). If you do not have your member ID card handy, select your State and your plan, PPO and click on "Search." You will have a variety of search options to help you find a provider who meets your needs. You may also call Anthem at **1-855-593-8123**.
- If you live in Metro-New York, Washington D.C./Maryland/Northern Virginia, Georgia, Kansas City, MO, or St. Louis, MO: You have access to an alternate network of providers. Please see your Anthem ID card to get the prefix you should use to search for providers on Anthem's website, or call Anthem's Health Guide Service Team for additional information about alternate networks and information on how to locate a participating provider.
- Once you meet your deductible, the plan will pay 80% of covered in-network expenses.

Specialists

If you need the services of a specialist, you may seek care from a specialist directly without a referral. Once you meet your deductible, the plan will pay 80% of covered in-network expenses.

Aetna Aexcel specialists

Aexcel is a designation within Aetna's network that includes specialists who have demonstrated effectiveness in the delivery of care based on defined measures of clinical performance and cost-efficiency. Currently, there are Aexcel-designated physicians in 12 medical specialty categories: Cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics and gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, urology, and vascular surgery.

Aexcel-designated specialists are currently available to members in AZ, CA, CO, CT, DC, DE, FL, GA, IL, IN, KS, KY, MD, MA, ME, MI, MO, NJ, NV, NY, OH, OK, PA, TX, VA, and WA.

When you visit an Aexcel specialist you do not need a referral. The plan will pay 90% of covered expenses after your deductible for Aexcel specialists. To find an Aexcel specialist visit, **www.aetna.com/docfind**; select the Aetna Standard Plans, Aetna Select, and look for the providers listed with the blue star. This blue star identifies the Aexcel specialists.

Allergist

When you see an in-network allergist, once you meet your deductible, you will be expected to pay 20% of the first office visit. If you receive an allergy injection only (without a physician's office visit charge), benefits will be covered at 100%. If services are for other than an allergy injection, coinsurance will apply.

Preventive care

Preventive care services are covered at 100%, no deductible to meet for the CP500. For additional information on what is considered to be preventive care, see "Preventive care" on page 68.

Preventive care services include:

- Routine physical exams: Well-child care and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines. For frequency guidelines, contact your Claims Administrator;
- Routine diagnostic tests, for example, CBC (complete blood count), cholesterol blood test, and urinalysis;

- Well-child services and routine pediatric care; and
- Routine well-woman exams.

In addition, CP500 will cover both cancer-screening tests and well-adult and well-child immunizations performed by in-network providers at 100%, not subject to deductible. Routine cancer screenings are:

- Pap smear performed by an in-network provider annually;
- Mammogram;
- Sigmoidoscopy;
- Colonoscopy; and
- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older.

Preventive care services covered in the network at 100% will be reviewed annually and updated prospectively to comply with recommendations of the:

- American Medical Association;
- United States Preventive Care Task Force;
- Advisory Committee on Immunization Practices that have been adopted by the Director of the Centers for Disease Control and Prevention; and
- Comprehensive Guidelines Supported by the Health Resources and Services Administration.

Routine care

CP500 offers additional coverage for routine care services to help in the early detection of health problems.

- Routine vision exam:
  - **In-network:** Covered at 100%, not subject to deductible; one exam per calendar year, performed by a network ophthalmologist or optometrist;
  - **Out-of-network:** Covered at 100%, not subject to deductible up to $250 per calendar year[1], then covered at 60% of MAA, not subject to deductible; limited to one exam per calendar year.

[1] Combined maximum with well-adult and well-child visits, routine cancer screenings and routine hearing

Aetna: covered expenses include a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam.

- Routine hearing exam:
  - **In-network:** Covered at 100%, not subject to deductible; one exam per calendar year, performed by a network provider.
  - **Out-of-Network:** Covered at 100%, not subject to deductible up to $250 per calendar year[1], then covered at 60% of MAA, not subject to deductible; limited to one exam per calendar year.

Aetna: covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A physician certified as an otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Hospital

Hospital care (inpatient and outpatient) received through a preferred provider is covered at 80% for covered services after the deductible has been met. Services provided by a network physician in an out-of-network hospital are covered at the in-network benefit level.

Note: Any charges submitted by an out-of-network hospital would be treated as out-of-network claims. Precertification of an inpatient admission is required. Precertification is also required for certain outpatient procedures and services.

Emergency care

The emergency room copayment is $100 per visit and then the plan pays 100% (not subject to annual deductible). If you are admitted to the hospital within 24 hours of the emergency room visit for any condition, the copayment is waived.

Aetna: When emergency care is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your physician provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify your physician as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur.

Urgent care

Urgent care centers are listed in the provider directory available on the Claims Administrators' websites. You do not need a referral or any pre-certification to use an urgent care center. Services provided by an urgent care center are covered at 80% for covered services after the deductible has been met.

Aetna: Call your PCP if you think you need urgent care. You may contact any physician or urgent care provider, in- or out-of-network, for an urgent care condition if you cannot reach your physician. If it is not feasible to contact your physician, please do so as soon as possible after urgent care is provided. In-network providers are required to provide urgent care coverage 24 hours a day, including weekends and holidays. If you need help finding an urgent care provider you may call Member Services at the toll-free number on your I.D. card, or you may access Aetna's online provider directory at **www.aetna.com**. Follow-up care is not considered an emergency or urgent condition and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care.

Anthem BCBS: Anthem uses actual charges billed, not MAA, when determining plan payment for an out-of-network provider.

Charges not covered

An in-network provider contracts with the CP500 Claims Administrator to participate in the network. Under the terms of this contract, an in-network provider may not charge you or the Claims Administrator for the balance of the charges above the contracted negotiated rate for covered services.

You may agree with the in-network provider to pay any charges for services or supplies not covered under CP500 or not approved by CP500. In that case, the in-network provider may bill charges to you. However, these charges are not covered expenses under CP500 and are not payable by the Claims Administrator.

For information about how to file a claim or appeal a denied claim, see “Claims and appeals for Aetna medical plans” on page 160 or “Claims and appeals for Anthem BlueCross BlueShield medical plans” on page 166.

Paying your bill at your in-network doctor’s office

After you meet your annual deductible, the plan will pay 80% for most covered services, while you will pay 20% of the plan’s negotiated rate. In most cases, your doctor will bill you for the 20%. Generally, you will not pay your in-network doctor on the day of your visit because you will have to wait for your portion of the charge to be calculated.

Choosing in-network providers

CP500 is administered by Aetna and Anthem BlueCross BlueShield. When you enroll in the CP500, you may request a provider directory that lists doctors and other providers who belong to the network.

- Aetna: **www.aetna.com**; select the Aetna Open Access, Choice POSII Open Access Plan or call **1-800-545-5862**.
- Anthem BlueCross BlueShield: **www.anthem.com**; to access an in-network provider through the BlueCross BlueShield Association BlueCard ® PPO Program, select “Find a Doctor,” and then choose “Across the Country (National Provider Search).” Enter your search details (provider name, provider specialty, search location,). Enter your identification prefix (which is the first three letters of your member ID located on your ID card). If you do not have your member ID card handy, select your State and your plan, PPO and click on “Search.” You will have a variety of search options to help you find a provider who meets your needs. You may also call **1-855-593-8123**.
- If you live in Metro-New York, Washington D.C./Maryland/Northern Virginia, Georgia, Kansas City, MO, or St. Louis, MO: You have access to an alternate network of providers. Please see your Anthem ID card to get the prefix you should use to search for providers on Anthem’s website, or call Anthem’s Health Guide Service Team for additional information about alternate networks and information on how to locate a participating provider.

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

Out-of-network features

You can use an out-of-network provider for medical services and still be reimbursed under the CP500. These expenses generally are reimbursed at a lower level than in-network expenses, after you have met the out-of-network deductible.

For information about how to file a claim for out-of-network services or appeal a denied claim, see “Claims and appeals for Aetna medical plans” on page 160, or “Claims and appeals for Anthem BlueCross BlueShield medical plans” on page 166.

Deductible and coinsurance

If you elect to use physicians or other providers outside the network, you will need to meet an annual deductible of $1,500 individual/$3,000 family maximum before any benefit will be paid. Once you meet your deductible, you must submit a claim form accompanied by your itemized bill to be reimbursed for covered expenses.

The individual deductibles apply to all covered expenses except routine preventive care and must be met each calendar year before any benefits will be paid.

The family deductibles represent the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible can be applied toward the family deductible. The family deductible can be met as follows:

- **Two in a family:** Each member must meet the $500 in-network/$1,500 out-of-network individual deductible; or
- **Three or more in a family:** Expenses can be combined to meet the $1,000 in-network/$3,000 out-of-network family deductible, but no one person can apply more than the individual deductible ($500/$1,500) toward the family deductible amount.

Once you have met the deductible, CP500 normally pays 60% of maximum allowed amount (MAA) for covered expenses that are received out-of-network. Providers may balance bill you for the charges above MAA, and you are responsible for those charges.

Medical out-of-pocket maximum

The out-of-pocket maximum for medical services rendered outside of the network is $6,000 (individual)/$12,000 (family). This amount includes the $1,500 individual/$3,000 family deductible, coinsurance and copayments, and represents the most you will have to pay out of your own pocket in a calendar year for medical services received outside the network, excluding charges that exceed MAA expenses, penalties, prescription drug expenses or services not covered under CP500. Once this out-of-pocket maximum is met, covered expenses are payable at 100% of MAA for the remainder of the calendar year.

Eligible expenses within a family can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount of $6,000 to the family out-of-pocket maximum of $12,000.

Not all expenses count toward your medical out-of-pocket maximum. Among those that do *not* count are:

- Expenses that exceed MAA;
- Penalties;
- Prescription drug expenses (which apply toward a separate prescription drug out-of-pocket maximum); and
- Charges for services not covered under the plan.

To help you manage the high cost of prescription drugs, there is also a separate annual prescription drug out-of-pocket maximum. Once you reach the prescription drug out-of-pocket maximum $1,500 (individual)/$3,000 (family), the plan pays the full cost of prescription drug expenses for the remainder of the year.

In addition, expenses incurred when using in-network services count toward your out-of-network, out-of-pocket maximum.

Preventive care

Each participant has a $250 annual credit toward all out-of-network wellness services. Thereafter, covered expenses are not subject to the deductible and expenses that exceed the $250 credit are covered at 60% of MAA. Preventive care services include:

- Routine physical exams: Well-child care and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines. For frequency guidelines, contact your Claims Administrator;
- Routine diagnostic tests: For example, CBC (complete blood count), cholesterol blood test, urinalysis;

- Well-child services and routine pediatric care; and
- Routine well-woman exams.

Routine care

The CP500 offers coverage for routine care services to help in the early detection of health problems.

- **Routine vision exam:** Covered at 100%, not subject to deductible, one exam per calendar year, performed by an in-network ophthalmologist or optometrist; and
- **Routine hearing exam:** Covered at 100%, not subject to deductible, one exam per calendar year, performed by an in-network otolaryngologist or otologist.

Hospital

Hospital care (inpatient and outpatient) will be reimbursed at 60% of MAA, after you meet your annual deductible. Coverage for room and board is limited to expenses for the regular daily charge made by the hospital for a semi-private room (or private room when medically appropriate or if it is the only room type available). Precertification of an inpatient admission is required. Precertification is required for certain outpatient procedures and services.

Emergency care

The emergency room copayment is $100 per visit and then the plan pays 100% (not subject to annual deductible). If you are admitted to the hospital within 24 hours of the emergency room visit for any condition, the copayment is waived.

Aetna: When emergency care is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your physician provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify your physician as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur.

Urgent care

Services provided by an urgent care center are covered at 80% for covered services after the deductible has been met.

Aetna: Call your PCP if you think you need urgent care. You may contact any physician or urgent care provider, in- or out-of-network, for an urgent care condition if you cannot reach your physician. If it is not feasible to contact your physician, please do so as soon as possible after urgent care is provided. In-network providers are required to provide urgent care coverage 24 hours a day, including weekends and holidays. If you need help finding an urgent care provider you may call Member Services at the toll-free number on your I.D. card, or you may access Aetna's online provider directory at **www.aetna.com**. Follow-up care is not considered an emergency or urgent condition and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care.

Multiple surgical procedure guidelines

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

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

- **First procedure:** The plan will allow 100% of the negotiated or MAA.
- **Second procedure:** The plan will allow 50% of the negotiated or MAA.
- **Additional procedures:** The plan will allow 50% of the negotiated or MAA for each additional procedure.
- **Bilateral and separate operative areas**: The plan will allow 100% of the negotiated or MAA for the primary procedure and 50% of the secondary procedure and 50% of the negotiated or MAA for tertiary/additional procedures.

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

Mental health/substance abuse in and out-of-network

CP500 provides confidential mental health and substance abuse coverage through a network of participating counselors and specialized practitioners.

When you call the Claims Administrator at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help find the right provider for you. In an emergency, the intake coordinator will also provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call your Claims Administrator before seeking treatment for mental health or substance abuse treatment.

Action (all visits are reviewed for medical necessity)	Inpatient	Outpatient
If you call the plan and use its network provider/facility	After the deductible, eligible expenses covered at 80% of the negotiated rate	After the deductible, eligible expenses covered at 80% of the negotiated rate
If you call the plan but do not use its network provider/facility	After the deductible, eligible expenses covered at 60% of MAA	After the deductible, eligible expenses covered at 60% of MAA

Coverage levels

Mental health and substance abuse treatment benefits are subject to the same medical necessity requirements, coverage limitations, and deductibles that are required under CP500.

Mental health benefits include, but are not limited to:

- Assessment, diagnosis, and treatment;
- Medication management;
- Individual, family, and group psychotherapy;
- Acute inpatient care;

- Partial hospitalization programs;
- Facility based intensive outpatient program services; and
- Psychological testing that is not primarily educational in nature.

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

Aetna: In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a physician or licensed provider; and
- The treatment plan is for a condition that can favorably be changed.
- Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office.

Inpatient services

CP500 pays benefits at the in-network level (80% of the negotiated rate contracted with the Claims Administrator) if you call the plan, use an in-network provider, and the treatment is medically necessary, and in the appropriate level-of-care setting. If you do not use an in-network provider, you will be reimbursed at 60% of MAA after the deductible is met provided that the treatment is medically necessary and in the appropriate level-of-care setting.

In general, inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by the Claims Administrator in advance of the admission.

Aetna: Benefits are payable for charges incurred in a hospital, psychiatric hospital, or residential treatment facility. Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Covered expenses also include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

Outpatient services

If you use an in-network provider, you will be reimbursed at 80% of covered expenses after the deductible is met. If you do not use an in-network provider, you will be reimbursed at 60% of MAA for covered services after the deductible is met.

Aetna: Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility. The plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Emergency care

Emergency care for mental health or substance abuse treatment does not require a referral. However you are encouraged to call the Claims Administrator within 48 hours after an emergency admission. The CP500's behavioral health providers are available 24/7 to accept calls.

Medically necessary

The Claims Administrator will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The Claims Administrator will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless the Claims Administrator determines that the covered services and supplies are medically necessary. Please refer to the "Glossary" for the definition of medical necessity.

For more information about what your plan covers, see "Covered services and supplies" on page 129. You may also contact your plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Concurrent review and discharge planning

The following items apply if the CP500 requires certification of any confinement, services, supplies, procedures, or treatments:

- **Concurrent review.** The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.
- **Discharge planning.** Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be used by the member upon discharge from an inpatient stay.

Anthem BlueCross BlueShield uses medical management guidelines developed by an internal team of physician medical directors, registered nurses and other clinical professionals, using data from a third party organization, when determining these medical management services.

Oxford Health Plans Preferred Provider Organization (PPO) (CT, NJ, and NY only)

The Oxford Health Plans Preferred Provider Organization (PPO) is administered by Oxford Health Plans and is available in the Connecticut, New Jersey, and New York tri-state area. The Oxford Health Plans PPO is self-insured; therefore, Citi pays the claims incurred. The Oxford Health Plans PPO is not subject to state laws.

Under the plan, you have the freedom to choose your doctor or health care facility when you need health care. How that care is covered and how much you pay for your care out of your own pocket depends on whether the expense is covered by the plan and whether you choose a preferred provider or a non-preferred provider. Using preferred (network) providers saves you money in two ways. First, preferred providers charge special, negotiated rates, which are generally lower than the maximum allowed amounts (MAA). Second, the level of reimbursement for many services is higher when using preferred providers. For a list of providers, visit the Oxford website at **www.oxhp.com** or call Oxford Member Services at **1-800-760-4566** (if you are not currently participating in the plan) or **1-800-396-1909** (if you are currently participating in the plan).

The Oxford Health Plans PPO at a glance

Note: For in-network covered expenses, the plan pays a percentage of discounted rates while for out-of-network charges, the plan pays a percentage of the maximum allowed amount (MAA). See the Glossary for a definition of MAA, which is sometimes referred to as "Recognized Charges."

Type of service	In-network	Out-of-network
Annual deductible		
> Individual	> $500	> $1,500
> Maximum per family	> $1,000	> $3,000
Annual medical out-of-pocket maximum (includes medical deductible, medical coinsurance, and medical copayments) **Note: There is a separate annual out-of-pocket maximum for prescription drugs.**		
> Individual	> $3,000	> $6,000
> Maximum per family	> $6,000	> $12,000
Lifetime maximum	> None	> None
Professional care (in office)		
> PCP visits	> 80% after deductible[2]	> 60% of MAA after deductible[2]
> Specialist visits	> 80% after deductible[2]	> 60% of MAA after deductible[2]
> Allergy treatment	> 80% after deductible[2] for the first office visit; 100% for each additional injection if office visit fee is not charged	> 60% of MAA after deductible[2]
Preventive care (subject to frequency limits)		
> Well-adult visits	> 100%, not subject to deductible	> 100%, not subject to deductible, up to $250 maximum[1], then covered at 60% of MAA, not subject to deductible
> Well-child visits	> 100%, not subject to deductible	> 100%, not subject to deductible, up to $250 maximum[1], then covered at 60% of MAA, not subject to deductible
> Adult and Child Routine Immunizations	> 100%, not subject to deductible	> 60% of MAA, not subject to deductible
> Routine cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening)	> 100%, not subject to deductible	> 100%, not subject to deductible, up to $250 maximum[1], then covered at 60% of MAA, not subject to deductible

Type of service	In-network	Out-of-network
> Contraceptive devices	> 100%, not subject to deductible, for diaphragms and Mirena, an implantable device. All other implantable devices will be covered at 80% after deductible[1]	> 60% of MAA after deductible[2]
> Voluntary sterilization – including tubal ligation, sterilization implants and surgical sterilizations	> 100%, not subject to deductible. Male sterilization services (e.g., vasectomies) are covered at 80% after deductible[1]	> 60% of MAA after deductible[1]
Routine care (subject to frequency limits)		
> Routine vision exams – In- and out-of-network combined limit: one exam per calendar year	> 100%, not subject to deductible	> 100%, not subject to deductible, up to $250 maximum[1], then covered at 60% of MAA, not subject to deductible
> Routine hearing exams – In- and out-of-network combined limit: one exam per calendar year	> 100%, not subject to deductible	> 100%, not subject to deductible, up to $250 maximum[1], then covered at 60% of MAA, not subject to deductible
Hospital inpatient and outpatient		
> Semiprivate room and board, doctor's charges, radiology, lab, X-ray, and surgical care	> 80% after deductible[2]; precertification required for hospitalization and certain outpatient procedures	> 60% of MAA after deductible[2]; precertification required for hospitalization and certain outpatient procedures
Non-routine outpatient		
> Radiology, lab, and X-ray	> 80% after deductible[2]; precertification required for certain outpatient procedures	> 60% of MAA after deductible[2]; precertification is required for certain outpatient procedures
Maternity care		
> Physician office visit	> 80% after deductible[2]	> 60% of MAA after deductible[2]
> Hospital delivery	> 80% after deductible[2] > Precertification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery	> 60% of MAA after deductible[2] > Precertification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery

Type of service	In-network	Out-of-network
Emergency care (no coverage if not a true emergency)		
> Hospital emergency room (includes emergency room facility and professional services provided in the emergency room)	> 100% after $100 copayment (waived if admitted within 24 hours; not subject to deductible)	> 100% after $100 copayment (waived if admitted within 24 hours; not subject to deductible)
> Urgent care facility	> 80% after deductible[2]	> 80% of MAA after deductible[2]
Emergency Transportation Services (no coverage when used as routine transportation to receive inpatient or outpatient services)		
	100%, not subject to the deductible; for transport to and from the nearest medical facility qualified to give the required treatment	100%, not subject to the deductible; for transport to and from the nearest medical facility qualified to give the required treatment; pre-certification required for inter-facility transfers
Outpatient short-term rehabilitation		
> Physical/occupational/speech therapy (combined): Limited to 90 visits a year for physical/occupational/speech therapy in-network and out-of-network combined.	> 80% after deductible[2] > 60% after deductible[2] for approved visits over plan limits	> 60% of MAA after deductible[2], > 50% of MAA after deductible[2] for approved visits over plan limits
> Chiropractic therapy, up to 20 visits per year for in-network and out-of-network services combined; precertification required	> 80% after deductible[2]	> 60% of MAA after deductible[2]
Other services		
> Durable medical equipment (includes orthotics/prosthetics and appliances)	> 80% after deductible[2]; precertification required for equipment with a purchase or cumulative rental cost of $500 or more	> 60% of MAA after deductible[2]; precertification required for equipment with a purchase or cumulative rental cost of $500 or more
> Private-duty nursing and home health care	> 80% after deductible[2], limited to 200 visits annually for in-network and out-of-network services combined; precertification required	> 60% of MAA after deductible[2], limited to 200 visits annually for in-network and out-of-network services combined; precertification required
> Hospice	> 80 after deductible[2]; precertification required	> 60% of MAA after deductible[2]; precertification required

Type of service	In-network	Out-of-network
> Skilled nursing facility	> 80% after deductible[2] (limited to 120 days annually for in-network and out-of-network services combined); precertification required	> 60% of MAA after deductible[2] (limited to 120 days annually for in-network and out-of-network services combined); precertification required
> Infertility treatments	> Covered up to a $24,000 family lifetime medical maximum combined in-network and out-of-network. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. > 80% after deductible[2] up to the family lifetime maximum; precertification required	> Covered up to a $24,000 family lifetime medical maximum combined in-network and out-of-network. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. > 60% after deductible[2] up to the family lifetime maximum; precertification required
Prescription drugs (see the Prescription Drugs section)		
Mental health and substance abuse (refer to "Mental health/substance abuse: in and out-of-network" on page 102.)		

1 Combined maximum benefit applies to well-adult visits, well-child visits, routine cancer screenings, routine hearing, and routine vision. The maximum is measured on a calendar year basis.

2 The plan will pay this percentage of the cost after you first pay the full deductible of the plan. The deductible can be paid with after-tax dollars, such as cash or check, or with before-tax dollars if you have available funds in a Health Care Spending Account (HCSA).

These tables are intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see "Covered services and supplies" on page 129 and "Exclusions and limitations" on page 152.

How the plan works

In-network coverage

To receive the highest level of benefits, referred to as the in-network level of benefits, from the Oxford PPO, you must receive care from a preferred provider. Citi members have access to the UnitedHealthcare Choice Plus Network nationwide. A current directory of the network providers who participate in the Oxford PPO is available at www.oxhp.com or at **1-800-760-4566** (if you are currently not participating in the plan) or **1-800-396-1909** (if you are a plan participant). .

Deductible

If you use physicians or other providers in the network, you will need to meet an annual deductible ($500 individual/$1,000 family) before any benefits will be paid. Once you meet your deductible, the plan will generally pay 80% of covered in-network expenses.

The individual deductibles apply to all covered expenses except preventive care and must be met each calendar year before any benefits will be paid.

The family deductible represents the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible can be applied toward the family deductibles. The family deductible can be met as follows:

> **Two in a family:** Each member must meet the $500 individual deductible; or

> **Three or more in a family:** Expenses can be combined to meet the $1,000 family deductible, but no one person can apply more than the individual deductible ($500) toward the family deductible amounts

Deductible expenses do not cross-apply between in-network and out-of-network limits.

Coinsurance

Coinsurance refers to the portion of a covered expense that you pay after you have met the deductible. For example, if the plan pays 80% of certain covered expenses, your coinsurance for these expenses is 20%.

Medical out-of-pocket maximum

The out-of-pocket maximum for medical services rendered in the network is $3,000 individual/$6,000 family. This amount represents the most you will have to pay out of your own pocket in a calendar year for services received in the network. This amount does not include penalties, prescription drug expenses, or services not covered under the Oxford PPO. Once this out-of-pocket maximum is met, covered medical expenses are payable at 100% of the negotiated rate contracted with the Claims Administrator for the remainder of the calendar year.

Eligible expenses within a family can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount ($3,000) to the family out-of-pocket maximum ($6,000).

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are:

> Penalties;

> Expenses that exceed MMA;

> Prescription drug expenses (which apply to a separate prescription drug out-of-pocket maximum); and

> Charges for services not covered under the plan.

To help you manage the high cost of prescription drugs, there is also a separate annual prescription drug out-of-pocket maximum. Once you reach the prescription drug out-of-pocket maximum $1,500 (individual)/$3,000 (family), the plan pays the full cost of prescription drug expenses for the remainder of the year.

Out-of-pocket maximum expenses do not cross-apply between in-network and out-of-network limits.

Primary care physician (PCP)

When seeking primary care services, you should choose a provider from primary care physicians in the directory of network providers. You may choose a pediatrician as a PCP for your covered child. Women may also select an OB/GYN without a referral from their PCP. A directory of the network providers who participate in the Oxford PPO is available from the Claims Administrator. You may call or visit the Claims Administrator's website at **www.oxhp.com** or **1-800-760-4566** (if you are not currently participating in the plan) or **1-800-396-1909** (if you are currently participating in the plan).

Once you meet your deductible, the plan will pay 80% of covered in-network expenses.

Specialists

If you need the services of a specialist, you may seek care from a specialist directly without a referral. Once you meet your deductible, the plan will pay 80% of covered in-network expenses.

Allergist

When you see an in-network allergist, once you meet your deductible, you will be expected to pay 20% of the first office visit. If you receive an allergy injection only (without a physician office visit charge), benefits will be covered at 100%. If services are for other than an allergy injection and you are charged for an office visit, coinsurance will apply.

Preventive care

Preventive care services are covered at 100%, not subject to deductible. The plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital.

Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

For more specific information regarding what is considered to be Preventive Care, see "Preventive care" on page 68.

Routine care

The Oxford PPO offers additional coverage for routine care services to help in the early detection of health problems.

- **Routine vision exam:** Covered at 100%, not subject to deductible, one exam per calendar year, performed by an in-network ophthalmologist or optometrist; and
- **Routine hearing exam:** Covered at 100%, not subject to deductible, one exam per calendar year, performed by an in-network otolaryngologist or otologist.

Infertility

Treatment of infertility must be pre-authorized. Penalties may apply if the treatment is received without pre-certification. Contact the plan for details.

Emergency care

The emergency room copayment is $100 per visit. If you are admitted to the hospital within 24 hours of the emergency room visit for any condition, the copayment is waived and 100%, no deductible.

Charges not covered

An in-network provider contracts with the Oxford PPO Claims Administrator to participate in the network. Under the terms of this contract, an in-network provider may not charge you or the Claims Administrator for the balance of the charges above the contracted negotiated rate for covered services.

You may agree with the in-network provider to pay any charges for services or supplies not covered under the Oxford PPO or not approved by the Oxford PPO. In that case, the in- provider may bill charges to you. However, these charges are not covered expenses under Oxford PPO and are not payable by the Claims Administrator.

For information about how to file a claim or appeal a denied claim, see “Claims and appeals for Oxford Health Plans medical plans” on page 170.

Out-of-network coverage

You can use an out-of-network provider for medical services and still receive reimbursement under the Oxford PPO. These expenses generally are reimbursed at a lower level than in-network expenses, and you will have to meet a deductible.

For information about how to file a claim for out-of-network services or appeal a denied claim, see “Claims and appeals for Oxford Health Plans medical plans” on page 170.

Deductible and coinsurance

If you use physicians or other providers outside the network, you will need to meet an annual deductible ($1,500 individual/$3,000 family) before any benefit will be paid. Once you meet your deductible, you must submit a claim form accompanied by your itemized bill to be reimbursed for covered expenses.

The individual deductibles apply to all covered expenses except routine preventive care and must be met each calendar year before any benefits will be paid.

The family deductibles represent the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent’s individual deductible can be applied toward the family deductible. The family deductible can be met as follows:

- **Two in a family:** Each member must meet the $1,500 individual deductible or
- **Three or more in a family:** Expenses can be combined to meet the $3,000 family deductible, but no one person can apply more than the individual deductible ($1,500) toward the family deductible amount.

Once you have met the deductible, Oxford PPO normally pays 60% of maximum allowed amount (MAA) charges for covered expenses that are received out-of-network.

Deductible expenses do not cross-apply between in-network and out-of-network limits.

Medical out-of-pocket maximum

The out-of-pocket maximum for medical services rendered outside of the network is $6,000 individual/$12,000 family. This amount includes the ($1,500 individual and $3,000 family) deductible, medical coinsurance and any medical copayments and represents the most you will have to pay out of your own pocket in a calendar year for medical services received outside the network, excluding charges that exceed MAA, penalties, or services not covered under the Oxford PPO. Once this out-of-pocket maximum is met, covered expenses are payable at 100% of MAA for the remainder of the calendar year.

Eligible expenses within a family can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount ($6,000) to the family out-of-pocket maximum ($12,000).

Not all expenses count toward your medical out-of-pocket maximum. Among those that do *not* count are:

- Penalties;
- Expenses that exceed MAA;

- Prescription drug expenses (which apply toward the separate prescription drug out-of-pocket maximum); and
- Charges for services not covered under the plan.

To help you manage the high cost of prescription drugs, there is also a separate annual prescription drug out-of-pocket maximum. Once you reach the prescription drug out-of-pocket maximum $1,500 (individual)/$3,000 (family), the plan pays the full cost of prescription drug expenses for the remainder of the year.

In addition, expenses incurred when using in-network services count toward your out-of-network, out-of-pocket maximum.

Out-of-pocket maximum expenses do not cross-apply between in-network and out-of-network limits.

Preventive care

Each participant has a $250 annual credit toward all out-of-network wellness services. Thereafter, covered expenses are not subject to the deductible and expenses that exceed the $250 credit are covered at 60% of MAA. Preventive care services include:

- Routine physical exams: Well-child care and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines. For frequency guidelines, contact your Claims Administrator;
- Routine diagnostic tests: For example, CBC (complete blood count), cholesterol blood test, urinalysis;
- Well-child services and routine pediatric care;
- Routine well-woman exams;
- Routine cancer screenings;
- Routine vision exams; and
- Routine hearing exams.

In addition, the Oxford PPO will cover well adult and well child routine immunizations performed by out-of-network providers. Well adult and well child routine immunizations are covered 60% of MAA, with no deductible to meet.

Infertility

Treatment of infertility must be pre-authorized. Penalties may apply if the treatment is received without pre-certification. Contact the plan for details.

Hospital

Hospital care (inpatient and outpatient) will be reimbursed at 60% of MAA, after you meet your annual deductible. Coverage for room and board is limited to expenses for the regular daily charge made by the hospital for a semi-private room (or private room when medically appropriate or if it is the only room type available). Notification of an inpatient admission is required. Notification is recommended for certain outpatient procedures and services.

Emergency care

The emergency room copayment is $100 per visit. If you are admitted to the hospital for any condition, the copayment is waived.

Urgent care

Services provided by an urgent care center are covered at 80% for covered services after the deductible has been met.

Mental health/substance abuse: in and out-of-network

The Oxford PPO provides confidential mental health and substance abuse coverage through a network of participating counselors and specialized practitioners.

When you call the customer service telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help find the right provider for you. In an emergency, the intake coordinator will also provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call your plan before seeking treatment for mental health or substance abuse treatment.

Action (all visits are reviewed for medical necessity)	Inpatient	Outpatient
If you call the plan and use its network provider/facility	After the deductible, eligible expenses are covered at 80% of the negotiated rate; precertification required	After the deductible, eligible expenses are covered at 80% of the negotiated rate; precertification required for certain outpatient procedures
If you call the plan but do not use its network provider/ facility	After the deductible, eligible expenses covered at 60% of MAA; precertification required	After the deductible, eligible expenses covered at 60% of MAA; precertification required for certain outpatient procedures

Coverage levels

Mental health and substance abuse treatment benefits are subject to the plan's medical necessity requirements, coverage limitations, and deductibles.

Mental health benefits include, but are not limited to:

- Assessment, diagnosis, and treatment;
- Medication management;
- Individual, family, and group psychotherapy;
- Acute inpatient care;
- Partial hospitalization programs;
- Facility based intensive outpatient program services; and
- Psychological testing that is not primarily educational in nature.

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

Inpatient services

The Oxford PPO pays benefits at the in-network level (80% of the negotiated rate contracted with the Claims Administrator) if you call the plan, use an in-network provider, and the treatment is medically necessary and in the appropriate level-of-care setting. If you do not use an in-network provider, you will be reimbursed at 60% of MAA after the deductible is met provided that the treatment is medically necessary and in the appropriate level-of-care setting.

In general, inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless precertified in advance of the admission.

Outpatient services

You are encouraged to call the Oxford PPO for outpatient referrals. If you call and use the recommended provider, you will be reimbursed at 80% of covered expenses after the deductible is met. If you do not use the recommended provider, you will be reimbursed at 60% of MAA for covered services after the deductible is met.

Emergency care

Emergency care for mental health or substance abuse treatment does not require a referral. However you are required to call the Oxford PPO within 48 hours after an emergency admission. The Oxford PPO behavioral health providers are available 24/7 to accept calls.

Medically necessary

Oxford PPO will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The Behavioral Health department will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless the Behavioral Health department determines that the covered services and supplies are medically necessary. Please refer to the "Glossary" for the definition of medical necessity.

For more information about what your plan covers, see "Covered services and supplies" on page 129. You may also contact the plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Concurrent review and discharge planning

The following items apply if the Oxford PPO requires certification of any confinement, services, supplies, procedures, or treatments:

- **Concurrent review:** The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.
- **Discharge planning:** Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be used by the member upon discharge from an inpatient stay.

Clinical Trials for Cancer or Disabling or Life Threatening Chronic Disease

The Oxford Health PPO plan will cover the routine patient costs associated with a qualifying clinical trial for cancer or a disabling or life-threatening chronic disease.

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as Oxford determines, a clinical trial meets the qualifying clinical trial criteria stated below.

- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as Oxford determines, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as Oxford determines, a clinical trial meets the qualifying clinical trial criteria stated below. Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.
- Benefits are available only when the covered person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered health services for which benefits are typically provided absent a clinical trial.
- Covered health services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The experimental or investigational service or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with Oxford's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).

- A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
  - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
  - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. Oxford may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

Please remember, the covered service must be precertified.

High Deductible Health Plan (HDHP)

The HDHP, administered by Aetna and Anthem BlueCross BlueShield, covers the same services as ChoicePlan 500 (CP500). However, there are certain major differences between the plans.

- The HDHP provides flexibility and choice around how to spend your health care dollars. The HDHP is generally available at a lower premium cost, yet has higher deductibles.
- Prescription drugs count toward the individual/family deductible and out-of-pocket maximum. You do not need to meet a separate prescription drug deductible.
- Participating in the HDHP gives you access to different accounts than other plans.
- The HDHP is designed to be used in conjunction with a Health Savings Account (HSA), in which you contribute before-tax dollars to pay for your deductible and other eligible out-of-pocket expenses.
- HDHP participants are permitted to enroll in the Limited Purpose Health Care Spending Account (LPSA). Participants cannot enroll in the Health Care Spending Account (HCSA). Enrollment in an HCSA during the plan year disqualifies participants from making HSA contributions. This includes any credits contributed to an HCSA by Citi on your behalf.
- If you had an HCSA prior to a qualified change in status (for example, if an HCSA was established for you due to excess Live Well Rewards), then you are permitted to retain the HCSA, even if you elect an HDHP. However, the establishment of the HCSA precludes you from being eligible for the HSA for the remainder of the plan year.

When you enroll in the HDHP, you must be prepared to spend the amount of your individual or family deductible out of pocket before the plan will pay benefits for non-routine care. As a reminder, certain preventive services/medications and routine cancer screenings are covered in full when you use in-network providers. Generally, benefits cannot be paid from the HDHP until you meet the deductible.

The HDHP is self-insured; therefore, Citi pays the claims. The plan is not subject to state laws.

Note: If enrolled in any of the family coverage categories (any category other than Employee Only), the entire family deductible amount must be met before the plan will pay benefits. The out-of-pocket maximum also applies to all covered participants, not to any individual.

HDHP at a glance

Note: For in-network covered expenses, the plan pays a percentage of discounted rates while for out-of-network charges, the plan pays a percentage of the maximum allowed amount (MAA). See the Glossary for a definition of MAA, which is sometimes referred to as "Recognized Charges."

Type of service	In-network	Out-of-network
Annual deductible (in-network and out-of-network combined)		
> Single	> $1,800 > Includes prescription drug expenses	> $2,800 > Includes prescription drug expenses
> Family	> $3,600 > Includes prescription drug expenses	> $5,600 > Includes prescription drug expenses
Annual out-of-pocket maximum (includes deductible, medical/prescription drug coinsurance, and medical/prescription drug copayments)		
> Single	> $5,000 > Includes prescription drug expenses	> $7,500 > Includes prescription drug expenses
> Family[1]	> $10,000 > Includes prescription drug expenses	> $15,000 > Includes prescription drug expenses
Lifetime maximum	> None	> None
Professional care (in office)		
> PCP visits	> 80% after deductible[2]	> 60% of MAA after deductible[2]
> Specialist visits	> 80% after deductible[2] > Aetna: 90% after deductible[2] for Aexcel specialists	> 60% of MAA after deductible[2]
> Allergy treatment	> 80% after deductible[2]	> 60% of MAA after deductible[2]
Preventive care (subject to frequency limits)		
> Well-adult visits and routine immunizations > Well-child visits and routine immunizations	> 100%, not subject to deductible	> 100% of MAA, not subject to deductible

Type of service	In-network	Out-of-network
> Routine cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening)		
> Contraceptive devices	> 100%, not subject to deductible, for diaphragms and Mirena, an implantable device. All other implantable devices will be covered at 80% after deductible[2]	> 60% of MAA after deductible[2]
> Voluntary sterilization – including tubal ligation, sterilization implants and surgical sterilizations	> 100%, not subject to deductible. Male sterilization services (e.g., vasectomies) are covered at 80% after deductible[2]	> 60% of MAA after deductible[2]
Routine care (subject to frequency limits)		
> Routine vision exam	> 100%, not subject to deductible; limit one exam per calendar year	> 100% of MAA, not subject to deductible; limit one exam per calendar year
> Routine hearing exam	> 100%, not subject to deductible; limit one exam per calendar year	> 100% of MAA, not subject to deductible; limit one exam per calendar year
Hospital inpatient and outpatient		
> Semiprivate room and board, doctor's charges, lab, X-ray, radiology, and surgical care	> 80% after deductible[2]; precertification required for hospitalization and certain outpatient procedures and services	> 60% of MAA after deductible[2]; precertification required for hospitalization and certain outpatient procedures and services
Non-routine outpatient		
> Lab, X-ray, and radiology	> 80% after deductible[2]; precertification is required for certain outpatient procedures	> 60% of MAA after deductible[2]; precertification is required for certain outpatient procedures
Maternity care		
> Physician office visit	> 80% after deductible[2]	> 60% of MAA after deductible[2]
> Hospital delivery	> 80% after deductible[2]	> 60% of MAA after deductible[2]
Emergency care (no coverage if not a true emergency)		
> Hospital emergency room (includes emergency room facility and professional services provided in the emergency room)	> 80% after deductible[2]; precertification required if admitted	> 60% after deductible[2]; precertification required if admitted
> Urgent care facility	> 80% after deductible[2]	> 60% of MAA after deductible[2]

Type of service	In-network	Out-of-network
Emergency Transportation Services (no coverage when used as routine transportation to receive inpatient or outpatient services)		
	80% after deductible[2] **Anthem:** Pre-certification required for air transport	80% of MAA after deductible; pre-certification required for inter-facility transfers
Outpatient short-term rehabilitation		
Physical/occupational therapy (combined): Limited to 60 visits a year in-network and out-of-network combined; you may be eligible for additional visits with plan approval after a medical necessity review	> 80% after deductible[2] > 70% after deductible[2] for visits approved for medical necessity above plan limits	> 60% after deductible[2] > 50% of MAA after deductible[2] for visits approved for medical necessity above plan limits
Speech therapy: Limited to 90 visits a year in-network and out-of-network combined; you may be eligible for additional visits with plan approval after a medical necessity review	> 80% after deductible[2] > 70% after deductible[2] for additional visits above plan limits	> 60% after deductible[2] > 50% of MAA after deductible[2] for additional visits above plan limits
Other services		
> Infertility treatment	> Covered up to a $24,000 family lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. > 80% after deductible[2]; precertification required > Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum per family	> Covered up to a $24,000 family lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. > 60% after deductible[2]; precertification required > Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum per family
Prescription drugs (see the Prescription Drugs section)		
Mental health and substance abuse (see "HSA features" beginning on page 116)		

[1] The family deductible, as well as the family out-of-pocket maximum, can be satisfied as a family or by an individual within the family.

[2] The plan will pay this percentage of the cost after you first pay the full deductible of the plan. The deductible can be paid with after-tax dollars, such as cash or check, or with before-tax dollars if you have available funds in a HSA.

HDHP features

- Most covered in-network expenses are reimbursed at 80% of negotiated charges after the annual deductible has been met. Claims submitted by an out-of-network provider generally are reimbursed at 60% of maximum allowed amount (MAA) after the deductible has been met. **Note:** Only your deductible, coinsurance and any copayments — not the amount billed by the doctor/facility — is applied to your out-of-pocket maximum.
- Routine physical exams for adults and children and well-woman exams are covered at 100% when using in-network providers and 100% of MAA when using out-of-network providers with no deductible to meet.
- Cancer screenings are covered at 100% when using in-network providers and 100% of MAA when using out-of-network providers with no deductible to meet. Cancer screening tests are the Pap smear, mammography, sigmoidoscopy, colonoscopy, and PSA test. (Please note that skin cancer screenings are not covered at 100%)
- Other recommended preventive care services are covered at 100% when using in-network providers and 100% of MAA when using out-of-network providers with no deductible to meet.
- Prescription drugs are covered by the Citigroup Prescription Drug Program administered by Express Scripts. You first must meet your combined medical and prescription drug deductible before you can purchase prescription drugs at a retail in-network pharmacy and through the Express Scripts Home Delivery program for the plan's copayment or coinsurance, except as described in the bullet immediately following.
- You can purchase certain preventive care medications for a copayment or coinsurance *before* the deductible is met. Copayments/coinsurance count toward your out-of-pocket maximum. For a list of preventive medications, visit the Express Scripts' website. If you are a participant in a medical plan with prescription drug coverage through Express Scripts, visit **www.express-scripts.com.**
- The plan has no lifetime maximum benefit other than for infertility coverage and travel and lodging expenses related to transplant services.

How the plan works

This section contains more detailed information about HDHP's provisions and how this medical plan works.

You have a choice of using in-network providers or out-of-network providers. Using in-network providers saves you money in two ways. First, in-network providers charge special, negotiated rates, which are generally lower than the MAA. Second, the level of reimbursement for many services is higher when you use an in-network provider.

A directory of network providers is available directly from the Claims Administrator.

- Aetna: **www.aetna.com**; select the Aetna Open Access, Choice POSII Open Access Plan or call **1-800-545-5862**
- Anthem BlueCross BlueShield: **www.anthem.com**; select the PPO or call **1-855-593-8123**

Deductible and coinsurance

You must meet an annual deductible of $1,800 for individual (employee only) coverage or $3,600 for family (two or more in a family) before the plan pays any benefits, unless the service is covered at 100%, such as preventive care.

The deductible applies to all covered expenses except preventive care and must be met each calendar year before any benefits will be paid. Whether you visit an in-network provider or an out-of-network provider, your costs count toward both deductibles.

Other than for services not subject to the deductible, any one or a combination of family members must meet the full family deductible before the plan pays any benefits. There is no individual limit within the family deductible limit. The deductible can be met as follows:

- **In-network**
  - **Employee only:** The individual deductible of $1,800 applies.
  - **Two or more in a family:** The $3,600 family deductible applies, one or a combination of all family members must meet the full family deductible before the plan pays any benefits.
  - **Note:** Once you have met the deductible, the plan normally pays 80% of the negotiated rate for covered health services if you or your covered dependent uses an in-network hospital/provider.
- **Out-of-Network**
  - **Employee only:** The individual deductible of $2,800 applies.
  - **Two or more in a family:** The $5,600 family deductible applies, one or a combination of all family members must meet the full family deductible before the plan pays any benefits.
  - **Note:** Expenses are normally reimbursed at 60% of MAA for claims for covered services submitted for an out-of-network provider. Providers may balance bill you for the charges above MAA, and you are responsible for those charges.

Deductible expenses cross-apply between in-network and out-of-network limits.

Out-of-pocket maximum

Your out-of-pocket maximum is $5,000 individual/$10,000 family (out-of-network $7,500/individual and $15,000/family). The amount includes the $1,800/individual and $3,600/family (out-of-network $2,800/$5,600) deductible, coinsurance and any medical copayments. This represents the most you will have to pay out of your own pocket in a calendar year.

Only your deductible, coinsurance amount, and any applicable medical copayments – not the amount billed over MAA by your doctor or facility – is applied to your out-of-pocket maximum. The maximum can be met as follows:

- **Employee only**: $5,000 (out-of-network $7,500)
- **Two or more in a family:** The $10,000 (out-of-network $15,000) family out-of-pocket maximum applies. There is no individual out-of-pocket maximum within the family out-of-pocket maximum. Eligible expenses can be combined to meet the family out-of-pocket maximum, which means that one or a combination of all family members must meet the full family out-of-pocket maximum

Once this out-of-pocket maximum is met, covered expenses are payable at 100% of the negotiated rate (or of MAA) for the remainder of the calendar year. However, the plan does not cover the amount over MAA. You can still be billed for that amount and are responsible for paying that portion.

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are:

- Expenses that exceed MAA;
- Charges for services not covered under the plan, and
- Any expense that would have been reimbursed if you had followed the notification requirements for care.

Out-of-pocket expenses cross-apply between in-network and out-of-network limits.

Preventive care

Covered expenses are not subject to the deductible and are covered at 100% when using in-network providers or 100% of MAA when using out-of-network providers.

Preventive care services include:

- Routine physical exams: Well-child care and adult care, performed by the patient's provider at a frequency based on American Medical Association guidelines or as directed by the provider. For frequency guidelines, call the Claims Administrator;
- Routine diagnostic tests: For example, CBC (complete blood count), cholesterol blood test, urinalysis; and
- Routine well-woman exams.

In addition, the plan will cover cancer-screening tests, well-adult immunizations and well-child care and immunizations at 100%. Cancer screenings are:

- Pap smear performed annually;
- Mammogram;
- Sigmoidoscopy;
- Colonoscopy; and
- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older.

Preventive care services covered in the network at 100% will be reviewed annually and updated prospectively to comply with recommendations of the:

- United States Preventive Care Task Force;
- Advisory Committee on Immunization Practices that have been adopted by the director of the Centers for Disease Control and Prevention; and
- Comprehensive Guidelines Supported by the Health Resources and Services Administration.

For more information on what is considered preventive care, see "Preventive care" on page 68.

Routine care

Routine health screenings are covered at:

- 100%, not subject to deductible; and
- 100% of the MAA, not subject to deductible (for care received from an out-of-network provider)

The annual deductible does not apply to routine care. However, routine care is subject to the following limits:

- **Routine vision exam:** Limited to one exam per calendar year; and
  - **Aetna**: covered expenses include a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam.
- **Routine hearing exam:** Limited to one exam per calendar year.

Aetna: covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A physician certified as an otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

To be sure your claim for a routine exam is paid properly, ask your physician to indicate “routine exam” on the bill. If a medical condition is diagnosed during a routine exam, your claim for a routine exam still will be paid as explained above, provided the bill is marked “routine exam.”

Hospital

After you meet your annual deductible, hospital care (inpatient and outpatient) will be reimbursed at:

- 80% for care received from an in-network provider; or
- 60% for care received from an out-of-network provider.

Precertification of an inpatient admission is required. Precertification is also recommended for certain outpatient procedures and services.

Aetna: Precertification requirements apply to both inpatient care and partial hospitalizations.

Emergency care

After you meet your annual deductible, emergency care will be reimbursed at 80% for care received from both in-network and out-of-network providers.

Non-emergency services provided in an emergency room are not covered.

Aetna: When emergency care is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your physician provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify your physician as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur.

Urgent care

Urgent care centers will be reimbursed at:

- 80% of the negotiated rate (after the deductible is met) for care received from an in-network provider; or
- 80% of MAA (after the deductible is met) for care received from an out-of-network provider

Aetna: Call your PCP if you think you need urgent care. You may contact any physician or urgent care provider, in- or out-of-network, for an urgent care condition if you cannot reach your physician. If it is not feasible to contact your physician, please do so as soon as possible after urgent care is provided. In-network providers are required to provide urgent care coverage 24 hours a day, including weekends and holidays. If you need help finding an urgent care provider you may call Member Services at the toll-free number on your

I.D. card, or you may access Aetna's online provider directory at **www.aetna.com**. Follow-up care is not considered an emergency or urgent condition and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care.

Anthem BCBS: When available, Anthem uses MAA when determining plan payment for an out of network provider. In the absence of MAA data, Anthem may calculate payment based on billed charges.

Aetna Aexcel specialists

Aexcel is a designation within Aetna's network that includes specialists who have demonstrated effectiveness in the delivery of care based on defined measures of clinical performance and cost-efficiency. Currently, there are Aexcel-designated physicians in 12 medical specialty categories: Cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics and gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, urology, and vascular surgery.

Aexcel-designated specialists are currently available to members in AZ, CA, CO, CT, DC, DE, FL, GA, IL, IN, KS, KY, MD, MA, ME, MI, MO, NJ, NV, NY, OH, OK, PA, TX, VA, and WA.

When you visit an Aexcel specialist you do not need a referral. The plan will pay 90% of covered expenses after your deductible for Aexcel specialists. To find an Aexcel specialist visit, **www.aetna.com/docfind**; select the Aetna Standard Plans, Aetna Select, and look for the providers listed with the blue star. This blue star identifies the Aexcel specialists.

Mental health/substance abuse

The Aetna/Anthem BlueCross BlueShield HDHP provides confidential mental health and substance abuse coverage through a network of participating counselors and specialized practitioners.

When you call the Claims Administrator at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help find the right provider for you. In an emergency, the intake coordinator will also provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call before seeking treatment for mental health or substance abuse treatment.

Action (all visits are reviewed for medical necessity)	Inpatient	Outpatient
If you call the plan and use its network provider/facility	After the deductible, eligible expenses covered at 80% of the negotiated rate	After the deductible, eligible expenses covered at 80% of negotiated rate
If you call the plan but do not use its network provider/facility	After the deductible, eligible expenses covered at 60% of MAA	After the deductible, eligible expenses covered at 60% of MAA

Coverage levels

Mental health and substance abuse treatment benefits are subject to the same medical necessity requirements, coverage limitations, and deductibles that are required under the HDHP.

Mental health benefits include, but are not limited to:

- Assessment, diagnosis, and treatment:
- Medication management;
- Individual, family, and group psychotherapy;
- Acute inpatient care;

- Partial hospitalization programs;
- Facility-based intensive outpatient program services; and
- Psychological testing that is not primarily educational in nature.

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

Aetna: In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a physician or licensed provider; and
- The treatment plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office.

Inpatient services

You *must* call the Claims Administrator to give notification of inpatient services. Inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. After you meet your deductible, inpatient stays are covered at 80% of the negotiated rate when you use an in-network provider or 60% of MAA if you use an out-of-network provider. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by the Claims Administrator in advance of the admission.

Aetna: Benefits are payable for charges incurred in a hospital, psychiatric hospital, or residential treatment facility. Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting. Covered expenses also include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

Outpatient services

You are encouraged to call the Claims Administrator for outpatient referrals. If you call and use the recommended provider, you will be reimbursed at 80% of covered expenses after the deductible is met. If you do not use an in-network provider, you will be reimbursed at 60% of MAA for covered services after the deductible is met.

Aetna: covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility. The plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Emergency care

Emergency care for mental health or substance abuse treatment does not require a referral. However you are encouraged to call the Claims Administrator within 48 hours after an emergency admission. The behavioral health provider is available 24/7 to accept calls.

Medically necessary

The Claims Administrator will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The Claims Administrator will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless the Claims Administrator determines that the covered services and supplies are medically necessary. See the "Glossary" for the definition of medical necessity.

For more information about what your plan covers, see "Covered services and supplies" on page 129. You may also contact your plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Health Savings Accounts (HSAs)

An HSA is used in conjunction with a qualified High Deductible Health Plan (HDHP).

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

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

To establish an HSA, you must:

- Be covered under the HDHP;
- Have no other health coverage except what is permitted under "other health coverage";
- Not be enrolled in Medicare part A & B or Medicaid; and
- Not be claimed as a dependent on someone else's tax return.

You may visit Citi's on-site medical clinics for preventive care and allergy injections (if you supply the allergy medication)/visits; to obtain non-prescription pain relievers; and as a result of an accident at work. If you established an HSA, you may *not* use Citi's on-site medical clinics for treatment when sick. Use of on-site medical clinics for reasons other than those noted in this paragraph would be considered "impermissible medical coverage."

Citi will contribute to your HSA if:

- You enroll in the HDHP for 2015;
- Open a Citi HSA administered by ConnectYourCare;
- Accept the terms of an HSA through Your Benefits Resources™; and
- Satisfy Citi's policies and procedures required to establish an HSA.

The annual contribution amounts are based on your medical plan coverage category and when you establish an HSA. Amounts paid are up to $500 for Employee Only coverage and up to $1,000 for any other coverage category. Citi's contribution is paid on a quarterly basis. Your HSA must be established by the following dates for you to be eligible for the Citi quarterly contributions.

Details of the deadlines to receive Citi's contribution to your HSA are below:

Deadline to receive Citi's quarterly contribution		Citi's contribution for Employee Only coverage	Citi's contribution for Employee + Spouse/ Children/Family coverage
Q1	4:00 p.m. EST on 12/31/14	$125	$250
Q2	4:00 p.m. EST on 3/31/15	$125	$250
Q3	4:00 p.m. EST on 6/30/15	$125	$250
Q4	4:00 p.m. EST on 9/30/15	$125	$250

Note: To receive Citi's quarterly contribution, you must establish an HSA by accepting the terms and conditions, and satisfying Citi's policies and procedures requirements by the deadlines listed above.

The maximums that you can contribute to an HSA for 2015 are:

> $3,350[1] for an eligible individual with employee only coverage, and

> $6,650[2] for an eligible individual enrolling in any other coverage category.

[1] Includes Citi's annual employer contribution of up to $500, if you open an HSA through ConnectYourCare.

[2] Includes Citi's annual employer contribution of up to $1,000, if you open an HSA through ConnectYourCare.

Under federal law, individuals who are 55 or older by December 31, 2015, can make a catch-up contribution of an additional $1,000 for 2015 and each year going forward.

If you do not enroll in the HDHP, by law you cannot establish an HSA.

Funds are available in the HSA once they have been contributed. This is different from the HCSA where your entire elected contribution amount is available for reimbursement at the beginning of the plan year.

HSA features

> You "own" your HSA; your account is portable.

> Contributions to an HSA can be made by individuals, employers, or both.

> Contributions (subject to limits) can be changed at any time as long as you continue to be enrolled in a qualified HDHP

> Contributions (subject to limits) and earnings are tax-free under federal and many state income tax laws.

> Withdrawals (to pay for qualified medical, dental, and vision expenses, as determined by the Internal Revenue Code (the "Code") are tax-free under federal and many state income tax laws.

> Withdrawals can be used to pay for qualified medical, dental, and vision expenses, as determined by the Code, for you and your tax dependents.

> You do not forfeit funds that you do not use by year-end. Instead, HSA funds remaining in your account will roll over to the following year.

> However, you will pay a penalty of 20% on the disbursed amount that are not used for qualified health care expenses, or health care expenses for dependents not considered as tax dependents under Section 152 of the Code

Note: The HSA is not part of the Citigroup medical plans or any other employee benefit plan sponsored by Citi.

The HSA and the LPSA

If you enroll in the HDHP and make tax-free contributions to an HSA you cannot participate in a HCSA. *HCSA enrollment is considered "impermissible medical care coverage" and disqualifies your contributions to an HSA. This includes any Rewards contributed to a HCSA by Citi on your behalf, in connection with the Live Well at Citi Program.*

According to IRS regulations, if you enroll in the HDHP you can enroll in the LPSA to reimburse yourself for eligible expenses such as those for vision, dental, and preventive medical care. You may also enroll in an LPSA if you enrolled in the HDHP but are not enrolled in an HSA.

An LPSA works like an HCSA, except only certain types of expenses are eligible for reimbursement. See the "LPSA" section in the Spending Accounts section for more information.

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

Fully insured health maintenance organizations (HMOs)

Citi has entered into fully insured arrangements with numerous HMOs to provide health benefits to eligible employees. Although HMOs generally deliver benefits in the same way, the coverage that each HMO provides differs from the others.

This section provides a description of the medical benefit information available to HMO participants and should be read together with the Eligibility and participation section, the Administrative information section, and the HMO Certificate of Insurance listed under "2015 insured HMOs". There is a separate HMO Certificate of Insurance for each fully insured HMO.

- Eligibility and participation and Administrative information provide information about eligibility and enrollment for you and your dependents, coordination of benefits, your legal rights, your contributions, and other administrative details.
- HMO Certificates of Insurance provide detailed information about the benefits and coverage available through each HMO. For example, the Certificate of Insurance will generally provide you with information concerning:
  - The nature of services provided to members, including all benefits and limitations;
  - Conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility to participate in the HMO) and circumstances under which services may be denied; and
  - The procedures to be followed when obtaining services and the procedures available for the review of claims for services that are denied in whole or in part.

The HMO will send a Certificate of Insurance and a provider directory to you at your home upon enrollment in the HMO. If you do not receive your Certificate of Insurance, call your HMO at the telephone number listed under "2015 insured HMOs" or on your ID card.

For a list of the HMOs offered by Citi and the Certificate of Insurance for each HMO, see "2015 insured HMOs". The HMOs available to you will depend on your home zip code.

Note: Citi offers the opportunity to join an insured HMO. The actual coverage provided by the HMO is the HMO's responsibility. Citi does not guarantee or have any responsibility for the quality of health care or service provided or arranged by the HMO. Citi is not responsible for medical expenses that are not covered services under the HMO. HMO participants have the right to choose their own health care professionals and the services they receive under the HMO.

Be sure to check directly with the HMO prior to enrolling to ensure that you fully understand the provisions of the HMO.

If you have questions about coverage, providers, or using an HMO, call the HMO directly at the telephone number listed under “2015 insured HMOs”. This number can also be found on your HMO ID card, if you are a member of that HMO.

All the materials described above make up the Plan Document for Citi’s fully insured HMOs. The Plan Document is intended to comply with the requirements of ERISA and other applicable laws and regulations. This HMO Plan Document does not create a contract or guarantee of employment between Citi and any individual.

Typical plan design features of an HMO offered by Citi

You must use in-network providers. If you do not use participating providers — except in an emergency — the HMO will not cover that care, and you will be responsible for paying the full cost of that care.

You must choose a primary care physician (PCP) from the list of providers before obtaining any medical services. You may also choose a pediatrician as the PCP for your child. Women may also select an OB/GYN without a referral from their PCP.

Your deductible is $500/individual and $1,000/family maximum. After meeting your deductible, the HMO will pay covered services at 80% while you will pay 20% (your coinsurance). Your annual out–of-pocket maximum is $3,000/individual and $6,000/family maximum.

Each HMO offers prescription drug coverage. Contact the HMO for the name of the prescription drug benefits manager.

Preventive care is covered at 100% without having to meet the deductible.

Routine vision exams are covered at 100% in all HMOs except Coventry Health Care of Iowa, Health Plan Hawaii Plus (HMSA), and Kaiser Hawaii.

As a reminder, benefits vary depending on the HMO.

For more information, review the Certificate of Insurance or call your HMO.

If you have questions or concerns about specific covered services, call the HMO in which you are enrolled directly. Visit “2015 insured HMOs” on page 120 for information HMO contact information.

PCPs

In general, as a participant in an HMO, your PCP provides and coordinates all of your in-network care. In most cases, if you need to visit a specialist, your PCP will refer you to in-network specialists and facilities. Consult your PCP whenever you have questions about your health.

Many HMOs will require each covered family member to select a PCP. You will find PCPs listed in the HMO’s provider directory, which are listed under “2015 insured HMOs”. Generally, if you do not choose a PCP, one will be selected for you until you select one.

Your options for choosing a PCP depend on the HMO you select. For instance, your PCP could be a general practitioner, an internist, or a family practitioner. You may choose a pediatrician as your child’s PCP. In addition to choosing a PCP for other health care needs, women may select a gynecologist without a referral from their PCP for their routine gynecological checkups.

Specialists

When you need a specialist, most HMOs will require you to obtain a referral from your HMO or the services will not be covered. With most HMOs, your PCP is responsible for providing these specialist referrals. Certain services may require both a referral from your PCP and pre-certification from your HMO. Your PCP may help to coordinate any required authorizations.

If your HMO requires a referral and you visit a specialist without one, you may be responsible for the full cost of your care. Generally, you cannot request referrals after you have received the care, except in emergencies. You should contact the HMO directly or see the HMO’s Certificate of Insurance for a detailed explanation of the referral procedures.

Routine care

Most HMOs cover preventive care services and health screenings. Such services may include:

- Routine physical exams, including well-child care and adult care;
- Routine health screenings, including gynecological exams, mammograms, sigmoidoscopy, colonoscopy, and PSA (prostatic-specific antigen) screenings;
- Routine vision exams; and
- Routine hearing exams.

Hospital care

Generally, hospital care — both inpatient and outpatient — requires a copayment or coinsurance. If you use an in-network provider or lab, but are not referred by your HMO, you may be required to pay for the services. Generally, hospital services require advance approval from the HMO. Your PCP may help to coordinate the approval.

See the HMO Certificate of Insurance listed under “2015 insured HMOs” for more information about hospital coverage.

Maternity care

Most HMOs cover physician and hospital care for both the mother and the newborn child, including prenatal care, delivery, and post-natal care. Generally, you will need a referral for your first visit to a participating obstetrician. However, you will not need a referral for the remaining visits during your pregnancy.

The mother and the newborn child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery and 96 hours following a cesarean section. Some HMOs provide coverage for home health care visits if your doctor determines that you and your child may be safely discharged after a shorter stay.

The 48/96-hour minimum stay after childbirth is required by federal law. State laws may provide additional requirements for maternity coverage. See the HMO Certificate of Insurance listed under “2015 insured HMOs” for more information about maternity coverage.

Call the Citi Benefits Center through ConnectOne within 31 days of the child’s birth to add your newborn child to your coverage. The health plans will not cover the child after 31 days. Call **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.

Emergency care

Benefits are always available in a medical emergency, whether you use in-network or out-of-network providers. A medical emergency is generally defined as a sickness or injury that, without immediate medical attention, could place a person’s life in danger or cause serious harm to bodily functions.

If you have a true medical emergency, you should go to the nearest emergency facility. Most HMOs require you to contact your PCP or the HMO within certain time limits, generally 48 hours. If you are unable to do this, you should have a family member contact your HMO.

Most HMOs require a copayment for each emergency room visit. If you are admitted to the hospital, the copayment is generally waived. Non-emergency services provided in an emergency room are not covered.

See the HMO Certificate of Insurance “2015 insured HMOs” for more information, including your HMO’s definition of a true medical emergency.

Benefit limits

Covered services, exclusion, and limitations vary by HMO. Check with the HMO prior to enrolling to ensure that you fully understand the provisions of the HMO.

2015 insured HMOs

The following fully insured HMOs are offered by Citi for 2015 in each state. The inclusion of an HMO in a state list does not mean that the option is available throughout the state. Your eligibility to participate in one of the HMOs offered is based on your home zip code. You can determine whether the HMO is available where you live by contacting the HMO.

To view the Certificate of Insurance, please click on the HMO plan name in the chart below. For more information on plan coverage details, contact your HMO.

HMO	Contact information
Coventry Health Care of Iowa	> **1-800-257-4692** > **www.chciowa.com**
Geisinger Health Plan (Pennsylvania)	> **1-800-447-4000** > **1-800-631-1656** (annual enrollment information) > **www.thehealthplan.com**
Health Plan Hawaii Plus (HMSA)	> **1-808-948-6372** > **1-808-948-5060** (annual enrollment information) > **www.hmsa.com**
SelectHealth (Utah and part of Idaho)	> **1-800-538-5038** > **www.selecthealth.org**
Independent Health (upstate New York)	> **1-800-501-3439** > **1-800-453-1910** (annual enrollment information) > **www.independenthealth.com**
Kaiser FHP of California - Northern	> **1-800-464-4000** > **http://my.kp.org/citigroup**
Kaiser FHP of California - Southern	> **1-800-464-4000** > **http://my.kp.org/citigroup**
Kaiser FHP of Colorado	> **1-800-632-9700** > **http://my.kp.org/citigroup**
Kaiser FHP of Georgia	> **1-888-865-5813** > **http://my.kp.org/citigroup**
Kaiser FHP of Hawaii	> **1-808-432-5955** > **1-800-966-5955** (annual enrollment information) > **http://my.kp.org/citigroup**
Kaiser FHP of the Mid-Atlantic States	> **1-301-468-6000** > **1-800-777-7902** (annual enrollment information) > **http://my.kp.org/citigroup**
Sanford Health Plan (South Dakota, North Dakota, parts of Minnesota and parts of Iowa)	> **1-800-752-5863** > **www.sanfordhealthplan.com**

Live Well Chronic Condition Management Programs

If you are enrolled in a medical plan through Citi, you may be eligible to participate in a Live Well Chronic Condition Management Program through your medical carrier. The information that follows provides an overview of the available programs. Please contact your carrier for more details.

Aetna

The Disease Management Program is included in Aetna health benefits and insurance plans. The Disease Management Program has support for more than 35 conditions, including diabetes, heart disease, cancer, low back pain and digestive conditions. It helps you to:

> Manage your condition

> Lower your risks for new conditions

> Work better with your doctor

> Take your medicine safely

> Find helpful online and community resources

If you enroll in the Disease Management Program upon invitation, you will work directly with an Aetna nurse, who acts as a personal health coach through the program. Support is also available through online wellness programs. Aetna will manage your care through your Personal Health Record and notify you of any errors or gaps in your care.

> Depending on your situation, you may receive a call or letter from Aetna.

Anthem BlueCross BlueShield

The Anthem BlueCross BlueShield disease management program helps you maintain your health, improve your health outcomes and control health care expenses associated with the following prevalent conditions:

> Asthma (pediatric and adult)

> Diabetes (pediatric and adult)

> Heart failure

> Coronary artery disease

> Chronic obstructive pulmonary disease

The Integrated Health Model (IHM)

The Integrated Health Model (IHM) offers personalized one-on-one support from a trained health professional who is dedicated to your needs. You can call your personal health consultant directly for questions about your family's health, assistance with setting health goals or help with a serious health concern. Your personal health consultant will also connect you to targeted programs and services that provide education, guidance and coaching for improved health outcomes.

Anthem Health Guide

Anthem Health Guide makes getting answers to your customer service and health-related questions easy and efficient. You can reach Anthem associates in the way that's most convenient for you – whether by telephone, online chat or secure email, or even by requesting a call back. Anthem will provide information and consultation, and will directly connect you to resources like health coaches, case managers or in-network doctors. Our goal is to guide you and your family to better health.

Oxford

Active Care Engagement (ACE)

The Active Care Engagement (ACE) program can give you and your doctor information to assist you in the management of conditions that may adversely affect your health. Registered nurses will provide education and coaching over the phone. You may also receive educational materials in the mail. If you prefer to receive materials by email, you can access these materials and other tools electronically at **www.iembracehealth.com**.

Through the program, you can:

- Learn more about your condition
- Understand your symptoms
- Better manage your prescription medications

A nurse will call you to verify your diagnosis and qualifications for the program. The nurse will tell you about the program and answer your questions. The program has three divisions:

Better Breathing®

If you or one of your covered dependents is diagnosed with asthma, you may be eligible to participate in the Better Breathing program. The Better Breathing program aims to help covered individuals learn more about asthma, the medications used to treat it, monitoring devices, and how a healthy lifestyle can help keep asthma under control. If you participate, you'll receive educational materials and, upon request, can also receive supplies like spacers and peak flow meters.

Heart Smart℠

If you have cardiovascular disease (CVD) or congestive heart failure (CHF), the Heart Smart program help you understand and improve your health and quality of life. The CVD component of the program addresses your health needs if you are at risk for CVD or have experienced a CVD-related event. The CHF component of the program addresses your immediate and long-term needs if you have CHF. Educational materials about hypertension, cholesterol management, and lifestyle modification, including smoking, diet and exercise are also available.

Living with Diabetes℠

If you or someone in your family is diagnosed with diabetes, you may be eligible to participate in the Oxford Living with Diabetes program. Educational materials are available, as well as additional support, depending upon the severity of the condition. If you or one of your dependents is newly diagnosed, you can receive a diabetes self-help guide and, upon request, can also receive healthy living resources.

Rare Chronic Care Program

Oxford's Rare Chronic Care Program is offered to empower members to successfully manage their chronic illness through education and symptom management. The program encourages compliance with the physician's care plan (medications, tests, diet) and helps to reduce emergency visits and acute admissions. The program focuses on focuses on members with the following conditions:

- Multiple Sclerosis
- Hemophilia
- Cystic Fibrosis
- Myasthenia Gravis
- Lupus

Members are assigned to a personal disease management nurse who coordinates all the member's services with a nurse case manager and social worker. Through nurses who provide education and intervention by phone, this program offers:

- Disease-specific risk assessments conducted quarterly (includes depression screen)
- Notification to Member's physician of health status changes
- Symptom management instruction and general wellness education
- Case management, including discharge planning

Centers of Excellence (COEs)

Centers of Excellence are top-rated facilities that meet or exceed rigorous, evidence-based criteria established in collaboration with expert physicians and medical organizations. These facilities demonstrate a history of achieving faster recovery times and better expected outcomes. Because facilities must reapply for the designation on a regular basis, you can be sure they provide consistently high-quality care. And high-quality care is more cost-effective care, because you'll experience fewer complications from your treatment.

Centers of Excellence are equipped to deliver complex medical care in specialties such as bariatric, orthopedic and transplant services.

If you enroll in a medical plan through Aetna, Anthem BlueCross BlueShield or Oxford, you'll have access to Centers of Excellence for certain conditions.

Aetna

The Institutes of Excellence (IOE) transplant network is Aetna's national network of facilities for transplants and transplant related services. Hospitals that have been selected to participate in Aetna's IOE transplant network have met enhanced quality thresholds for volumes and outcomes. Facilities have been contracted on a transplant specific basis and are considered to be participating only for the specific transplants for which they are contracted and have IOE designations.

The IOE transplant network was established to enhance quality standards and lower the cost of transplant care. Three criteria were applied with respect to network selection,

- Enhanced organ-specific quality standards;
- The national availability of and need for transplant facilities, on a transplant specific basis. Need was assessed relative to the distribution of our membership and relative incidence of transplant types; and
- Mutually acceptable contractual terms and conditions.

Transplants represent highly specialized care delivered by a limited number of providers who have expertise in performing these procedures. By utilizing an IOE transplant facility, you will be receiving treatment from a provider that has demonstrated experience and success in their specific transplant type. Facilities in the IOE transplant network meet Aetna quality standards for volumes and outcomes. IOE facilities also meet Aetna access standards and agree to mutually acceptable contractual terms and conditions.

Anthem BlueCross BlueShield

Anthem Blue Cross and Blue Shield, in partnership with the Blue Cross and Blue Shield Association, has developed 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

The hospitals that are named as Blue Distinction Centers are chosen for a few reasons. They are known for their expert health care team, the number of times they have performed a procedure and their track record for results in specialized care. When you make important health care choices with your doctor, having access to the Blue Distinction Centers and Blue Distinction Centers+ makes these choices easier.

All Blue Distinction Centers offer quality specialty care. However, the new Blue Distinction Centers+ are honored for how cost effectively they provide care.

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

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

If a provider listed is a Blue Distinction Center, you will find a Blue Distinction recognition/award in the Quality Snapshot next to the provider’s name.

Oxford

Oxford’s transplant services are built upon a network comprised of Centers of Excellence facilities that meet high quality criteria. Oxford invests resources to identify and qualify the programs that have delivered superior outcomes at cost-effective rates.

Transplant Access Program (TAP) providers

The TAP program provides an extension of the COE network to help ensure network access, delivering the same financial rates; however, they do not meet the same high clinical criteria required for a COE. The transplants are inclusive of evaluation and transplant admission including hospital, physician and organ procurement, blood and marrow harvest, and pre-transplant/post-transplant care.

Extra contractual services

Extra Contractual Services are available on a case-by-case basis when a patient referral falls outside of both the transplant COE network and TAP network.

Transplant clinical management

Transplant clinical management works to reduce costs by helping you avoid inappropriate transplants, reducing re-transplants, identifying Medicare-eligibility and assisting in making informed decisions about transplant care through:

- Treatment education
- Centers of Excellence education and referrals
- Considerations in choosing where to get care
- Assistance in navigating the health care system, and
- Transplant medical director support.

OptumHealth’s Managed Infertility Program Centers of Excellence (COE) Network

Composed of 12 facilities, this network grants most members access to a facility within 30 miles of their location. For a list of participating facilities, call the Managed Infertility program at **1-877-512-9340**.

Other health management programs

If you are enrolled in a medical plan through Citi, you may be eligible to participate in a variety of health management programs through your medical carrier. The information that follows provides an overview of the available programs. Please contact your carrier for more details.

Aetna

Teladoc — Doctors On Demand

Teladoc provides access to a national network of U.S. board-certified doctors and pediatricians who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations. Teladoc does not replace the existing primary care physician relationship, but enhances it as a convenient, affordable alternative for medical care.

You pay a $40 copay subject to the deductible per Teladoc phone or video consultation with a physician. After the deductible has been met, you will pay 20% of the consult, or $8, per consult. Charges for phone or video consultations with a physician and/or other provider who is not contracted with Aetna's Teladoc service are excluded. For more information, visit www.teladoc.com[⊥] .

Personal Health Record

Employees and covered family members enrolled in a medical program with Aetna have access to a Personal Health Record, which scans your information and compares it to the latest medical guidelines to identify potential problems and send you alerts.

When you visit the doctor, have a test or fill a prescription, the claims information gets populated automatically into your Personal Health Record. You can add important information yourself too, such as:

- Family health history
- Immunizations
- Doctors
- Allergies
- Blood pressure, weight, blood sugar and cholesterol numbers
- Tests, procedures and more

There are several ways the tool can help you:

- **Share it with your doctor**. The "home page" of your Personal Health Record is the Health Summary. It's your health information at a glance. You can decide what to share with your doctor. You can print out your Health Summary, take it with you to your doctor, or share it securely online before your visit.
- **Keep track of when you are due for important checkups**. It can help remind you when to get preventive screenings like a mammogram or colonoscopy.
- **Track important health numbers**. See how your blood pressure, blood sugar, weight and other health markers change over time in clear, easy-to-understand graphs and charts.
- **Manage your family's health information**. The Personal Health Record is available to employees who enroll in an Aetna health benefits or health insurance plan. Covered family members have their own Personal Health Records. As the plan subscriber, you can access and add information to their Personal Health Records — as long as they are under age 18. You can give your covered spouse this access, too.

To get started, visit **www.aetna.com** and create a user name and password on the Aetna Navigator® website. Then go to the Health Records tab and click on Personal Health Record.

Beginning Right

Beginning Right is a maternity management program available to Aetna members that can be used throughout your pregnancy and after your baby is born. You'll get information on:

- Prenatal care
- Preterm labor symptoms
- What to expect before and after delivery
- Newborn care and more

All program materials are in English and Spanish. Translation services are also available in over 170 languages.

If you have health conditions or risk factors that could impact your pregnancy, you can work with a nurse case manager to help lower those risks. If eligible, you also get:

- Two follow-up calls after your delivery
- A screening for depression
- Extra support, if needed

Beginning Right also offers a Smoke-Free Moms-to-Be® program, where you'll get one-on-one nurse support to help you quit smoking for good.

To access the program, call **1-800-CRADLE-1 (1-800-272-3531)**, weekdays from 8 a.m. to 7 p.m., ET, or log in to Aetna Navigator at **www.aetna.com** and look under Health Programs.

Aetna In Touch Care℠

Aetna's In Touch Care program gives you direct phone access to a registered nurse. Through this program, one nurse is assigned to you and any family members. This care is also available online. To register, visit **www.aetna.com**.

Anthem BlueCross BlueShield

LiveHealth Online — Doctors On Demand

LiveHealth Online provides access to a national network of U.S. board-certified doctors and pediatricians who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations. LiveHealth Online does not replace the existing primary care physician relationship, but enhances it as a convenient, affordable alternative for medical care.

For 2015, you pay $49 per LiveHealth Online phone or video consultation with a physician until the deductible is met. After that, you pay $9.80 per consultation. Once you meet the annual out-of-pocket maximum, consultations are covered in full for the remainder of the year. Charges for phone or video consultations with a physician and/or other provider who is not contracted with Anthem's LiveHealth Online service are excluded. In most states, the physician can e-prescribe medications for you after a LiveHealth Online consultation if needed. For more information, visit **www.livehealthonline.com**.

Complex Case Management

The Anthem BlueCross BlueShield Complex Case Management program helps you control your health care expenses through proactive outreach. If you are managing a condition such as cancer, multiple congenital anomalies, or significant orthopedic, cardiology, or neurological-related conditions, the Complex Case Management team will contact you to assist with your care and managing your treatment.

Maternity Management

If you or one of your dependents is pregnant, the Maternity Management program can help you develop a guided course of care and treatment.

Neonatal Intensive Care Unit (NICU)

The program consists of inpatient, post-discharge and extended outpatient management by a NICU case manager with neonatal and/or pediatric nursing experience.

Transplant

If you're identified as a potential (or actual) transplant candidate, you will be referred to the transplant team. The transplant nurse will manage all of your care (inpatient, outpatient, home care, discharge planning, etc.) from the day of approval through six months post-transplant.

Behavioral Health Resource

Behavioral Health Resource includes a 24/7 Resource Center for you to call for assistance at any time, with care management programs for behavioral health and depression.

ConditionCare

If you or a covered family member have a long-term (chronic) health problem, ConditionCare can help with,

- 24-hour, toll-free access to a nurse
- A health assessment by phone
- Support from Nurse Coaches, pharmacists, dietitians, doctors and other health care professionals, and
- Educational guides, newsletters, and tools to help you learn more about your condition.

ConditionCare nurses work with members of all ages who have asthma or diabetes. They also work with adults who have chronic obstructive pulmonary disease (COPD), heart failure or coronary artery disease.

MyHealth Coach

The Anthem BlueCross BlueShield MyHealth Coach program offers you and any covered family members one-on-one support by phone from a health coach. MyHealth Coach has strategies to help with:

- Losing weight
- Getting ready for surgery
- Lowering stress levels and more.

Health coaches set individualized health and wellness goals, develop treatment plans, and can provide guidance on what programs are covered under your benefits. This program is different than the Health Coaching program offered through the Live Well at Citi Program.

Oxford

Cancer support

If you or a covered dependent has cancer, Oxford's Cancer Nurse Advocates can provide information about treatment, answer your questions, help you make informed decisions, and guide you to a provider in your local community or within your provider's network. Information is also available for Cancer Centers of Excellence network facilities, which are nationally respected organizations chosen because of their high-quality care and results.

To seek support or to find more information about the Cancer Support Program and the Cancer Centers of Excellence network, please call **1-866-936-6002** between 7 a.m. and 7 p.m. CT, Monday through Friday. For the hearing impaired, please call the National TTY Relay Center at **1-800-855-2880**. The Cancer Support program is optional, and you have no obligation to use the service or receive treatment at a Cancer Centers of Excellence network facility.

The Transitional Case Management (TCM)

The TCM program can help support you as you transition from an inpatient setting to a home setting. In an effort to prevent avoidable readmissions, TCM consists of discharge follow up and case management. Discharge follow-up calls are made to assist you with:

- Treatment plan adherence
- Medication adherence
- Physician follow-up
- Disease process education
- Caregiver availability information
- Homecare evaluation and resources
- Referrals to other CM/DM programs (i.e., Active Care Engagement℠, Cancer Support and Transplant)
- For Medicare members, case stabilization is also available (i.e., homecare, resources)

Medicare members, covered individuals who are participating in another Oxford clinical program, such as our Active Care Engagement℠, Rare Chronic Care, Cancer Support, or Transplant program, and covered individuals who have secondary coverage through an Oxford plan are not eligible for TCM.

Neonatal Resource Services (NRS) Program

Oxford's Neonatal Resource Services (NRS) program has a dedicated team of specialized, experienced Neonatal Intensive Care Unit (NICU) nurse case managers and full-time medical directors who are well equipped to plan care for fragile neonates. Specially trained neonatal nurse case managers manage the NICU stay and provide support to families of newborns who require critical care. On-staff medical directors with a background in neonatology and pediatrics oversee NICU admissions and provide physician-to-physician consultations as appropriate.

The Complex Case Management (CCM)

The CCM program connects you with specialized nurses as well as other resources if you are managing a complex condition. A Complex Case Management Nurse will:

- Provide one-on-one health care information, guidance and support
- Help coordinate care with physicians and health care professionals
- Provide support in understanding and following a physician's treatment plan
- Help provide education to support self-care skills
- Provide guidance in obtaining the right equipment and self-care supplies
- Provide support to assure medication compliance

More than 23 high-risk conditions are supported through the CCM program, with referrals to cancer support, transplant and neonatology resource services, programs and specialists in these complex areas. If you are managing a complex condition, the CCM program will reach out to you to assist you with your care and treatment. Medicare members, covered individuals who are participating in another Oxford clinical program, such as our Active Care Engagement, Rare Chronic Care, Cancer Support, or Transplant program, and covered individuals who have secondary coverage through an Oxford plan are not eligible for CCM.

Managed Infertility Program (MIP)

MIP compliments the treatment plan created by you and your doctor to make informed decisions regarding infertility care. MIP nurse case managers and the Reproductive Endocrinologist can help you find quality infertility care, review benefit plans and applicable state mandates, discuss treatment options, and review any proposed treatment plans. Specialized nurses can review outcomes with you as well as discuss next steps.

For more information call the number on the back of your ID card.

Covered services and supplies

This list of covered services and supplies applies to all ChoicePlan 500, High Deductible Health Plan, and Oxford PPO medical plans sponsored by Citi, except where noted.

Covered services and supplies must be medically necessary and related to the diagnosis or treatment of an accidental injury, sickness, or pregnancy. Reimbursement for all covered services and supplies listed in this section are subject to maximum allowed amount (MAA) or, for in-network services, the negotiated rates of the plan.

You and your physician decide which services and supplies are required, but the plan pays only for the following covered services and supplies that are medically necessary as determined by the Claims Administrators.

Covered services and supplies also include services and supplies that are part of a case management program. A case management program is a course of treatment developed by the Claims Administrator as an alternative to the services and supplies that would otherwise have been considered covered services and supplies. Unless the case management program specifies otherwise, the provisions of the plan related to benefit amounts, maximum amounts, copayments, and deductibles will apply to these services.

Acupuncture

Acupuncture must be administered by a medical doctor or a licensed acupuncturist (if state license is available).

Aetna: Acupuncture is covered for the following:

- Pain management, treatment for nausea related to pregnancy and post-operative and chemotherapy-induced nausea and vomiting
- Chronic low back pain (Maintenance treatment, where the patient's symptoms are neither regressing nor improving, is considered not medically necessary. If no clinical benefit is appreciated after four weeks, then the treatment plan should be re-evaluated)
- Migraine headache
- Pain from osteoarthritis of the knee or hip (adjunctive therapy; if no clinical benefit is appreciated after four weeks, then the treatment plan should be reevaluated)
- Post-operative dental pain
- Temporomandibular disorders (TMD)

Anthem: Acupuncture is covered with no visit limits or diagnosis requirements.

Oxford: Acupuncture is covered if administered by a medical doctor, an osteopathic physician, a chiropractor, or a licensed acupuncturist (if state license is available).

Adult immunizations

The following are the guidelines for covered adult immunizations:

- **Tetanus, diphtheria (Td):** Booster every 10 years;
- **Influenza (flu):** Annual for adults under age 50 and at risk; annual for adults age 50 plus;
- **Pneumococcal vaccine (PPV):** Once for adults under age 50 with risk factors with booster after five years for adults at highest risk and those most likely to lose their immunity; once at age 65 with booster after five years if less than 65 at the time of primary vaccination;
- **Varicella (chicken pox):** Persons under age 50 with no history of varicella and who test negative for immunity. Persons over age 50 are assumed to be immune. **Note:** Women who are pregnant (or planning to become pregnant in the four weeks following vaccination) should NOT be vaccinated;
- **Measles, mumps, rubella (MMR):** For people born after 1956 - two doses measles with additional doses as MMR; people born before 1957 can be considered immune. **Note:** Women who are pregnant (or planning to become pregnant in the four weeks following vaccination) and people whose immune system is not working properly should NOT be vaccinated;
- **Hepatitis A:** Only those at risk; those at risk, two doses at least six months apart;
- **Hepatitis B:** Immunize if age 46 or under; if over age 45, only those at high risk; if at risk, three doses (second dose one to two months after the first dose, and the third dose no earlier than two months after the first dose and four months after the second dose);
- **Meningococcal:** Meningitis (only those at risk); if at increased risk, one dose (an additional dose may be recommended for those who remain at high risk);
- **Tuberculin skin test:** Annual testing for high-risk group (method: Five tuberculin units of PPD);
- **Gardasil vaccine for HPV:** Males and females age 9 years to 26 years (age restrictions do not apply to Anthem Blue Cross and Blue Shield); and
- **Zostavax vaccine for shingles:** Adults age 60 or older.

Ambulatory surgical center

A center's services given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

Anesthetics

Drugs that produce loss of feeling or sensation either generally or locally, except when done for dental care not covered by the plan. When administered as part of a medical procedure, anesthesia must be administered by a board-certified anesthesiologist. Anesthesia is not covered when rendered in the doctor's office or when administered by the operating surgeon, unless it is administered by a dentist for dental care that is covered by the plan.

Note: The Oxford PPO will cover this service when medically necessary and appropriate.

Baby care

The following services and supplies given during an eligible newborn child's initial hospital confinement:

- Hospital services for nursery care;
- Other services and supplies given by the hospital;

- Services of a surgeon for circumcision in the hospital; and
- Physician services.

Note: If the newborn child is discharged at the same time as the mother, then the charges for the services rendered for the child are subject to coinsurance only. The mother's claims are subject to the deductible and coinsurance. If the newborn child remains in the hospital longer than the mother, the claims for the child apply to his or her own deductible and coinsurance limits if the member has not already met the family limits.

Birth center

Room and board and other services, supplies, and anesthetics.

Cancer detection

Diagnostic screenings not subject to precertification or notification include:

- Mammogram;
- Pap smear;
- Prostatic-specific antigen (PSA);
- Sigmoidoscopy; and
- Colonoscopy.

Chemotherapy

For cancer treatment.

Contraceptive services/devices

Contraceptive services and devices including, but not limited to:

- Diaphragm and intrauterine device and related physician services;
- Voluntary sterilization including vasectomy, tubal ligation, sterilization implants and surgical sterilizations;
- Injectables such as Depo-Provera; and
- Surgical implants for contraception, such as Mirena or Norplant.

Dietitian/nutritionist

Nutritional counseling is covered by a licensed dietitian and/or licensed nutritionist for diabetes, bulimia, anorexia nervosa, and morbid obesity.

Durable medical equipment

Durable medical equipment means equipment that meets all of the following:

- It is for repeated use and is not a consumable or disposable item;
- It is used primarily for a medical purpose; and
- It is appropriate for use in the home.

Some examples of durable medical equipment are:

- Appliances that replace a lost body part or organ or help an impaired organ or part;
- Orthotic devices such as arm, leg, neck, and back braces;
- Hospital-type beds;

- Equipment needed to increase mobility, such as a wheelchair;
- Respirators or other equipment for the use of oxygen; and
- Monitoring devices (e.g., blood glucose monitor).

Each Claims Administrator decides whether to cover the purchase or rental of the equipment based on coverage guidelines. Changes made to your home, automobile, or personal property are not covered. Rental coverage is limited to the purchase price of the durable medical equipment. Replacement, repair, and maintenance are covered only if:

- They are needed due to a change in your physical condition or
- It is likely to cost less to buy a replacement than to repair the existing equipment or rent similar equipment.

Foot care

Care and treatment of the feet, if afflicted by severe systemic disease. Routine care such as removal of warts, corns, or calluses; the cutting and trimming of toenails; and foot care for flat feet, fallen arches, and chronic foot strain is covered only if needed due to severe systemic disease. Note: foot care is not covered under the Oxford PPO plan.

- **Aetna and Anthem BlueCross BlueShield ChoicePlan 500** cover the services of a podiatrist for the treatment of a disease or injury, including the treatment of corns, calluses, keratoses, bunions, and ingrown toenails.

Hearing aids

Hearing aids are covered, regardless of the reason for hearing loss.

- **Adults:** Once every three calendar years.
- **Children:** Once every two calendar years.

Home health care (combined with private-duty nursing)

The following covered services must be given by a home health care agency:

- Temporary or part-time skilled nursing care by or supervised by a registered nurse (RN) or licensed practical nurse (LPN)
- Medical social services provided by, or supervised by, a qualified physician or social worker if your physician certifies with the plan that the medical social services are necessary for the treatment of your medical condition.

Covered services are limited to 200 visits each calendar year (combined visits with private-duty nursing), and you must notify the plan in advance. Each period of home health aide care of up to eight hours given in the same day counts as one visit. Each visit by any other member of the home health team will count as one visit. Multiple services provided on the same day count as one visit and are billed by the same provider on the same bill. Visits may be increased with prior approval from your health plan.

Hospice care

Hospice services for a participant who is terminally ill include:

- Room and board coverage limited to expenses for the regular daily charge made by the hospital for a semiprivate room (or private room when medically appropriate or if it is the only room type available);
- Other services and supplies prescribed by a physician to keep the patient comfortable while in hospice care;

- Part-time nursing care by or supervised by a RN or LPN;
- Home health care services as shown under home health care; the limit on the number of visits shown under home health care does not apply to hospice patients;
- Counseling for the patient and covered dependents;
- Pain management and symptom control; and
- Bereavement counseling for covered dependents; services must be given within six months of the patient's death, and covered services are limited to a total of 15 visits for each family member.
  - For **Aetna ChoicePlan 500, Anthem BlueCross BlueShield ChoicePlan 500, and Oxford Health Plans**, bereavement counseling is covered under the mental health benefit. Mental Health benefits do not have visit limits.

Bereavement counseling must be provided by a licensed counselor. Services for the patient must be given in an inpatient hospice facility or in the patient's home. The physician must certify that the patient is terminally ill with six months or less to live. Any counseling services given in connection with a terminal illness will not be considered as mental health and substance abuse treatment for purposes of applying the mental health/substance abuse maximum visit limit.

Hospital services

Hospital services include:

- Room and board: Covered expenses are limited to the regular daily charge made by the hospital for a semiprivate room (or private room when medically appropriate);
- Other services and supplies, including:
  - Intensive or special care facilities when medically appropriate;
  - Visits by your physician while you are confined;
  - General nursing care;
  - Surgical, medical, and obstetrical services;
  - Use of operating rooms and related facilities;
  - Medical and surgical dressings, supplies, casts, and splints;
  - Drugs and medications;
  - Intravenous injections and solutions;
  - Nuclear medicine; and
  - Preoperative care and post-operative care:
    - Administration and processing of blood;
    - Anesthesia and anesthesia services;
    - Oxygen and oxygen therapy;
    - Inpatient physical and rehabilitative therapy, including cardiac and pulmonary rehabilitation;
    - X-rays, laboratory tests, and diagnostic services; and
    - Magnetic resonance imaging (MRI).

Emergency room services are covered only if determined to be medically appropriate and there is not a less intensive or more appropriate place of service, diagnostic, or treatment alternative that could have been used. If your health plan, at its discretion, determines that a less intensive or more appropriate treatment could have been given, then no benefits are payable.

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, to discharge 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 (or 96 hours as applicable). Authorizations are required for longer stays.

Infertility treatment

Aetna:

Treatment of infertility must be pre-authorized. Penalties apply if the treatment is received without pre-certification.

- **Basic Infertility Expenses:** Covered expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility. These expenses do not count towards the medical lifetime maximum.
- **Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses**: To be an eligible covered female for benefits you must be covered as an employee, or be a covered dependent who is the employee's spouse (same- or opposite-sex)/domestic partner/civil union partner. Even though not incurred for treatment of an illness or injury, covered expenses will include expenses incurred by an eligible covered female for infertility if all of the following tests are met:
  - A condition that is a demonstrated cause of infertility which has been recognized by a gynecologist, or an infertility specialist, and your physician who diagnosed you as infertile, and it has been documented in your medical records.
  - The procedures are done while not confined in a hospital or any other facility as an inpatient.
  - Your FSH levels are less than, 19 miU on day 3 of the menstrual cycle.
  - The infertility is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.
  - A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- **Comprehensive Infertility Services Benefits**: If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by an infertility specialist upon pre-certification by Aetna, subject to all the exclusions and limitations.
  - Ovulation induction with menotropins is subject to the maximum benefit and
  - Intrauterine insemination is subject to the maximum benefit.
- **Advanced Reproductive Technology (ART) Benefits:** ART is defined as:
  - In vitro fertilization (IVF);
  - Zygote intrafallopian transfer (ZIFT);
  - Gamete intra-fallopian transfer (GIFT);

- Cryopreserved embryo transfers;
- Intracytoplasmic sperm injection (ICSI); or ovum microsurgery.
- ART services for procedures that are covered expenses.

> **Eligibility for ART Benefits**: To be eligible for ART benefits, you must meet the requirements above and:

- Coverage for ART services is available only if comprehensive infertility services do not result in a pregnancy in which a fetal heartbeat is detected;
- Be referred by your physician to Aetna's infertility case management unit;
- Obtain pre-certification from Aetna's infertility case management unit for ART services by an ART specialist.

> **Covered ART Benefits**: The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the Exclusions and Limitations

- Subject to the maximum benefit of any combination of the following ART services per lifetime (where lifetime is defined to include all ART services received, provided or administered by Aetna or any affiliated company of Aetna) which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers;
- IVF; Intra-cytoplasmic sperm injection ("ICSI"); ovum microsurgery; GIFT; ZIFT; or cryopreserved embryo transfers subject to the maximum benefit;
- Payment for charges associated with the care of the an eligible covered person under this plan who is participating in a donor IVF program, including fertilization and culture; and
- Charges associated with obtaining the spouse's sperm for ART, when the spouse is also covered under the plan

Anthem BlueCross BlueShield and Oxford:

Diagnosis of infertility and surgical correction of a medical condition causing infertility are covered subject to the plan's copayment or deductible and coinsurance.

Covered services include:

> Services for diagnosis and treatment of the underlying medical condition:

- Initial evaluation, including history, physical exam, and laboratory studies;
- 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;
- Evaluation of ovulation function;
- Ultrasound of ovaries;
- Post-coital test;
- Hysterosalpingogram;
- Endometrial biopsy;
- Hysteroscopy; and
- Semen analysis for male participants.

- Advanced reproductive services:
  - Ovulation induction cycle with menotropins;
  - Harvesting of plan participant's eggs;
  - Artificial insemination;
  - Infertility surgery (diagnostic or therapeutic);
  - ART services and treatment, including in-vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), and cryopreserved embryo transfer and Frozen Embryo Transfer (FET);
- Medical expenses for infertility treatment are covered up to a family lifetime maximum of $24,000. Only expenses for advanced services (e.g., IVF, GIFT, ZIFT) and comprehensive services (e.g., artificial insemination) accumulate towards the lifetime maximum. Expenses for diagnosis and treatment of the underlying medical condition do not count towards the lifetime maximum.
- Prescription drug expenses associated with infertility treatment are covered up to a lifetime maximum of $7,500, through the *Prescription Drugs* section.
- Covered services do not include the costs associated with surrogate mothers and the costs of donating donor eggs.

HMOs

Each HMO offers different infertility coverage and limits, if at all. Check with your HMO for details of infertility coverage.

Laboratory tests/X-rays

X-rays or tests for diagnosis or treatment.

Licensed counselor services

Services of a licensed counselor for mental health and substance abuse treatment.

Medical care

- Hospital, office, and home visits; and
- Emergency room services.

Medical supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure; and
- Blood or blood derivatives only if not donated or replaced. This means:
  - Autologous blood donation: The donation of your own blood for use during a scheduled covered surgical procedure;
  - Directed blood donation: The donation of blood by a person chosen by the patient to donate blood for the patient's use during a scheduled covered surgical procedure; and
  - Autologous or directed blood donation prior to a scheduled surgery when it generally requires blood transfusions and the provider/organization that obtains and processes the blood makes a charge that the patient is legally obligated to pay.

Medical transportation services

Transportation by professional ambulance or air ambulance to and from the nearest medical facility qualified to give the required treatment. These services must be given within the United States, Puerto Rico, and Canada.

- **Aetna ChoicePlan 500** and **Anthem BlueCross BlueShield ChoicePlan 500** cover medical transportation services outside of these geographic areas to and from the nearest medical facility.
- **Oxford Health Plans:** When a member has traveled out of the country, emergency or 911 transportation to the nearest hospital and/or hospital emergency facility does not require notification, precertification, or certification. However, Oxford Medical Management should be notified of an admission within 48 hours or as soon as possible, consistent with the member's certificate. All requests for other out-of-the-country transportation require precertification and Medical Director review.

The health plans cover professional ambulance service on a standard basis to transport the individual from the place where he/she is injured or stricken by disease to the first hospital where treatment is given. Ambulettes are not covered.

Morbid obesity expenses (non-HMO/PPO plans)

Covered medical expenses include charges made on an inpatient or outpatient basis by a hospital or a physician for the surgical treatment of morbid obesity of a covered person. Limitations apply. For more information, contact your plan directly.

Dietician/nutritionist coverage is also available for morbid obesity. See "Dietitian/nutritionist" on page 131.

Nurse-midwife

Services of a licensed or certified nurse-midwife. Maternity-related benefits are payable on the same basis as services given by a physician.

Nurse-practitioner

Services of a licensed or certified nurse-practitioner acting within the scope of that license or certification. Benefits are payable on the same basis as covered services given by a physician.

Oral surgery/dental services

The plan pays first (the primary plan) for oral surgery if needed as a necessary, but incidental, part of a larger service in treatment of an underlying medical condition.

The following oral surgeries are considered medical in nature and covered under the medical plan as necessary:

- Treat a fracture, dislocation, or wound;
- Cut out:
  - Teeth partly or completely impacted in the bone of the jaw;
  - Teeth that will not erupt through the gum;
  - Other teeth that cannot be removed without cutting into bone;
  - The roots of a tooth without removing the entire tooth; and
  - Cysts, tumors, or other diseased tissues.

- Cut into gums and tissues of the mouth. This is covered only when not done in connection with the removal, replacement, or repair of teeth; and
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement
- If oral surgery/dental services are needed in connection with an accident or injury
  - **Aetna** requires that any treatment must be completed in the calendar year of the accident or in the next calendar year unless postponed due to a patient's physical condition.
- If crowns, dentures, bridges, or in-mouth appliances are installed due to injury, covered expenses only include charges for:
  - The first denture or fixed bridgework to replace lost teeth;
  - The first crown needed to repair each damaged tooth; and
  - An in-mouth appliance used in the first course of orthodontic treatment after the injury.
  - Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the injury.
- **Anthem BlueCross BlueShield** accepts the following oral surgeries as medical in nature and covered under the medical plan as necessary:
  - Extraction of impacted wisdom teeth;
  - Services to treat an injury to sound natural teeth that are given within 12 months of accident/injury;
  - TMJ surgery; and
  - Anesthesia for dental services only when the dental service itself is covered, is administered by an anesthesiologist and is done outside of the doctor's office.

Corrective surgery is covered if medically necessary for purposes of chewing and speaking.

The following services and supplies are covered only if needed because of accidental injury to sound and natural teeth that happened to you or your dependent while covered under this plan. Treatment must be received within 12 months of the accident/injury.

- Oral surgery;
- Full or partial dentures;
- Fixed bridgework;
- Prompt repair to sound and natural teeth; and
- Crowns.

Oxford Health Plans accepts the following oral surgeries as medical in nature and covered under the medical plan as necessary:

- Extraction of impacted wisdom teeth;
- Services to treat an injury to sound natural teeth; and
- TMJ surgery.

- **Note:** Oxford does not cover General Dental Care. Coverage is available for the following limited dental and oral surgical procedures:
  - Oral surgery for the repair of sound natural teeth, jaw bones, or surrounding tissue which is related to accidental injury.
  - Treatment for tumors or cysts requiring pathological examinations of the jaw, cheek, lip, tongue, or roof or floor of the mouth.
  - TMJ Surgery is covered. All surgery must be precertified in advance through Oxford's Medical Management Department.
- Care may be accessed on either an In-Plan or Out-of-Plan basis. Pre-certification is required.

Organ/tissue transplants

Your Claims Administrator must be notified before the scheduled date (or as soon as reasonably possible) of any of the following:

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant procedure.
- **Anthem BlueCross BlueShield** and **Aetna** do not require precertification within a certain number of days, but **Oxford** requires precertification within at least 14 days.

Donor charges for organ/tissue transplants

- In the case of an organ or tissue transplant, donor charges are considered covered expenses only if the recipient is a covered person under the plan. If the recipient is not a covered person, no benefits are payable for donor charges.
- The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a covered service unless the search is made in connection with a transplant procedure arranged by a designated transplant facility.
  - **Aetna, Anthem BlueCross Blue Shield and Oxford** cover donor search fees through the National Marrow Donor Program.

Qualified procedures

If a qualified procedure, listed in this section, is medically necessary and performed at a designated transplant facility, the "medical care and treatment" and "transportation and lodging" provisions described in this section apply.

- Heart transplants;
- Lung transplants;
- Heart/lung transplants;
- Liver transplants;
- Kidney transplants;
- Pancreas transplants;
- Kidney/pancreas transplants;

- Bone marrow/stem cell transplants; and
- Other transplant procedures when your Claims Administrator determines that they are medically necessary to perform the procedure as a designated transplant.

For **Aetna**, transplant services are covered as long as the transplant is not experimental or investigational and has been approved in advance. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluations and follow-up care. Each facility has been selected to perform only certain types of transplants, based on its quality of care and successful clinical outcomes.

For **Aetna** plans (CP500 and HDHP), a transplant will be covered as an in-network service only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered a non-participating facility for transplant-related services, even if the facility is considered a participating facility for other types of services.

Members must receive precertification for transplant procedures. When a member or physician calls Aetna to precertify a transplant evaluation, a case nurse will direct him or her to an IOE facility.

For **Anthem BlueCross BlueShield**, there is tiered coverage based on the facility used for the transplant. If a Blue Distinction Center for Transplants (BDCT) is used, the transplant will be covered at 100% with access to the travel and lodging benefit. Blue Distinction Centers for Transplants meet stringent clinical criteria, established in collaboration with expert physician panels and national medical societies, including the Center for International Blood and Marrow Transplant Research (CIBMTR), the Scientific Registry of Transplant Recipients (SRTR), and the Foundation for the Accreditation of Cellular Therapy (FACT), and are subject to periodic re-evaluation as criteria continue to evolve. Call Anthem at **1-855-593-8123** for additional coverage information as well as assistance in locating a BDCT facility.

Transplants performed at participating, non-BDCT facilities are covered at 80% with access to the travel and lodging benefit; all other facilities are covered at 60% with no access to the travel and lodging benefit.

Medical care and treatment

Covered expenses for services provided in connection with the transplant procedure include:

- Pretransplant evaluation for one of the procedures listed above;
- Organ acquisition and procurement;
- Hospital and physician fees;
- Transplant procedures;
- Follow-up care for a period of up to one year after the transplant;
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search. **Note**: Coverage of donor costs is generally limited to medically necessary procedures, inpatient confinement (e.g., semi-private room and board in an acute hospital setting) and a postoperative global period not to exceed 180 calendar days. (This maximum applies to the Oxford PPO. It does not apply to the **Aetna and Anthem BlueCross BlueShield** plans); and
- Transportation and lodging.

When available, the plan will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging for the transplant recipient and a companion are available as follows:

- Transportation, including expenses for personal car mileage at the current federal rate of reimbursement, of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for an evaluation, the transplant procedure, or necessary post-discharge follow-up;
- Reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per-diem rate of $50 for one person or $100 a day for two people (a maximum of $50 per person — $100 for patient and companion combined — per night is paid toward lodging expenses; meals are not covered);
- Travel and lodging expenses are available only if the transplant recipient resides more than:
  - 100 miles from the designated transplant facility for **Aetna** plans;
  - **Anthem BlueCross BlueShield** plans do not have a mileage requirement.
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered; lodging expenses will be reimbursed at the $100 per-diem rate;
- A combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the transplant recipient and companion (companions, if the covered dependent is a minor) and reimbursed under the plan in connection with all transplant procedures. (For **Aetna** plans, a $10,000 maximum [per occurrence] will apply to all non-health benefits in connection with any one type of procedure. These benefits are available until one year following the date of the procedure.)

If the covered person chooses not to receive his or her care in connection with a qualified procedure pursuant to this organ/tissue transplant section, the services and supplies received by the covered person in connection with that qualified procedure will be paid under the plan if and to the extent covered by the plan without regard to this organ/tissue transplant section.

- There may be some differences in coverage for transportation and lodging.

Oxford Health Plans covers only those solid organ transplants that are non-experimental and non-investigational. All transplants must be performed by a UNOS (United Network for Sharing Organs)-participating academic transplant center. All solid organ transplants must be performed in facilities that Oxford has specifically contracted and designated to perform these procedures to be eligible for plan coverage.

The following types of solid organ transplants will be covered when performed by a UNOS-participating academic transplant center:

- Heart transplant;
- Lung transplant;
- Heart-lung transplant;
- Liver transplant;
- Kidney transplant;
- Intestinal and multi-visceral transplants; and
- Pancreas transplant.

For more information, contact your Claims Administrator directly.

Orthoptic training

Training by a licensed optometrist or an orthoptic technician. The plan covers a hidden ocular muscle condition where the eyes have a tendency to underconverge or overconverge. Manifest conditions of exotropia (turning out) or esotropia (turning in) are covered. Coverage is limited to 32 visits per calendar year.

Outpatient occupational therapy

See “Rehabilitation therapy” on page 142.

Outpatient physical therapy

See “Rehabilitation therapy” on page 142.

Prescribed drugs

Prescribed drugs and medicines for inpatient services.

Preventive care

Covered expenses include:

- Routine physical exam (including a well-woman exam) is covered once per calendar year;
- Routine immunizations;
- Smoking cessation; and
- Screening and counseling for obesity for adults and children.

A $250 calendar year maximum applies to out-of-network services per covered family member.

For more specific information regarding what is concerned to be Preventive Care, see “Preventive care” on page 68.

Private-duty nursing care (combined with home health care)

Private-duty nursing care is given on an outpatient basis by a RN, LPN, or licensed vocational nurse (LVN). This service must be approved by your Claims Administrator.

- **Aetna CP500 and Anthem BlueCross BlueShield CP500:** A combined in-network and out-of-network maximum benefit of 200 visits per calendar year (combined with home health care visits) applies. One visit is equal to one eight-hour shift. Inpatient private-duty nursing is not covered. Precertification is required. Additional visits may be covered if approved in advance by your plan.
- **Oxford Health Plans:** Private-duty nursing services are covered as medically necessary. A combined in-network and out-of-network maximum benefit of 200 visits per calendar year (combined with home health care visits) applies. One visit is equal to one four-hour shift. Inpatient private-duty nursing is not covered.

Psychologist services

Services of a psychologist for psychological testing and psychotherapy.

Rehabilitation therapy

Defined as short-term occupational therapy, physical therapy, speech therapy, and spinal manipulation:

- Services of a licensed occupational or physical therapist, provided the following conditions are met:
  - The therapy must be ordered and monitored by a licensed physician (when required by state law); and

- The therapy must be given according to a written treatment plan approved by a licensed physician. The therapist must submit progress reports at the intervals stated in the treatment plan;

> Services of a licensed speech therapist. These services must be given to restore speech lost or impaired due to one of the following:

- Surgery, radiation therapy, or other treatment that affects the vocal chords;
- Cerebral thrombosis (cerebral vascular accident);
- Brain damage due to accidental injury or organic brain lesion (aphasia);
- Accidental injury that happens while the person is covered under the plan;
- Chronic conditions (such as cerebral palsy or multiple sclerosis); or
- Developmental delay.

Inpatient

> Services of a hospital or rehabilitation facility for room, board, care, and treatment during a confinement. Coverage for room and board is limited to expenses for the regular daily charge made by the hospital for a semiprivate room (or private room when medically appropriate or if it is the only room type available).

> Inpatient rehabilitative therapy is a covered service only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.

Outpatient

> Services of a hospital, comprehensive outpatient rehabilitative facility (CORF), or licensed therapist as described above.

> Coverage includes short-term cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure, or myocardial infarction.

> Coverage includes short-term pulmonary rehabilitation for the treatment of reversible pulmonary disease.

> All visit limits apply for both in-network and out-of-network, wherever the services are being provided, for example, at home, at a therapist's office, or in a free-standing therapy facility.

> **CP500 and HDHP:** Spinal manipulation therapy limited to 20 visits per calendar year. Physical and occupational therapies combined are limited to 60 visits per calendar year. Speech therapy is limited to 90 visits per calendar year.

> **Oxford:** Spinal manipulation therapy limited to 20 visits per calendar year. Physical, speech and occupational therapies combined are limited to 90 visits per calendar year.

Routine Care

Covered expenses include:

> Vision exam once per calendar year; and

> Hearing exam once per calendar year.

A $250 calendar year maximum applies to out-of-network services per covered family member.

Skilled nursing facility services

- Room and board: Covered expenses for room and board are limited to the facility's regular daily charge for a semiprivate room.
- Other services and supplies.

Covered services are limited to the first 120 days of confinement each calendar year.

Speech therapy

See "Rehabilitation therapy" on page 142.

Spinal manipulations

Services of a physician given for the detection or correction (manipulation) by manual or mechanical means or structural imbalance or distortion of the spine. Routine maintenance and adjustments are not a covered service under this plan.

Surgery

Services for surgical procedures. (**Oxford Health Plans:** All surgical procedures must be precertified in advance.)

Reconstructive surgery

- Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:
  - Birth defect;
  - Sickness;
  - Surgery to treat a sickness or accidental injury; or
  - Accidental injury that happens while the person is covered under the plan,
- Reconstructive breast surgery following a mastectomy including areolar reconstruction and the insertion of a breast implant. The plan covers expenses associated with reconstructive surgery following a mastectomy, expenses for reconstructive surgery on the other breast to achieve symmetry, the cost of prostheses, and the cost for treatment of physical complications at any stage of the mastectomy including lymphedemas. Plan deductibles, coinsurance, and copayments will apply; and
- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to sickness or accidental injury that happens while the person is covered under the plan.

Assistant-surgeon services

Covered expenses for assistant-surgeon services are limited to 20% of the amount of covered expenses for the primary surgeon's charge for the surgery for non-HMO/PPO plans. An assistant-surgeon generally must be a licensed physician. Physician's-assistant services are not covered if billed on his or her own behalf. (**Aetna and Anthem BlueCross BlueShield** cover assistant surgeon services for certain surgeries. **Aetna** covers registered nurses acting as assistant surgeons for certain surgeries. Contact Anthem BlueCross BlueShield for information about which providers qualify as assistant surgeons.)

Multiple surgical procedure guidelines

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

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

- First procedure: The plan will allow 100% of the negotiated or MAA.
- Second procedure: The plan will allow 50% of the negotiated or MAA.
- Third and additional procedures: The plan will allow 50% of the negotiated or MAA for each additional procedure.
- Bilateral and separate operative areas: The plan will allow 100% of the negotiated or MAA for the primary procedure and 50% of the secondary procedure and 50% of the negotiated or MAA for tertiary/additional procedures.

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

Transsexual surgery, sex change, or transformation

The plan does cover procedures, treatments and related services designed to alter a participant's physical characteristics from his or her biologically determined sex to those of another sex.

Termination of pregnancy

- Voluntary (i.e., abortion) and
- Involuntary (i.e., miscarriage).

Temporomandibular Joint Syndrome (TMJ)

Surgical treatment of TMJ does not include treatment performed by prosthesis placed directly on the teeth or physical therapy for TMJ.

Transgender benefits

Transgender benefits are covered under the plan. The way the coverage is administered varies slightly between the carriers. This section describes specific coverage details for Aetna, Anthem Blue Cross Blue Shield, and Oxford.

Aetna: Aetna considers sex reassignment surgery medically necessary when all of the following criteria are met:

- Member is at least 18 years old; *and*
- Member has met criteria for the diagnosis of "true" transsexualism, including:
  - A sense of estrangement from one's own body, so that any evidence of one's own biological sex is regarded as repugnant; and
  - A stable transsexual orientation evidenced by a desire to be rid of one's genitals and to live in society as a member of the other sex for at least 2 years, that is, not limited to periods of stress; and
  - Absence of physical inter-sex of genetic abnormality; and
  - Does not gain sexual arousal from cross-dressing; and
  - Life-long sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood; and
  - Not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia; and
  - Wishes to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and

- Member has completed a recognized program of transgender identity treatment as evidenced by all of the following:
  - A qualified mental health professional[1] who has been acquainted with the member for at least 18 months recommends sex reassignment surgery documented in the form of a written comprehensive evaluation; *and*
  - For genital surgical sex reassignment, a second concurring recommendation by another qualified mental health professional[1] must be documented in the form of a written expert opinion[2]; *and*
  - For genital surgical sex reassignment, member has undergone a urological examination for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract, since genital surgical sex reassignment includes the invasion of, and the alteration of, the genitourinary tract (urological examination is not required for persons not undergoing genital reassignment); *and*
  - Member has demonstrated an understanding of the proposed male-to-female or female-to-male sex reassignment surgery with its attendant costs, required lengths of hospitalization, likely complications, and post-surgical rehabilitation requirements of the planned surgery; *and*
  - Psychotherapy is not an absolute requirement for surgery unless the mental health professional's initial assessment leads to a recommendation for psychotherapy that specifies the goals of treatment, estimates its frequency and duration throughout the real life experience (usually a minimum of 3 months); *and*
  - For genital surgical sex reassignment, the member has successfully lived and worked within the desired gender role full-time for at least 12 months (so-called real-life experience), without periods of returning to the original gender; *and*
  - For genital surgical sex reassignment, member has received at least 12 months of continuous hormonal sex reassignment therapy recommended by a mental health professional and carried out by an endocrinologist (which can be simultaneous with the real-life experience), unless medically contraindicated.

Medically necessary core surgical procedures for female to male persons include: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty and placement of testicular prostheses, and erectile prostheses.

Medically necessary core surgical procedures for male to female persons include: penectomy, orchidectomy, vaginoplasty, clitoroplasty, and labiaplasty.

Note: Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic and are not covered.

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

- Breast cancer screening may be medically necessary for female to male transgender persons who have not undergone a mastectomy;
- Prostate cancer screening may be medically necessary for male to female transgender individuals who have retained their prostate.

Anthem BlueCross BlueShield: Gender reassignment surgery[1] is considered medically necessary when the *all* of the following criteria are met:

- The patient is at least 18 years of age; and
- The patient has been diagnosed with the Gender Identity Disorder (GID) of transsexualism, including all of the following:
  - The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
  - The transsexual identity has been present persistently for at least two years; and
  - The disorder is not a symptom of another mental disorder or a chromosomal abnormality; and
  - The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
- For those patients without a medical contraindication, the patient has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; and
- The patient has completed a minimum of 12 months of successful continuous full time real-life experience in their new gender, with no returning to their original gender, including one or more of the following:
  - Maintain part- or full-time employment; or
  - Function as a student in an academic setting; or
  - Function in a community-based volunteer activity; and
- The patient has acquired a legal gender-identity-appropriate name change; and
- The patient has provided documentation to the treating therapist that persons other than the treating therapist know that the patient functions in the desired gender role; and
- Regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or behavioral health practitioner; and
- Demonstrable knowledge of the required length of hospitalizations, likely complications, and post-surgical rehabilitation requirements of various surgical approaches; and
- Demonstrable progress in consolidating one's gender identity, including demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health (this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance); and
- A letter[2] from the patient's physician or mental health provider, who has treated the patient for a minimum of 18 months, documenting the following:
  - The patient's general identifying characteristics; and
  - The initial and evolving gender, sexual, and other psychiatric diagnoses; and
  - The duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent; and

  - The eligibility criteria that have been met and the physician or mental health professional's rationale for surgery; and
  - The degree to which the patient has followed the eligibility criteria to date and the likelihood of future compliance; and
  - Whether the author of the report is part of a gender identity disorder treatment team; and

- A letter[2] from a second physician or mental health provider familiar with the patient's treatment and the psychological aspects of Gender Identity Disorders, corroborating the information provided in the first letter (see #10 above); and
- When one of the signatories on the letters indicated above is not the treating surgeon, a letter from the surgeon confirming that they have personally communicated with the treating mental health provider or physician, as well as the patient, and confirming that the patient meets the above criteria, understands the ramifications and possible complications of surgery, and that the surgeon feels that the patient is likely to benefit from surgery.

Gender reassignment surgery may include any of the following procedures:

- *Male-to-Female Procedures*
  - Orchiectomy
  - Penectomy
  - Vaginoplasty
  - Clitoroplasty
  - Labiaplasty
- *Female-to-Male Procedures*
  - Hysterectomy
  - Salpingo-oophorectomy
  - Vaginectomy
  - Metoidioplasty
  - Scrotoplasty
  - Urethroplasty
  - Placement of testicular prostheses
  - Phalloplasty

At least one of the professionals submitting a letter must have a doctoral degree (Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) and be capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the doctoral degree specifications, in addition to the specifications set forth above.

Not Medically Necessary:

- Gender reassignment surgery is considered not medically necessary when one or more of the criteria above have not been met.

Cosmetic and Not Medically Necessary:

- The following surgeries are considered cosmetic and not medically necessary when used to improve the gender specific appearance of a patient who has undergone or is planning to undergo gender reassignment surgery:
  - Reduction thyroid chondroplasty
  - Liposuction
  - Rhinoplasty
  - Facial bone reconstruction
  - Face lift
  - Blepharoplasty
  - Voice modification surgery
  - Hair removal/hairplasty
  - Breast augmentation

Oxford: Covered services include:

- Psychotherapy for gender identity disorders and associated co-morbid psychiatric diagnoses;
- Continuous hormone replacement
  - Hormones of the desired gender;
  - Hormones injected by a medical provider (for example during an office visit) are covered by the medical plan. Benefits for these injections vary depending on the plan design.
  - Oral and self-injected hormones from a pharmacy are not covered under the medical plan. Refer to the Outpatient Prescription Drug Rider, or SPD for self-funded plans, for specific prescription drug product coverage and exclusion terms.
- Genital Surgery (by various techniques which must be appropriate to each patient), including:
  - Complete hysterectomy
  - Orchiectomy
  - Penectomy
  - Vaginoplasty
  - Vaginectomy
  - Clitoroplasty
  - Labiaplasty
  - Salpingo-oophorectomy
  - Metoidioplasty
  - Scrotoplasty
  - Urethroplasty
  - Placement of testicular prosthesis
  - Phalloplasty

- Surgery to change specified secondary sex characteristics, specifically:
  - Thyroid chondroplasty (removal of the Adam's Apple); and
  - Bilateral mastectomy; and
  - Augmentation mammoplasty (including breast prosthesis if necessary) if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role;
- Laboratory testing to monitor the safety of continuous hormone therapy.

Hormone Replacement:

The Covered Person must meet all of the following eligibility qualifications for hormone replacement (in addition to the plan's overall eligibility requirements as shown in the plan document).

- Age 18 years or older for hormones to change physical characteristics; and
- Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks; and
- The Covered Person must meet the definition of Gender Identity Disorder (see definition below); and
- Initial hormone therapy must be preceded by:
  - a documented real-life experience (living as the other gender) of at least three months prior to the administration of hormones; or
  - a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

Genital surgery and surgery to change secondary sex characteristics eligibility qualifications:

The Covered Person must meet all of the following eligibility qualifications for genital surgery and surgery to change secondary sex characteristics (in addition to the plan's overall eligibility requirements as shown in the plan document):

- The surgery must be performed by a qualified provider at a facility with a history of treating individuals with gender identity disorder;
- The treatment plan must conform to the World Professional Association for Transgender Health Association (WPATH) standards[1];
- The Covered Person must be age 18 years or older for irreversible surgical interventions;
- The Covered Person must complete 12 months of continuous hormone therapy for those without contraindications;
- The Covered Person must complete 12 months of successful continuous full time real life experience in the desired gender;
- The Covered Person must meet the definition of Gender Identity Disorder (see definition below); and
- The Covered Person's Physician who is performing the surgery must follow the Notification process prior to performing the surgery.

Exclusions:

The following treatments are not covered:

- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.

- Sperm preservation in advance of hormone treatment or gender surgery.
- Cryopreservation of fertilized embryos.
- Voice modification surgery.
- Facial feminization surgery, including but not limited to: facial bone reduction, face “lift”, facial hair removal, and certain facial plastic reconstruction.
- Suction-assisted lipoplasty of the waist.
- Rhinoplasty (except if rhinoplasty criteria is met. See the Rhinoplasty, Septoplasty, and Repair of Vestibular Stenosis Coverage Determination Guideline.)
- Blepharoplasty (except if blepharoplasty criteria is met. See the Blepharoplasty, Blepharoptosis and Brow Ptosis Repair Coverage Determination Guideline.)
- Surgical or hormone treatment on enrollees under 18 years of age.
- Surgical treatment not prior authorized by Oxford.
- Drugs for hair loss or growth.
- Drugs for sexual performance or cosmetic purposes (except for hormone therapy described above.
- Voice therapy.
- Services that exceed the maximum dollar limit on the plan.
- Transportation, meals, lodging or similar expenses.

[1] At least one of the two clinical behavioral scientists making the favorable recommendation for surgical (genital) sex reassignment must possess a doctoral degree (e.g., Ph.D., Ed.D., D.Sc., D.S.W., Psy.D., or M.D.). **Note:** Evaluation of candidacy for sex reassignment surgery by a mental health professional is covered under the member’s medical benefit, unless the services of a mental health professional are necessary to evaluate and treat a mental health problem, in which case the mental health professional’s services are covered under the member’s behavioral health benefit. Please check benefit plan descriptions.

[2] Either two separate letters or one letter with two signatures is acceptable.

Treatment centers

- Room and board; and
- Other services and supplies.

Voluntary sterilization

- Vasectomy; and
- Tubal ligation.

Reversals are not covered.

Well-child care

Office visit charges for routine well-child care exams and immunizations based on guidelines from the American Medical Association.

Exclusions and limitations

There are services and expenses that are not covered under the non-HMO/PPO plans. The following list of exclusions and limitations applies to your plan benefits unless otherwise provided under your HMO:

- Ambulance services, when used as routine transportation to receive inpatient or outpatient services;
  - **Aetna:** Any charges in excess of the benefit, dollar, day, visit or supply limits unless specified otherwise. This includes charges for a service or supply furnished by an in-network provider in excess of the negotiated charge, and charges for a service or supply furnished by an out-of-network provider in excess of the maximum allowed amount or recognized charge. Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan are excluded. Charges submitted for services by an unlicensed hospital, physician, or other provider or not within the scope of the provider's license are excluded;
- Applied behavioral analysis (ABA) therapy
  - **Aetna**: also excludes applied behavioral analysis, the LEAP, TEACCH, Denver and Rutgers programs.
- Any service in connection with, or required by, a procedure or benefit not covered by the plan;
- Any services or supplies that are not medically necessary, as determined by the Claims Administrator;
- BEAM (brain electrical activity mapping) neurologic testing;
  - **Oxford:** Oxford will provide coverage for magnetoencephalography and magnetic source imaging as outlined in the guidelines below.
    - Magnetoencephalography and magnetic source imaging (MEG/MSI) are considered to be medically necessary for presurgical evaluation in patients with intractable focal epilepsy and presurgical evaluation of brain tumors and vascular malformations
    - Magnetoencephalography and magnetic source imaging (MEG/MSI) are not considered to be medically necessary for the evaluation of brain function in patients with trauma, stroke, learning disorders, or other neurologic disorders and psychiatric conditions such as schizophrenia.
  - There is insufficient evidence to conclude that the use of MEG/MSI improves health outcomes such as improved diagnostic accuracy and treatment planning for patients with trauma, stroke, learning disorders, or other neurologic disorders and psychiatric conditions. Further clinical trials demonstrating the clinical usefulness of this procedure are necessary before it can be considered proven to have a benefit on health outcomes for these conditions.
- Biofeedback, except as specifically approved by the Claims Administrator;
- Blood, blood plasma, synthetic blood, or other blood derivatives or substitutes, and the provision of blood, other than blood derived clotting factors, except as described under "Covered services and supplies" on page 129. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered;
- Breast augmentation and otoplasties, including treatment of gynecomastia. Reduction mammoplasty is not covered unless medically appropriate, as determined by the Claims Administrator;
- Charges for canceled office visits or missed appointments; boutique, access, or concierge fees to doctors;

- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury;
- Charges made by a hospital for confinement in a special area of the hospital that provides non-acute care, by whatever name called, including, but not limited to, the type of care given by the facilities listed below:
  - Adult or child day care center;
  - Ambulatory surgical center;
  - Birth center;
  - Halfway house;
  - Hospice;
  - Skilled nursing facility;
  - Treatment center;
  - Vocational rehabilitation center; and
  - Any other area of a hospital that renders services on an inpatient basis for other than acute care of sick, or injured persons, or pregnant women. If that type of facility is otherwise covered under the plan, then benefits for that covered facility, which is part of a hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a hospital;
- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments;
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. Cosmetic procedures including, but not limited to, pharmacological regimens, nutritional procedures or treatments, plastic surgery, salabrasion, chemosurgery, and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes, and/or that are performed as a treatment for acne. However, the plan covers reconstructive surgery as described under “Covered services and supplies” on page 129;
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically appropriate and provided by participating providers upon referral from your PCP (no referral required for Aetna, Anthem BlueCross BlueShield, or Oxford);
- Coverage for an otherwise eligible person or a dependent who is on active military duty, including health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
- Custodial care made up of services and supplies that meets one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment; or
  - Care that can safely and adequately be provided by persons who do not have the technical skills of a health care professional;

- Care that meets one of the above conditions is custodial care regardless of any of the following:
  - Who recommends, provides, or directs the care;
  - Where the care is provided; and
  - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself;
- Dental care or treatment of injuries or diseases to the mouth, teeth, gums, or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, implants, and non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment. See “Covered services and supplies” on page 129 for limited coverage of oral surgery and dental services;
- Devices used specifically as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs, such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation;
- Ecological or environmental medicine, diagnosis, and/or treatment;
- Educational services, special education, remedial education, or job training. The plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct, including impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use) problems and learning disabilities are not covered by the plan; See “Covered services and supplies” on page 129 for limited coverage of cognitive services.
- Education, training, and bed and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged, or a nursing home;
- Enteral feedings and other nutritional and electrolyte supplements, unless it is the sole source of sustenance;
- Expenses charged by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which marks their services available.
- Expenses that are the legal responsibility of a third-party payer, such as Workers’ Compensation or as a result of a claim;
- Expenses incurred by a dependent if the dependent is covered as an employee, under the plan for the same services;
- Experimental, investigational, or unproven services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by the Claims Administrator, unless approved by the Claims Administrator in advance. This exclusion will not apply to drugs:
  - That have been granted investigational new drug (IND) treatment or Group treatment IND status;
  - That are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

- That the Claims Administrator has determined, based on scientific evidence, demonstrate effectiveness or show promise of being effective for the disease. See the "Glossary" for the definition of experimental, investigational or unproven services;

- Eyeglasses and contact lenses (**Anthem BlueCross BlueShield and Oxford** will cover eyeglasses or contact lenses within 12 months following cataract surgery);
- False teeth;
- **Aetna**: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth;
- Hair analysis;
- Hair transplants, hair weaving, or any drug used in connection with baldness. Wigs and hairpieces are not covered unless the hair loss is due to chemotherapy or radiation therapy. Wigs and hairpieces needed for endocrine, metabolic diseases, psychological disorders (such as stress or depression), burns, or acute traumatic scalp injury associated with hair loss must be evaluated and preauthorized by the Claims Administrator;
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated;
- **Aetna:** Hearing services or supplies that do not meet professionally accepted standards; hearing exams given during a stay in a hospital or other facility; replacement parts or repairs for a hearing aid; and any tests, appliance, and devices for the improvement of hearing or to enhance other forms of communication to compensate for hearing loss or devices that stimulate speech, except as described under "Covered services and supplies" on page 129;
- Herbal medicine, holistic, or homeopathic care, including drugs;
  - **Aetna:** Not covered; however, discounts are available through the Aetna Natural Products and Services Discount Program;
  - **Anthem BlueCross BlueShield:** Not covered; however, discounts on alternative medicine and treatment are available through the Anthem SpecialOffers Program. Log in to Anthem's website at **www.anthem.com** and click on "Discounts" for information about the Anthem SpecialOffers Program;
  - **Oxford:** Not covered; however, discounts are available for some services under the Oxford Healthy Bonus Program;
- Household equipment including, but not limited to, the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, equipment or supplies to aid sleeping or sitting, removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other sources of allergies or illness are not covered. Improvements to your home or place of work, including, but not limited to, ramps, elevators, handrails, stair glides, and swimming pools, are not covered;
- Hypnotherapy, except when approved in advance by the Claims Administrator;
- Implantable drugs (other than contraceptive implants);

- Infertility services, except as described under “Covered services and supplies” on page 129. The plan does not cover charges for the freezing and storage of cryopreserved embryos and charges for storage of sperm or surrogate mothers or any charges associated with them.
- Aetna’s exclusions and limitations on infertility services includes:
  - Infertility services for a female attempting to become pregnant who has *not* had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the infertility program;
  - Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
  - Reversal of sterilization surgery;
  - Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
  - The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;
  - Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.);
  - Home ovulation prediction kits;
  - Drugs related to the treatment of non-covered benefits;
  - Injectable infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
  - Any services or supplies provided without pre-certification from Aetna’s infertility case management unit;
  - Infertility Services that are not reasonably likely to result in success;
  - Ovulation induction and intrauterine insemination services if you are not infertile.
- Inpatient private-duty or special nursing care. Outpatient private-duty nursing services must be preauthorized by the Claims Administrator
- Membership costs for health clubs, personal trainers, massages, weight loss clinics, and similar programs; (**Oxford Health Plans** offers a $200 reimbursement every six months for employees who can prove they have had 50 gym visits in that time period and $100 every six months for spouses who can prove they have had 50 gym visits in that time period).
- Naturopathy;
- Nutritional counseling and nutritionists except as described under “Covered services and supplies” on page 129;
- Occupational injury or sickness. An occupational injury or sickness is an injury or sickness that is covered under a Workers’ Compensation act or similar law. For persons for whom coverage under a Workers’ Compensation act or similar law is optional because they could elect it, or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the Workers’ Compensation act or similar law had that coverage been elected;

- Outpatient supplies, including, but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic garments, support hose, bedpans, splints, braces, compresses, reagent strips and other devices not intended for reuse by another patient; contact your plan for details. (These may not always be excluded.);
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services;
- Physical, psychiatric, or psychological exams, testing, or treatments not otherwise covered, when such services are:
  - For purposes of obtaining, maintaining, or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage, or adoption;
  - Relating to judicial or administrative proceedings or orders;
  - Conducted for purposes of medical research; or
  - To obtain or maintain a license of any type;
- Radial keratotomy or any other related procedures designed to surgically correct refractive errors, such as LASIK, PRK, or ALK;
- Recreational, educational, and sleep therapy, including any related diagnostic testing;
  - **Oxford:** Sleep therapy covered when medically necessary
- Religious, marital, family, career, social adjustment, pastoral, financial, and sex counseling, including related services and treatment;
- Reversal of voluntary sterilizations, including related follow-up care;
- Routine hand and foot care services, including routine reduction of nails, calluses, and corns;
- Services not covered by the plan;
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation;
- Services provided by your close relative (your spouse, child, brother, sister, or your or your spouse's parent or grandparent) for which, in the absence of coverage, no charge would be made;
- Services given by volunteers or persons who do not normally charge for their services;
- Services required by a third party including, but not limited to, physical exams and diagnostic services in connection with:
  - Obtaining or continuing employment;
  - Obtaining or maintaining any license issued by a municipality, state, or federal government;
  - Securing insurance coverage;
  - Travel; and
  - School admissions or attendance, including exams required to participate in athletics unless the service is considered to be part of an appropriate schedule of wellness services;
- Services you are not legally obligated to pay for in the absence of this coverage;

- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a covered person under the plan and is undergoing a covered transplant. Services for, or related to, transplants involving mechanical or animal organs are not covered;
- Special education, including lessons in sign language to instruct a plan participant whose ability to speak has been lost or impaired to function without that ability;
- Special medical reports, including those not directly related to the medical treatment of a plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation;
- Specific non-standard allergy services and supplies, including, but not limited to:
  - Skin titration (Rinkle method);
  - Cytotoxicity testing (Bryan's Test);
  - Treatment of non-specific candida sensitivity;
  - Urine autoinjections;
- Stand-by services: Boutique, concierge, or on-call fees required by a physician;
- Surgical operations, procedures, or treatment of obesity, except when approved in advance by the Claims Administrator;
- Telephone consultations;
  - **Aetna:** Covered through Teladoc
  - **Anthem:** Covered through LiveHealth Online
  - **Oxford**: Telemedicine recognized by Medicare and Medicaid Services are covered when submitted with correct coding.
- Therapy or rehabilitation including, but not limited to:
  - Primal therapy;
  - Chelation therapy (except to treat heavy metal poisoning);
  - Rolfing;
  - Psychodrama;
  - Recreational;
  - Deep Sleep therapy;
  - Thermograms and thermography;
  - Megavitamin therapy;
  - Purging;
  - Bioenergetic therapy;
  - Vision perception training, except when medically necessary; and
  - Carbon dioxide therapy;
- Thermograms and thermography;

- Treatment in a federal, state, or governmental facility, including care and treatment provided in a non-participating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws;
- Treatment of injuries sustained while committing a felony or an assault or during a riot or insurrection;
- Treatment of diseases, injuries, or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you;
- Treatment, including therapy, supplies, and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis;
- Treatment of spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or dislocation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or dislocation of or in the vertebral column; and
- Weight reduction or control (unless there is a diagnosis of morbid obesity), special foods/nutritional supplements, liquid diets, diet plans, or any related products. **Aetna**: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Additional medical plan information

These features apply to ChoicePlan 500 (CP500), the High Deductible Health Plan (HDHP), and Oxford Health Plans PPO, as noted.

Mental health and substance abuse benefits

All visits for both inpatient and outpatient mental health and substance abuse treatment are reimbursed at the same coinsurance level as other medical services, according to your plan, subject to medical necessity.

The plans administered by Aetna, Anthem BlueCross BlueShield, and Oxford Health Plans provide confidential mental health and substance abuse services through a network of counselors and specialized practitioners.

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

You must call your plan before seeking treatment for inpatient mental health or substance abuse treatment. Call your plan for the names of network providers.

Programs available to medical plan participants

Some medical plans offer special programs and services for plan participants. To find out about these programs and services, contact your plan for details.

Claims and appeals

Claims and appeals for Aetna medical plans

All claims for benefits must be filed within certain time limits. Medical claims must be filed within two years of the date of service. The amount of time Aetna will take to make a decision on a claim will depend on the type of claim.

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

[1] The time period allowed to make a decision is suspended pending receipt of additional information.

Contact your medical plan Claims Administrator to obtain a claims appeal form. For claims regarding eligibility or enrollment in a plan, call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “health and welfare benefits” option. For TDD and international assistance, please see the “For More Information” section.

The form explains how and when to file a claim.

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

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

- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the plan's appeals procedure.

Appeals for Aetna medical plans

Under the plan, you may file claims for plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claims, Appeals and External Review section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company (Aetna). The notice will explain the reason for the denial and the appeal procedures available under the plan.

Urgent Care Claims

An "Urgent Care Claim" is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you have received pre-certification for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Aetna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Health Claims – Standard Appeals

As an individual enrolled in the plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the plan.

An "Adverse Benefit Determination" is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is **experimental or investigational**; or
- A decision that the service or supply is not **medically necessary**.

A "Final Internal Adverse Benefit Determination" is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of Internal Appeals Process

Generally, you are required to complete all appeal processes of the plan before being able to obtain External Review or bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the plan's appeal requirements ("Deemed Exhaustion") and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to External Review if:

- A rule violation was minor and is not likely to influence a decision or harm you; and
- It was for a good cause or was beyond Aetna's or the Plan's or its designee's control; and
- It was part of an ongoing good faith exchange between you and Aetna or the Plan.

This exception is not available if the rule violation is part of a pattern or practice of violations by Aetna or the Plan.

You may request a written explanation of the violation from the Plan or Aetna, and the Plan or Aetna must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an External Reviewer or a court rejects your request for immediate review on the basis that the plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the External Reviewer or court rejects the claim for immediate

review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

Full and Fair Review of Claim Determinations and Appeals

Aetna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna's Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Aetna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, provided that you file any lawsuit or similar enforcement proceeding, commenced in any forum, 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.

Health Claims – Voluntary Appeals

External Review

"External Review" is a review of an eligible Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A "Final External Review Decision" is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review

The External Review process under this plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the claim decision involves medical judgment and the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations); or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review

Within 5 business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review and you are eligible for external review.

Within one business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to ERO

Aetna will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the plan or issuer, you, or your treating provider;
- The terms of your plan to ensure that the ERO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with applicable law; and
- The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

The plan must allow you to request an expedited External Review at the time you receive:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard External Review. Aetna must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for External Review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

Claims and appeals for Anthem BlueCross BlueShield medical plans

All claims for benefits must be filed within certain time limits. Medical claims must be filed within two years of the date of service.

For purposes of these Appeal provisions, “claim for benefits” means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of adverse benefit determination

If your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- Information sufficient to identify the claim involved
- The specific reason(s) for the denial;
- A reference to the specific plan provision(s) on which the claims administrator's determination is based;
- A description of any additional material or information needed to perfect your claim;
- An explanation of why the additional material or information is needed;
- A description of the plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA if you appeal and the claim denial is upheld;
- Information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- Information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision.
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- The Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- The Claims Administrator may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Claims Administrator at (the number shown on your identification card) and provide at least the following information:

- The identity of the claimant;
- The date (s) of the medical service;
- The specific medical condition or symptom;
- The provider's name
- The service or supply for which approval of benefits was sought; and
- Any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the *Member* or the *Member's authorized representative*, except where the acceptance of oral *appeals* is otherwise required by the nature of the *appeal* (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem BCBS
PO Box 105568
Atlanta, GA 30348

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- Was relied on in making the benefit determination; or
- Was submitted, considered, or produced in the course of making the benefit determination; or
- Demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- Is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

The Claims Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the rationale.

How your appeal will be decided

When the Claims Administrator considers your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the outcome of the appeal

If you appeal a claim involving urgent/concurrent care, the Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Claims Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal

If you appeal a post-service claim, the Claims Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled “Notice of Adverse Benefit Determination.”

Voluntary second level appeals

If you are dissatisfied with the plan’s mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator’s decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at (the number shown on your identification card) and provide at least the following information:

- The identity of the claimant;
- The date (s) of the medical service;
- The specific medical condition or symptom;
- The provider’s name
- The service or supply for which approval of benefits was sought; and
- Any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem BCBS
PO Box 105568
Atlanta, GA 30348

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the plan's final decision on the claim or other request for benefits. If the plan decides an appeal is untimely, the plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the plan. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

Claims and appeals for Oxford Health Plans medical plans

All claims for benefits must be filed within certain time limits. Medical claims must be filed within two years of the date of service.

In-network benefits

In general, if you receive Covered Services from an in-network provider, Oxford will pay the physician or facility directly. If an in-network provider bills you for any covered service other than your copay or coinsurance, please contact the provider or call the Customer Service phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the annual deductible and paying any copay or coinsurance owed to an in-network provider at the time of service, or when you receive a bill from the provider.

If you receive covered services from an in-network provider but not in accordance with the terms and conditions of the Plan/SPD, coverage will be provided as described in the Plan/SPD. When you see an in-network provider under these circumstances, the covered services will be treated as if they were delivered by an out-of-network provider, and you must file a claim as described below.

Out-of-network benefits

If you receive a bill for covered services from an out-of-network provider, you (or the provider if they prefer) must send the bill to Oxford for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to Oxford at the address on the back of your ID card.

How to submit a claim

You can obtain a claim form by visiting oxhp.com, calling the toll-free Customer Service number on your ID card or contacting your plan Administrator. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

> Your name and address;

- The patient's name, age and relationship to the participant;
- The number as shown on your ID card;
- The name, address and tax identification number of the provider of the service(s);
- A diagnosis from the physician;
- The date of service;
- An itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the sickness or injury began; and
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

The above information should be filed with Oxford at the address on your ID card. When filing a claim for outpatient Prescription Drug Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

Payment options

When you receive covered services from an out-of-network provider, the plan will reimburse you and you will then be responsible for reimbursing the provider. You may not assign the right to reimbursement under the Plan/SPD to an out-of-network provider without Oxford's consent. However, in Oxford's discretion, the Plan may pay an out-of-network provider directly.

Limitations

All requests for reimbursement from participating providers must be made within 90 days of the date covered services were rendered. If coordination of benefits applies, the filing deadline is 120 days of the date on the explanation of benefits. Failure to request reimbursement within the required time will not invalidate or reduce any claim if it was not reasonably possible to provide such proof within the 90-day period. However, such request must be made as soon as reasonably possible thereafter. Under no circumstances will the plan be liable for a claim that is submitted more than six months after the date services were rendered, unless you are legally incapacitated and unable to submit the request. All reimbursements to out-of-network providers are subject to UCR unless you were referred to an in-network provider by your PCP or Oxford.

- **Participating providers:** The filing deadline for claim submission is 90 days from the date of service or date of discharge. If COB applies, the filing deadline is 120 days from the date on the EOB.
- **Members and non-participating providers:** The filing deadline for claim submission is two years from the date of service.

If you receive a bill from an in-network provider

The cost of covered services provided by in-network providers in accordance with the terms of this Plan/SPD will be billed directly to Oxford. No claim forms are necessary.

If you should receive a bill from an in-network provider for covered services, please contact the Customer Service Department immediately.

Claim information

Please allow up to 30 business days for the processing of in-network claims. Claims for out-of-network covered services will be paid within 60 business days after Oxford receives proof of the claim.

If necessary, Oxford's Claims Department will contact you for more information regarding your claim in order to speed up the processing. If you would like to inquire about the status of a claim, call the "Claims" telephone number list in the front of the Plan/SPD. Please have the date of service and your ID number ready.

Explanation of Benefits (EOB)

You may request that Oxford send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free Customer Service number on your ID card to request them. You can also view and print all of your EOBs online **oxhp.com.**

Limitation of action

You cannot bring any legal action against the Plan Administrator or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Plan Administrator or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

Claim denials and appeals

If your claim is denied

If a claim for Benefits is denied in part or in whole, you may call Oxford at the number on your ID card before requesting a formal appeal. If Oxford cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to appeal a denied claim

If you wish to appeal a denied pre-service request for benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card;
- The provider's name;
- The date of medical service;
- The reason you disagree with the denial; and
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

Oxford – Appeals
P.O. Box 29139
Hot Springs, Arkansas 71903

For Urgent Care requests for benefits that have been denied, you or your provider can call Oxford at the toll-free number on your ID card to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for benefits
- Pre-service request for benefits;
- Post-service claims; or
- Concurrent claim.

Review of an appeal

Oxford will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination; and
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if Oxford upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a second appeal

Your plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal Oxford within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any covered member may examine documents relevant to their claim and/or appeals and submit opinions and comments. Oxford will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal external review program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Oxford, or if Oxford fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of Oxford's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons;
- The exclusions for Experimental or Investigational Services or Unproven Services;
- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received Oxford's decision.

An external review request should include all of the following:

- A specific request for an external review;
- The covered person's name, address, and insurance ID number;
- Your designated representative's name and address, when applicable;
- The service that was denied; and
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). Oxford has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review; and
- An expedited external review.

Standard external review

A standard external review is comprised of all of the following:

- A preliminary review by Oxford of the request;
- A referral of the request by Oxford to the IRO; and
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, Oxford will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the plan at the time the health care service or procedure that is at issue in the request was provided;
- Has exhausted the applicable internal appeals process; and
- Has provided all the information and forms required so that Oxford may process the request.

After Oxford completes the preliminary review, Oxford will issue a notification in writing to you. If the request is eligible for external review, Oxford will assign an IRO to conduct such review. Oxford will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

Oxford will provide to the assigned IRO the documents and information considered in making Oxford's determination. The documents include:

- All relevant medical records;
- All other documents relied upon by Oxford; and
- All other information or evidence that you or your physician submitted. If there is any information or evidence you or your physician wish to submit that was not previously provided, you may include this information with your external review request and Oxford will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Oxford. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and Oxford, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing Oxford determination, the plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the plan will not be obligated to provide benefits for the health care service or procedure.

Expedited external review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, Oxford will determine whether the individual meets both of the following:

- Is or was covered under the plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that Oxford may process the request.

After Oxford completes the review, Oxford will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, Oxford will assign an IRO in the same manner Oxford utilizes to assign standard external reviews to IROs. Oxford will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Oxford. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to Oxford.

You may contact Oxford at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of appeals determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for benefits - a request for benefits provided in connection with Urgent Care services, as defined in Section 13, Glossary;
- Pre-Service request for benefits - a request for benefits which the plan must approve or in which you must call Oxford before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and Oxford are required to follow.

Urgent care request for benefits	
Type of request for benefits or appeal	**Timing**
If your request for benefits is incomplete, Oxford must notify you within:	24 hours
You must then provide completed request for benefits to Oxford within:	48 hours after receiving notice of additional information required
Oxford must notify you of the benefit determination within:	72 hours
If Oxford denies your request for benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Oxford must notify you of the appeal decision within:	72 hours after receiving the appeal

[1]You do not need to submit Urgent Care appeals in writing. You should call Oxford as soon as possible to appeal an Urgent Care request for benefits.

Pre-service request for benefits	
Type of request for benefits or appeal	**Timing**
If your request for benefits is filed improperly, Oxford must notify you within:	5 days
If your request for benefits is incomplete, Oxford must notify you within:	15 days
You must then provide completed request for benefits information to Oxford within:	45 days
Oxford must notify you of the benefit determination:	
if the initial request for benefits is complete, within:	15 days
after receiving the completed request for benefits (if the initial request for benefits is incomplete), within:	15 days

Pre-service request for benefits	
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Oxford must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Oxford must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

Post-service claims	
Type of request for benefits or appeal	**Timing**
If your claim is incomplete, Oxford must notify you within:	30 days
You must then provide completed claim information to Oxford within:	45 days
Oxford must notify you of the benefit determination:	
if the initial claim is complete, within:	30 days
after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Oxford must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Oxford must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Concurrent care claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. Oxford will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of action

You cannot bring any legal action against Citi or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Citi or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Citi or the Claims Administrator.

You cannot bring any legal action against Citi or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Citi or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Citi or the Claims Administrator.

Prescription drugs

Express Scripts (ESI) manages the Citigroup Prescription Drug Program ("Program") for participants in the ChoicePlan 500, High Deductible Health Plan (HDHP), and Oxford PPO. The Citigroup Prescription Drug Program is a component of the Citigroup Health Benefit Plan.

Prescription drug benefits for HMOs are provided through the HMOs and are not included here. Contact your HMO for its prescription drug benefits.

Express Scripts covers Food and Drug Administration (FDA) approved (federal legend) medications that require a prescription from your physician. The Program will also cover certain over-the-counter (OTC) products in compliance with The Affordable Care Act. If you have any questions about whether a medication is covered, call Express Scripts at **1-800-227-8338**.

Express Scripts offers three ways to purchase prescription drugs:

1. Through a network of retail pharmacies nationwide where you can obtain prescription drugs for your immediate short-term needs, such as an antibiotic to treat an infection;
2. Through the Express Scripts Home Delivery program where you may save money by having your maintenance and preventive drugs delivered by mail; and
3. Through the ESI Specialty Pharmacy known as Accredo Health Group (Accredo), which was previously known as Curascript, for specialty medications. You can fill your first two specialty drug prescriptions at a retail pharmacy or at Accredo; for the third and future specialty prescription refills, you must use Accredo.

You will pay a deductible, as shown in the following table, for drugs purchased at a retail pharmacy, through mail order, or through Accredo before the Program will pay benefits. *You will never pay more than the cost of the drug.*

Contents

Prescription drug benefits at a glance

PRESCRIPTION DRUG BENEFITS			
	ChoicePlan 500	**High Deductible Health Plan**[1]	**Oxford PPO**
Annual deductible (in-network and out-of-network combined in ChoicePlan 500 and Oxford PPO)			
Individual	$100 per person (prescription drug deductible)	$1,800 in-network/$2,800 out of network; includes medical expenses	$100 maximum (prescription drug deductible)
Maximum per family	$200 family maximum (prescription drug deductible)	$3,600 in-network/$5,600 out of network; includes medical expenses (no benefits will be paid to an individual until the family deductible has been met)	$200 family maximum (prescription drug deductible)
ChoicePlan 500 and Oxford PPO: Annual prescription drug out-of-pocket maximum includes prescription deductible, prescription coinsurance and prescription copayments. In-network and out-of-network are combined. Note: This is separate from the annual medical out-of-pocket maximum. **High Deductible Health Plan:** Prescription drug expenses count toward the medical annual out-of-pocket maximum. Keep in mind, you will still pay 100% of the prescription cost after the out-of-pocket maximum is met after the third fill of a maintenance prescription at a retail pharmacy or after the second fill of a specialty medication through a retail pharmacy.			
Individual	$1,500 per person (prescription drug out-of-pocket maximum)	N/A (counts toward medical annual out-of-pocket maximum)	$1,500 per person (prescription drug out-of-pocket maximum)
Maximum per family	$3,000 family maximum (prescription drug out-of-pocket maximum)	N/A (counts toward medical annual out-of-pocket maximum)	$3,000 family maximum (prescription drug out-of-pocket maximum)
Copayment for up to a 34-day supply at an in-network pharmacy, after you meet your deductible. You may have the same maintenance prescription filled up to three times at a retail pharmacy; on the fourth fill, you will pay 100% of the cost of the medication. However, this medication will be available from home delivery for your 90-day copay.[2]			
> Generic drug[3]	$5		
> Preferred brand-name drug[4]	$30		
> Non-preferred brand-name drug	50% of the cost of the drug with a minimum payment of $50 up to a maximum of $150. If the cost of the drug is less than $50, you will pay the cost of the prescription drug.		
> Contraceptives (hormonal and emergency)	**Generics:** not subject to annual deductible, and no cost to you **Brand name drugs:** subject to the annual deductible and applicable preferred or non-preferred cost share requirement **Note:** If you cannot take generics, brand-name drugs will be available at no cost to you if you receive prior approval (your provider must provide evidence that you cannot take generics)		

PRESCRIPTION DRUG BENEFITS			
	ChoicePlan 500	**High Deductible Health Plan[1]**	**Oxford PPO**
Copayment for a 90-day supply through the Express Scripts Home Delivery program after you meet your deductible			
> Generic drug[3]	$12.50		
> Preferred brand-name drug[4]	$75		
> Non-preferred brand-name drug	50% of the cost of the drug with a minimum payment of $125 to a maximum of $375		
> Oral contraceptives (hormonal and emergency)	**Generics:** not subject to annual deductible, and no cost to you **Brand name drugs:** subject to the annual deductible and applicable preferred or non-preferred cost share requirement **Note:** If you cannot take generics, brand-name drugs will be available at no cost to you if you receive prior approval (your provider must provide evidence that you cannot take generics)		
Copayment for a 30-day supply of specialty medication through the Accredo Specialty Pharmacy after you meet your deductible[5]			
> Generic drug[3]	$5		
> Preferred brand-name drug[4]	$75		
> Non-preferred brand-name drug	50% of the cost of the drug with a minimum payment of $50 to a maximum of $150		
Benefits at an out-of-network pharmacy			
50% of your cost after you meet the deductible; you must file a claim for reimbursement			

1 In the High Deductible Health Plan (HDHP), you must meet your combined medical/prescription drug deductible before the Program will pay benefits, except for certain preventive drugs. To determine if your medication is considered preventive, visit **www.express-scripts.com**. Your cost for these preventive drugs is the applicable copayment or coinsurance, which will count toward your out-of-pocket maximum.

2 Retail pharmacy purchases are not reimbursable under the Program after three refills of the same maintenance drug.

3 The use of generic equivalents whenever possible (through both the retail and Express Scripts Home Delivery programs) is more cost-effective. Ask your medical professional about this distinction. If you request a brand-name drug and a generic alternative is available, you will pay the difference between the cost of the brand-name drug and the generic drug in addition to the copayment for the generic drug.

4 Citi does not determine preferred brand-name drugs. Rather, Express Scripts brings together an independent group of practicing physicians and pharmacists who meet quarterly to review the preferred brand-name formulary list and make determinations based on current clinical information. Call Express Scripts at **1-800-227-8338** or visit **www.express-scripts.com** for a copy of its Preferred Formulary (updated at least quarterly).

5 Except in case of an emergency, each prescription for specialty medications can be filled only twice through a retail pharmacy. For third and future refills, you are required to fill the prescription through Accredo.

Note: For the ChoicePlan 500 and Oxford PPO, pharmacy and/or Express Scripts Home Delivery copayments do not count toward your medical plan's annual deductible or out-of-pocket maximum as there is a separate pharmacy deductible and a separate pharmacy out-of-pocket maximum.

Retail network pharmacies with Express Scripts

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

For some drugs to be covered, you may have to provide a letter from your physician. Prescriptions may be screened for specific requirements and must be related to the diagnosis for which they are prescribed.

If you expect to have a prescription filled more than three times, it is more cost-efficient to use the Express Scripts Home Delivery program.

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

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

A network pharmacy will accept your prescription and prescription drug ID card and, once you have met your deductible, will charge you the appropriate copayment/coinsurance for a covered drug. Your copayment/coinsurance will be based on whether your prescription is for a generic drug, a preferred brand-name drug on the Express Scripts Preferred Formulary, or a non-preferred drug. If you purchase a drug that is not covered under the Program, you will pay 100% of the full, non-discounted price of the drug. See “Drugs not covered” on page 190 for more information.

‘Dispense as written’

If your physician writes “Dispense as written” on the prescription or if your physician prescribes a drug for which there is no generic equivalent, your copayment is that of either a preferred brand-name drug or a non-preferred brand-name drug. If the pharmacy’s price is less than the copayment, you will pay the pharmacy’s price. Benefits do not start until the annual deductible has been met.

Using your prescription drug ID card

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

Upon your enrollment, Express Scripts will receive your eligibility information. If you do not have an ID card, please ask your pharmacist to contact Express Scripts so they can be billed for the prescription. In the event that you must pay cash for the prescription, you will have a 45-day grace period from the effective date of your enrollment in which you will be covered even though you do not present your prescription drug ID card when purchasing drugs at a retail pharmacy. If you do not present your prescription drug ID card at the time of service during this initial 45-day period, you will still be reimbursed for 100% of the cost of any covered drugs, less the network copayment, after meeting the annual deductible.

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

In either case, you must pay the entire cost of the prescription drug and then submit a claim form to be reimbursed. To access a claim form, visit Citi Benefits Online at **www.citibenefitsonline.com** and select “Claim forms.”

Send all completed claim forms to:

Express Scripts Pharmacy
P.O. Box 66583
St. Louis, MO 63166

Meeting your deductible

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

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

Your out-of-pocket maximum

There is a separate prescription drug out-of-pocket maximum ($1,500 per individual and $3,000 per family) under the ChoicePlan 500 and Oxford PPO effective January 1, 2015. This feature is designed to help protect you from a large annual expense for prescription drugs since this is the most you will ever pay for prescriptions per year. Once you reach the out-of-pocket maximum, the Program will pay 100% of your covered prescription costs for the remainder of the plan year.

Keep in mind, you will still pay 100% of the prescription cost after the out-of-pocket maximum is met after the third fill of a covered maintenance prescription at a retail pharmacy or after the second fill of a covered specialty medication through a retail pharmacy.

There is a combined medical and prescription drug out-of-pocket maximum under the High Deductible Health Plan (HDHP) of $5,000 individual and $10,000 family in-network ($7,500 individual and $15,000 family out-of-network). This amount includes your medical/prescription drug deductible, coinsurance and copayments. This represents the most you will have to pay out of your own pocket in a plan year.

For answers to your questions about the out-of-pocket maximum, call Express Scripts at **1-800-227-8338**.

Express Scripts Home Delivery

For prescriptions for maintenance medications that you have filled three times at a retail pharmacy, you must use the Express Scripts Home Delivery program beginning on your fourth fill to avoid paying 100% of the cost of the drug.

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

When you use Express Scripts Home Delivery:

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

Obtaining a refill of a maintenance medication with Express Scripts

The first three times you purchase a maintenance medication at a retail network pharmacy or out-of-network pharmacy after you meet the applicable deductible, you will pay the applicable copayment or coinsurance. You will receive a notice from Express Scripts advising you of the benefits of the Express Scripts Home Delivery program.

If, after the prescription is filled three times, you still want to purchase this maintenance medication at a retail pharmacy instead of through Express Scripts Home Delivery, you will pay 100% of the cost of the current prescription or a new prescription for the same medication and strength. Maintenance drugs, generally, are drugs taken on a regular basis for conditions such as asthma, heartburn, blood pressure, and high cholesterol. If you need to know if your prescription drug is considered a maintenance medication, call Express Scripts at **1-800-227-8338**.

Specialty medication with Express Scripts

Accredo — Express Scripts' specialty pharmacy — dispenses oral and injectable specialty medications for the treatment of complex chronic diseases, such as, but not limited to, multiple sclerosis, hemophilia, cancer, and rheumatoid arthritis. Prescriptions sent to Express Scripts Home Delivery that should be filled by Accredo will be forwarded. Specialty medications purchased through Accredo are limited to a 30-day supply or less.

Accredo offers the following:

- Once you are using the Accredo program, Accredo will call your physician to obtain a prescription and then call you to schedule delivery.
- Prescription drugs can be delivered via overnight delivery to your home, work, or physician's office within 48 hours of ordering.
- You are not charged for needles, syringes, bandages, sharps containers, or any supplies needed for your injection program.
- An Accredo team of representatives is available to take your calls, and you can consult 24/7 with a pharmacist or nurse experienced in injectable medications.
- Accredo will send monthly refill reminders to you.

To learn more about Accredo's services, including the cost of your prescription drugs, call Accredo at **1-866-413-4135**.

Exclusive Accredo

Citi participates in the Exclusive Accredo program (one of the Accredo specialty pharmacy programs), which means that, except in the case of an emergency, you can fill a prescription for a specialty medication only twice through a retail pharmacy. After that, the pharmacy will be unable to fill the prescription and you will be required to fill it through Accredo.

In the event of an emergency, please contact Express Scripts to fill the prescription more than twice at a retail pharmacy. You will continue to be charged only the applicable retail/specialty copayment.

Controlled substances with Express Scripts

Upon request, Express Scripts will fill prescriptions for controlled substances for up to a 90-day supply, subject to state limits (and any Program limits).

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

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

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

How the controlled substance processing works

Controlled substance restrictions:

- The Food and Drug Administration (FDA) does not allow refills on Class II controlled substances. A new prescription must be presented each time the medication is filled.

- The Drug Enforcement Administration (DEA) requires presentation of a hardcopy on Class II prescriptions. They cannot be phoned or faxed into ANY pharmacy. They can, however, be e-prescribed by prescribers who have DEA certified systems and whose states allow for e-prescriptions for Class II drugs.
- The DEA mandates that prescriptions for Class III — Class V medications must be expired six months from the date that they are written. **Note:** Express Scripts must comply to any state regulations that are stricter than federal regulations.
- Express Scripts Pharmacy fills all controlled medications out of its St. Louis facility. There is a very stringent verification process that takes place. The pharmacist reviews the actual hardcopy against the system entry prior to releasing for fulfillment.

Special requirements for controlled substance processing:

- Controlled substances require very specific information to be present on the prescription in order to be processed by Express Scripts. In the majority of cases the information required is missing upon original receipt of prescriptions.
- **A hand signature** is required on all prescriptions for controlled substances. Any controlled prescription with an electronic or missing signature requires pharmacy outreach to physician. (Electronic signatures on e-prescriptions, where allowed, are acceptable.)
- **A valid DEA number** is required on all controlled substance prescriptions. If the DEA number is present, technicians must validate the DEA number. If the DEA number for the prescribing physician is NOT present or is invalid, pharmacy outreach to the physician is required.
- **A physical address on file** is required for all controlled substances. A physical address must be obtained if the address on the prescription or in our system is a PO Box.
- **A medical reason** is required for any Class II prescriptions being dispensed **over a 30-day** supply regardless of the state where the prescription is issued. A medical reason can either be a diagnosis or a detailed description. For example, “chronic pain” would not be sufficient, but “cervical pain unresolved by surgery” or “stabilized ADHD” would be sufficient. Going off to college is not an acceptable medical reason.

Process for making outreach:

- A **technician or pharmacist** (depending on the information needed) is responsible for making the necessary outreach to the physician’s office or to the patient by phone, fax, or electronic communication.
- The prescriber’s office or patient has two **business days** to respond. If clarification is obtained, the prescription image will **be annotated** and the prescription will continue along in the processing. If not received, the script will be routed to the interventions team who will make additional attempts to contact the physician and or patient for resolution.

Generics Preferred with Express Scripts

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

If you choose the brand-name drug where a generic exists, you must pay the difference between the brand and generic in addition to your copayment. *Express Scripts will always dispense an available generic medication unless otherwise indicated by the prescriber or the member.* See “‘Dispense as written’” on page 183 for more information.

Compound Medications

For compound drugs to be covered under the Program, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain an ingredient on a list of excluded ingredients. Furthermore, the cost of the compound must be determined by Express Scripts to be reasonable (e.g., if the cost of any ingredient has increased more than 5% every other week or more than 10% annually, the cost will not be considered reasonable). Any denial of coverage for a compound drug may be appealed in the same manner as any other drug claim denial under the Program.

Prior authorization with Express Scripts

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

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

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

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

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

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

Medication review with Express Scripts

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

High Deductible Health Plan (HDHP) information

The HDHP covers the cost of certain preventive drugs without having to meet a deductible. You will pay the applicable copayment or coinsurance, which will count toward your combined medical/prescription drug out-of-pocket maximum.

For a list of these preventive medications, call Express Scripts at **1-800-227-8338**. You can also visit **www.express-scripts.com**.

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

Covered drugs

The following drugs and products are covered under the Citigroup Prescription Drug Program:

- Federal legend drugs;
- State-restricted drugs;
- Compound medications of which at least one ingredient is a legend drug not included on the compound exclusion list;
- Insulin;
- Needles and syringes;
- Over-the-counter (OTC) diabetic supplies (except blood glucose testing monitors);
- Oral and injectable contraceptives;
- Fertility agents;
- Legend vitamins;
- Amphetamines used for ADHD, through age 18;
- Drugs to treat impotency, for males age 18 or older (quantity limits apply);
- Retin-A/Avita (cream only), through age 34;
- Retin-A (gel), with no age restrictions; and
- Botulinum toxin type A or B (Botox/Myobloc).

Some drugs require prior authorization, such as (this list is not all inclusive):

- Legend anti-obesity preparations;
- Amphetamines used for ADHD, age 19 or over;
- Retin-A/Avita (cream only), age 35 or over; and
- Botulinum toxin type A or B (Botox/Myobloc).

HEALTH CARE REFORM

In compliance with the Affordable Care Act, certain prescribed drugs are covered at 100%, not subject to the deductible, if certain conditions are met. Certain dosage and other restrictions apply. If conditions are not met, OTC drugs are not covered and generic drugs are subject to the applicable copay or deductible.

	Criteria
Aspirin (to prevent cardiovascular disease)	> Generic OTC > Men ages 45 to 79 years and women ages 55 to 79 years old
Bowel Preps	> Generic OTC & Generic Prescription Drugs > Men and women ages 50 to 75 years old
Contraceptive Methods for Women	> Generic barrier methods (diaphragm and cervical cap) > Generic hormonal contraceptives > Generic emergency contraceptives > Prescribed OTC generic contraceptives (except condoms or other men's contraceptives)
Fluoride (oral formulations)	> Generic OTC & Generic Prescription Drugs > Children 6 months of age through 5 years of age

HEALTH CARE REFORM In compliance with the Affordable Care Act, certain prescribed drugs are covered at 100%, not subject to the deductible, if certain conditions are met. Certain dosage and other restrictions apply. If conditions are not met, OTC drugs are not covered and generic drugs are subject to the applicable copay or deductible.	
Folic Acid	> Generic OTC & Generic Prescription Drugs > Women through age 50
Iron Supplements	> Generic OTC & Generic Prescription Drugs > Children ages 6 to 12 months
Smoking Cessation	> OTC & Prescription Drugs > Adults age 18 and over
Vitamin D	> Generic OTC & Generic Prescription Drugs > Adults age 65 and over
Tamoxifen and Raloxifene for breast cancer prevention	> Generic Prescription Drugs (plus brand Soltamox where medically necessary) > Women aged 35 and over for primary prevention only (physician or member must request no copayment)

Step therapy

A Step Therapy program is a “step” approach to providing prescription drug coverage. Step Therapy is designed to encourage the use of cost-effective prescription drugs when appropriate. To determine if your prescription requires Step Therapy, or is subject to limitations, call Express Scripts at **1-800-227-8338**. If you have a discontinuance or lapse in therapy (typically more than 130 days) while using the brand-name medication and need to restart therapy, you will be subject to another review under the Step Therapy program to determine if the cost of the brand-name medication will be covered under the Program. There is no minimum age requirement for Step Therapy.

Here’s how Step Therapy works:

1. A member presents a prescription for a drug requiring step therapy at a retail pharmacy or via Home Delivery.
2. The pharmacist enters the prescription information into the Express Scripts information (“ESI”) system.
3. The claim is submitted for processing – the ESI system automatically looks back at the member’s claim history to see if the member had a prescription filled in that time period for the alternative drug (typically 130 days).
4. If a claim for an alternative drug is found, the claim will automatically process.
5. If there is no history of a prescription filled for an alternative drug, the prescription claim is rejected.
6. The pharmacist can either contact the member’s physician to see if an alternative drug is acceptable or advise the member to contact his/her physician.
7. The physician can provide a prescription for an alternative drug. If the physician strongly feels that the original drug prescribed will best treat the member’s condition, then he/she can submit a prior authorization request. If the request meets the clinical criteria, the originally prescribed drug will be covered.
8. A notification will be sent to both the member and physician on whether the request has been approved or denied.

Call Express Scripts at **1-800-227-8338** or **www.Express-Scripts.com** to obtain information on if your medication requires step therapy and/or the applicable copay for the generic, preferred brand or non-preferred category of drug.

Other limits

Coverage limits apply to some categories of drugs. These categories include but are not limited to:

- Erectile dysfunction medications;
- Anti-influenza medications;
- Smoking deterrents;
- Migraine medications;
- H2-receptor antagonists; and
- Proton pump inhibitors.

Drugs not covered

For a list of the drugs and products that are not covered under the Citigroup Prescription Drug Program, as well as a list of covered alternatives for select medications, see the 2015 Express Scripts Preferred Drug List Exclusions at Citi Benefits Online. Employees will pay 100% of the full, non-discounted price of these drugs. This list is not exhaustive and there may be other drugs that are not covered. If you have any questions about a specific drug, please call Express Scripts at **1-800-227-8338**.

General exclusions include:

- The following medications:
  - Abbott (FreeStyle, Precision)
  - Abstral
  - Alvesco
  - Apidra
  - Aranesp
  - Axert
  - Bayer (Breeze, Contour)
  - Beconase AQ
  - BenzaClin Gel Pump
  - Betaseron
  - Bravelle
  - Breo Ellipta
  - Cetraxal
  - Cimzia
  - Duexis
  - Edarbi/Edarbyclor
  - Epogen
  - Euflexxa
  - Fentora
  - Flovent Diskus/HFA
  - Follistim AQ
  - Fortesta
  - Frova
  - Gel-One
  - Hyalgan
  - Incivek
  - Jentadueto
  - Kadian
  - Kazano
  - Levitra
  - Nesina
  - Nipro (TRUEtest, TRUEtrack)
  - Novolin
  - NovoLog
  - Nutropin/Nutropin AQ
  - Omnaris
  - Omnitrope
  - Pancreaze
  - PegIntron
  - Pertzye
  - Proventil HFA
  - Roche (Accu-Chek)
  - Saizen
  - Simponi
  - Staxyn
  - Stendra
  - Subsys
  - Supartz
  - Tanzeum
  - Testim
  - Testosterone 1% Gel
  - Teveten HCT
  - Tev-Tropin
  - Tradjenta
  - Ultresa
  - Veltin
  - Veramyst
  - Victoza
  - Vimovo
  - Vogelxo
  - Xeljanz
  - Xopenex HFA
  - Zetonna
  - Zioptan
  - Zohydro ER
- Non-federal legend drugs;
- Prescription drugs for which there are OTC equivalents available, including, but not limited to, benzoyl peroxide, hydrocortisone, meclizine, ranitidine, and Zantac;
- Contraceptive implants:
  - **Note:** Implantable devices such as Mirena or Norplant are covered under the Citigroup Health Benefit Plan (not under the Citigroup Prescription Drug Program portion of the Plan);
- Drugs to treat impotency for all females and males through age 17;
- Irrigants;

- Gardasil and Zostavax (vaccinations are covered under the Citigroup Health Benefit Plan; therefore, the provider must bill accordingly);
- Topical fluoride products;
- Blood glucose testing monitors (covered under medical benefits);
- Therapeutic devices and appliances;
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine®, Propecia®) or are for cosmetic purposes only (e.g., Renova®);
- Allergy serums;
- Biologicals, blood or blood plasma products;
- Drugs labeled "Caution — limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual;
- Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law or any state or governmental agency or medication furnished by any other drug or medical service for which no charge is made to the member;
- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended-care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution that operates as, or allows to be operated as, a facility for dispensing pharmaceuticals on its premises;
- Any prescription refilled in excess of the number of refills specified by the physician or any refill dispensed after one year from the physician's original order; and
- Charges for the administration or injection of any drug.

Claims and appeals for Express Scripts

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

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension due to matters beyond the control of the Claims Administrator (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim[1]
Preservice claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim[1]

Type of claim	Timeline after claim is filed
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information

[1] Time period allowed to make a decision is suspended pending receipt of additional information.

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

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

Express Scripts first-level appeal

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

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

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

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

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

Express Scripts urgent claim appeals

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

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

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;
- If an internal rule or guideline was relied on in making the adverse determination, either the specific rule or guideline, or a statement that such a rule or guideline was relied on in making the adverse determination and that a copy of such rule or guideline will be provided free of charge on request; and
- 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.

Legal Action

No suit or action for benefits under the Plan shall be sustainable in any court of law or equity, unless you complete the appeals procedure, and unless your suit or action is commenced within 12 consecutive months after the committee's final decision on appeal, or if earlier, within two years from the date on which the claimant was aware, or should have been aware, of the claim at issue in the proceeding. The two-year limitation shall be increased by any time a claim or appeal on the issue in under consideration by the appropriate fiduciary.

MCMC external claim review

External Review is a review of an eligible Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A Final External Review Decision is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal.

You have the right to file a request for an External Review with the plan if the request is filed within four months after the date of receipt of this notice of an adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following receipt of this notice. To request this appeal, use the contact information below:

MCMC LLC
ERISA Appeal Team
Express Scripts Appeal Program
300 Crown Colony Drive, Suite 203
Quincy, MA 02169

Telephone: **1-800-652-4840**
Fax: **1-800-882-4715**

Dental

The Citigroup Dental Benefit Plan (the "Dental Plan" or the "Plan") offers two dental options to provide dental care for you and your eligible dependents (including your spouse [same and opposite sex], domestic partner, or civil union partner). They are the:

- MetLife Preferred Dentist Program (MetLife PDP); and
- Cigna Dental HMO (dental health maintenance organization).

You can enroll in Citi dental coverage even if you do not enroll in Citi medical coverage. You can enroll in any of the following four coverage categories: Employee Only, Employee Plus Spouse/Partner, Employee Plus Children, or Employee Plus Family. See "Coverage categories" in the Eligibility and Participation section.

The MetLife PDP allows you to visit any dentist. However, when you visit an in-network dentist, you will pay a discounted fee. The Cigna Dental HMO generally requires you to use a Cigna Dental HMO provider (whom you select or who is selected for you) to receive a benefit under the Dental Plan. See Your Personal Enrollment Worksheet on Your Benefits Resources™ for the cost of the options available to you.

For more information on the dental coverage available, see the MetLife PDP fact sheet and the Cigna Dental HMO fact sheet.

Quick tips

Dental plan differences

The Cigna Dental HMO costs less than the MetLife PDP. However, if you elect the Cigna Dental HMO coverage, you must use a Cigna Dental HMO provider (whom you select or who is selected for you) to receive a benefit under the Dental Plan, except in very limited circumstances. See "Cigna Dental HMO" beginning on page 203.

Consider a spending account or Health Savings Account (HSA)

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

For details, see the information on the HCSA and the LPSA in the Citigroup Spending Account Plan section.

If you choose medical coverage under the High Deductible Health Plan (HDHP) and establish a Health Savings Account (HSA), you may pay for eligible dental expenses with funds from your HSA.

For details, see "Health Savings Accounts (HSAs)" in the Citigroup Health Benefits Plan section.

Contents

Dental options at a glance

	MetLife Preferred Dentist Program (PDP)[1]	Cigna Dental HMO[2]
Annual deductible		
> Individual	$50	None
> Family maximum	$150	None
Preventive and diagnostic services	100% paid, no deductible to meet	Most services are paid at 100% when you use your network dentist
Basic services such as fillings, amalgams (“silver”) and composite (“white”) filings, root canals, periodontal services, extractions, and oral surgery	80% after deductible	Copayment when you use your network dentist. See “Patient Charge Schedule” on page 205 for more information.
Major restorative services such as crowns, inlays/onlays, bridges, and dentures	50% after deductible	Copayment when you use your network dentist. See “Patient Charge Schedule” on page 205 for more information.
Orthodontia	50% after deductible	Copayment when you use your network dentist. See “Patient Charge Schedule” on page 205 for more information.
Lifetime orthodontia limit for children and adults	$3,000 per person	Coverage limited to 24 months of treatment
TMJ (temporomandibular joint) treatment excluding surgery	50% after deductible if not the result of an accident (covered under orthodontia)	100% paid for oral evaluation; copayment for other related services when you use your network dentist
Implants	Subject to “dental necessity”	Copayment when you use your network dentist. Limit of one implant per calendar year; with one replacement per 10 years
Annual maximum	$3,000 per person	None

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

[2] You can obtain a schedule of charges and a list of providers by calling Cigna Dental HMO at **1-800-CIGNA24 (1-800-244-6224)**. Once enrolled, you can obtain a schedule of charges at **www.myCigna.com**. You can also view the Cigna Patient Charge Schedule at **www.citibenefitsonline.com/CignaDentalPatientChargeSchedule.pdf.**

MetLife Preferred Dentist Program (PDP)

The MetLife Preferred Dentist Program (MetLife PDP) is a preferred provider organization (PPO) consisting of a nationwide network of dentists and specialists, who charge negotiated fees that are typically lower than the provider's normal fee; this reduces your out-of-pocket cost.

The MetLife PDP offers:

- Stringent credentialing requirements for providers; and
- Personalized provider directories that you can view online or order by telephone and have faxed or mailed to you; and
- Total freedom of choice; you can visit any dentist at any time.

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

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

- Visit the MetLife MyBenefits website through TotalComp@Citi at **www.totalcomponline.com**; or
- Call **1-888-830-7380** for a provider directory.

When calling to make an appointment, let the dentist know that you participate in the MetLife PDP. Your Citi GEID is your MetLife member ID. Be sure to provide your Citi GEID when calling MetLife or submitting claims. You do not need to present your ID card to your provider to confirm that you are eligible for dental benefits.

How the Plan works

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

Annual deductible and maximum

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

You can meet the family deductible as follows:

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

You and/or your covered dependent(s) have an annual maximum benefit of $3,000 per person (excluding orthodontia). A separate lifetime maximum of $3,000 per person applies to orthodontia treatment.

Covered charges

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

A dental charge is incurred on the date the service is performed or the supply is furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the "preparation date" is considered the date the charge is incurred. The claim will be paid in a lump sum (excluding orthodontia). For example, the preparation date is considered for:

- Root canal therapy as the date the pulp chamber was opened;
- A crown as the date the tooth was prepared for the crown;
- Partial and complete dentures as the date the impressions were taken; and
- Fixed bridgework as the date the abutment teeth were prepared for the bridge.

Orthodontic payments are paid differently.

Coverage for new orthodontic work

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

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

- $5,000 × 20% = $1,000 × 50% benefit = $500;
- Therefore, the first payment will be $500

Coverage for monthly payments:

- $5,000 - $1,000 = $4,000;
- $4,000 ÷ 24 months = $167 × 50% benefit = $84
- Therefore, the monthly payment will be $84

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

Coverage for orthodontic work in progress

The MetLife PDP pays 50% coinsurance, after the annual deductible is met, up to a $3,000 lifetime orthodontia maximum. Orthodontia benefits paid since January 1, 2004, under the MetLife and Delta Dental Citi-sponsored plan (the Delta Plan is no longer available) will count toward the lifetime orthodontia maximum under the MetLife PDP.

Before you receive care

Before you receive certain dental services, you are advised to discuss the treatment plan with your dentist to determine what is covered by the MetLife PDP Plan.

Covered services

Preventive and diagnostic services

- Routine oral exams: maximum of two exams per calendar year (additional medically necessary oral exams will be reviewed by MetLife Dental Consultants);
- Routine cleanings: maximum of two cleanings per calendar year;

- Fluoride treatments through age 14, maximum of one application per calendar year;
- Space maintainers through age 18;
- Full mouth series and panoramic X-rays: once every 60 months;
- Bitewing X-rays: up to one set of per calendar year (up to eight films per visit) for adults, and two sets per calendar year for children;
- Sealants: permanent molars only, through age 16; one application every 36 months; and
- Palliative treatments: emergency treatment only; not paid as a separate benefit from other services on the same day.

Basic services

- Fillings (except gold fillings): includes amalgam ("silver") and composite ("white") fillings to restore injured or decayed teeth;
- Extractions;
- Endodontic treatment;
- Oral surgery, unless covered under your medical plan or your HMO;
- Periodontal surgery: once every 36 months;
- Repair prosthetics: no limit;
- Recementing (crowns, inlays, onlays, bridgework, or dentures): no limit;
- Addition of teeth to existing partial or full denture;
- Denture relining and rebasing: once every 36 months;
- Periodontal maintenance treatments, up to four per calendar year; this covers up to two regular cleanings per year paid at 100% and up to four periodontal maintenance visits per year paid at 80%. These services are combined and do not exceed four total per year;
- Periodontal scaling and root planing: once every 24 months (subject to consultant review);
- Bruxism appliances; and
- General anesthesia: when medically necessary, as determined by the Claims Administrator, and administered in connection with a covered service.

Major services

- Inlays, onlays, and crowns (including precision attachments for dentures; must be at least five years old and unserviceable): limited to one per tooth every five years;
- Removable dentures: initial installation and any adjustments made within the first six months;
- Removable dentures (replacement of an existing removable denture or fixed bridgework with new denture; dentures must be at least five years old and unserviceable): limited to once every five years;
- Fixed bridgework, including inlays, onlays, and crowns used to secure a bridge: initial installation;

- Fixed bridgework, including inlays, onlays, and crowns used to secure a bridge (replacement of an existing removable denture or fixed bridgework with new fixed bridgework or addition of teeth to existing fixed bridgework; bridgework must be at least five years old and unserviceable): limited to once every five years; and
- Dental implants (subject to medical necessity and consultant review): medical necessity, as determined by the Claims Administrator, is based on the number and distribution of all missing, unreplaced teeth in the arch, as well as the overall periodontal condition of the remaining normal teeth.

Oral cancer services

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

Orthodontia services

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

Procedures and services that are not covered

Benefits are not provided for services and supplies not medically necessary for the diagnosis or treatment of dental illness or injury. For example, cosmetic services such as tooth whitening are elective in nature and, therefore, not covered by the Plan.

Exclusions that apply to the MetLife PDP include, but are not limited to, the following:

- Dental care received from a dental department maintained by an employer, mutual benefit association, or similar group;
- Treatment performed for cosmetic purposes;
- Use of nitrous oxide;
- Treatment by anyone other than a licensed dentist, except for dental prophylaxis performed by a licensed dental hygienist under the supervision of a licensed dentist;
- Services in connection with dentures, bridgework, crowns, and prosthetics if for:
  - Prosthetics started before the patient became covered;
  - Replacement within five years of a prior placement covered under this Plan;
  - Extensions of bridges or prosthetics paid for under this Plan, unless into new areas;
  - Replacement due to loss or theft;

  - Teeth that are restorable by other means or for the purpose of periodontal splinting; and
  - Connecting (splinting) teeth, changing or altering the way the teeth meet, restoring the bite (occlusion), or making cosmetic changes;
- Any work done or appliance used to increase the distance between nose and chin (vertical dimension);
- Facings or veneers on molar crowns or molar false teeth;
- Training or supplies used to educate people on the care of teeth;
- Charges for crowns and fillings not covered under basic services;
- Any charges incurred for services or supplies not recommended by a licensed dentist;
- Any charges incurred due to sickness or injury that is covered by a Workers' Compensation act or other similar legislation or that arise out of or in the course of any employment or occupation whatsoever for wage or profit;
- Any charges incurred while confined in a hospital owned or operated by the U.S. government or an agency thereof, for treatment of a service-connected disability;
- Any charges that, in the absence of this coverage, you would not be legally required to pay;
- Any charges incurred that result directly or indirectly from war (whether declared or undeclared);
- Any charges due to injuries sustained while committing a felony or assault or during a riot or insurrection;
- Any charges for services and supplies furnished for you or your eligible dependent(s) prior to the effective date of coverage or subsequent to the termination date of coverage;
- Any charges for services or supplies that are not generally accepted in the United States as being necessary and appropriate for the treatment of dental conditions including experimental care;
- Any charges for nutritional supplements and vitamins;
- Services covered by motor vehicle liability insurance;
- Services that would be provided free of charge but for coverage;
- Broken appointments;
- Charges for filing claims or charges for copies of X-rays;
- Any charges for services rendered to sound and natural teeth injured in an accident;
- Care and treatment that are in excess of the maximum allowed amount; and
- Services that, to any extent, are payable under any medical benefits, including HMOs.

Alternate benefit provision

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

Predetermination of benefits

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

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

Medical necessity

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

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

Filing a claim

When you visit the dentist, you will pay the dentist directly and then submit a claim for benefits. See “Claims and appeals for the MetLife PDP” on page 209.

Cigna Dental HMO

Cigna Dental HMO is fully-insured and operates like a health maintenance organization: Once enrolled, you must receive all services from the Cigna Dental HMO provider you selected. Except for emergency treatment for pain, you will not be covered for any dental services you receive outside the Cigna Dental HMO network.

As a Cigna Dental Plan member, you may be eligible for various discounts, benefits, and other considerations to promote your general health and well-being. Visit the Cigna website at **www.myCigna.com**.

Enrollment in the Cigna Dental HMO allows the release of your and your covered dependents’ dental records to Cigna Dental for administrative purposes.

The Cigna Dental HMO has no annual individual or family deductibles and no lifetime dollar maximums. Most preventive services are paid at 100% when you use a network general dentist. You pay a patient charge when you use a network general dentist for other services. See “Patient Charge Schedule” on page 205 for more information. You can obtain a schedule of charges when you enroll in the Cigna Dental HMO or by calling Cigna Dental at **1-800-Cigna24** or visiting **www.myCigna.com/dental**. It is also available at **www.citibenefitsonline.com/CignaDentalPatientChargeSchedule.pdf**.

Is your dentist in the Cigna Dental HMO network?

Cigna Dental contracts with network dentists in most areas of the country. Network dentists provide covered services to Cigna Dental HMO members at independently owned network dental offices. You can request a list of network dental offices in your area by calling Cigna Dental at **1-800-Cigna24 (1-800-244-6224)**. You can also find a provider on the Cigna website at **http://cigna.benefitnation.net/cigna/docdir.aspx.**

If you want to enroll in the Cigna Dental HMO but have a dentist whom you want to continue using, you should verify that he or she is in the Cigna Dental HMO. Because there are no out-of-network benefits, other than for emergency treatment for pain, you will not be reimbursed for any dental services if you continue to visit your current dentist and he or she is not in the Cigna Dental HMO network.

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

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

Cigna Dental HMO features

- A nationwide network of approximately 18,000 dentists in 65,000+ offices (you must use one of these providers);
- No deductibles to meet;
- No annual or lifetime dollar maximums;
- No charge for exams, certain types of X-rays, or routine cleanings;
- Reduced prices on covered procedures when there is a charge;
- Specialist care with an approved referral at the same fees you would pay a general dentist;
- Automated Dental Office Locator for 24-hour information by telephone or fax to help you find the right dentist;
- Automatic participation in the Cigna Healthy Rewards® program, which offers discounts on various health-related services and products; for more information, visit **www.Cigna.com**;
- Automatic participation in the Cigna Oral Health Integration® program; for more information, visit **www.Cigna.com**;
- Orthodontia for children and adults: limited to 24 months of treatment; additional treatment is available at a prorated cost of the initial treatment;
- Coverage for general anesthesia and IV sedation *when medically necessary and performed by a network oral surgeon or periodontist for covered procedures* (general anesthesia does not include nitrous oxide); and
- Two routine cleanings for normal healthy teeth and gums every calendar year at no charge and two additional per calendar year with a copayment; charges are listed on your Patient Charge Schedule.

Referrals for children

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

How the Plan works

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

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

Specialized care

If your network general dentist determines that you need specialized dental care, he or she will begin the specialty referral process. Follow your network general dentist's instructions regarding access to specialty care. Care from a network specialist is covered when Cigna Dental authorizes payment. Treatment by a network specialist must begin within 90 days from the date of Cigna Dental's authorization. If you are unable to obtain treatment within the 90-day period, call Member Services to request an extension. Your coverage must be in effect when each procedure begins. A referral is not necessary when visiting an orthodontist or pediatric dentist who participates in the Cigna Dental HMO network. **Note:** Services performed by a pediatric dentist are covered until the child reaches age 7. Services performed by a pediatric dentist after the child reaches age 7 are not covered.

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

Changing your dentist/dental office

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

To arrange a transfer, call Member Services at **1-800-Cigna24 (1-800-244-6224)**. Your transfer request will take about five days to process. Transfers generally will be effective the first day of the month after your request is processed. Unless you have an emergency, you will be unable to schedule an appointment at the new dental office until your transfer becomes effective.

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

Appointments

To make an appointment with your network general dentist, call the dental office that you have selected or to which you have been assigned. When you call, your dental office will ask for your ID number (which can be found on your Cigna Dental HMO ID card) and will check your eligibility.

Broken appointments

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

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

Patient Charge Schedule

Your Patient Charge Schedule lists the benefits of the Cigna Dental HMO including covered procedures and patient charges. Patients pay the patient charges listed only when the procedures are performed by a network dentist. Procedures performed by an out-of-network dentist are not covered, and patients will be charged the dentist's usual fee for those procedures. Procedures not listed on your Patient Charge Schedule are not covered and are the patient's responsibility at the dentist's usual fees. You may request your Patient Charge Schedule when you enroll in the Cigna Dental HMO or by calling Cigna Dental at **1-800-Cigna24 (1-800-244-6224)** or visiting **www.myCigna.com** (if you are already a member). It is also available at **www.citibenefitsonline.com/CignaDentalPatientChargeSchedule.pdf**.

Emergencies

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

Examples of a dental emergency include:

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

Examples of non-dental emergencies include:

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

Routine restorative or definitive treatment (root canal therapy) is not considered emergency care and should be performed or referred by the network general dentist or network pediatric dentist.

Away from home

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

- For *Arizona* residents: An emergency is a dental problem that requires immediate treatment (includes control of bleeding, acute infection, or relief of pain including local anesthesia). Reimbursement for emergencies will be made by Cigna Dental in accordance with your plan benefits regardless of the location of the facility providing the services.
- For *Pennsylvania* residents: If any emergency arises and you are out of your service area or are unable to contact your network general dentist, Cigna Dental covers the cost of emergency dental services so that you are not responsible for greater out-of-pocket expenses than if you were attended by your network general dentist.
- For *Texas* residents: Emergency dental services are limited to procedures administered in a dental office, dental clinic, or another comparable facility to evaluate and stabilize emergency dental conditions of recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would cause a prudent layperson with average knowledge of dentistry to believe that immediate care is needed.

To receive reimbursement, send appropriate reports and X-rays to the following Cigna Dental address:

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

After hours

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

Member Services

If you have any questions or concerns about the Cigna Dental HMO, call a Member Services representative who can explain your benefits or help with matters regarding your dental office. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, covered services, plan benefits, ID cards, location of dental offices, conversion coverage, or other matters, call Member Services at **1-800-Cigna24 (1-800-244-6224)**. If you are hearing impaired, call the state TTY toll-free relay service in your local telephone directory.

Limitations on covered services

- **Frequency:** See your Patient Charge Schedule for limitations on frequency of covered services, such as cleanings.
- **Specialty care:** Except for pediatric dentistry and endodontics, payment authorization from the Cigna Dental HMO is required for coverage of services performed by a network specialty dentist.
- **Pediatric dentistry:** Coverage from a pediatric dentist ends on a covered child's seventh birthday. Cigna Dental HMO may consider exceptions for medical reasons on an individual basis. The network general dentist will provide care after the child's seventh birthday.
- **Oral surgery:** The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is for orthodontic reasons only. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Orthodontics in progress:** If orthodontic treatment is in progress for you or your dependent at the time you enroll, call Member Services at **1-800-Cigna24 (1-800-244-6224)** to find out if you are entitled to any benefit under the Plan.

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

You will pay the full cost of procedures and services that are not covered. Visit the Cigna website at **www.Cigna.com**, or call **1-800-244-6224** for more information.

Conversion to an individual policy

You may have the right to convert your Cigna Dental HMO coverage into an individual policy after you terminate employment with Citi. For more information, contact the Citi Benefits Center through ConnectOne at **1-800-881-3938**. For TDD and international assistance, please see the "For More Information" section. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Procedures and services that are not covered

Listed below are the services or expenses that are *not* covered under the Cigna Dental HMO (this list is not exhaustive, and other exclusions may apply). These services are your responsibility and are billed by the dentist at his/her usual fee:

- Services not listed on your Patient Charge Schedule;
- Services provided by an out-of-network dentist without Cigna Dental's prior approval (except emergencies, as explained under "Emergencies" on page 206);

- Services related to an injury or illness covered under Workers' Compensation, occupational disease or similar laws (for *Florida* residents, this exclusion relates to such services paid under Workers' Compensation, occupational disease, or similar laws);
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision, or public program other than Medicaid;
- Services required while serving in the armed forces of any country or international agency or authority, or relating to a declared or undeclared war or acts of war;
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule;
- General anesthesia, sedation, and nitrous oxide unless specifically listed on your Patient Charge Schedule; when listed on your Patient Charge Schedule general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with covered services performed by an oral surgeon or periodontist (for *Maryland* residents, general anesthesia is covered when medically necessary and authorized by your physician);
- Prescription drugs;
- Procedures, appliances, or restorations if the main purpose is to change vertical dimension (degree of separation of the jaw when teeth are in contact); to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ) unless TMJ therapy is specifically listed on your Patient Charge Schedule; or to restore teeth damaged by attrition, erosion, abrasion and/or abfraction (for *California* residents, the word "attrition" is modified as follows: except for medically necessary treatment where functionality of teeth has been impaired);
- Replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen, or damaged due to patient abuse, misuse, or neglect;
- Services considered unnecessary or experimental in nature (for *Pennsylvania* residents, this exclusion applies only to services considered experimental in nature; for *California* and *Maryland* residents, this exclusion applies only to services considered unnecessary);
- Procedures or appliances for minor tooth guidance or to control harmful habits;
- Hospitalization, including any associated incremental charges for dental services performed in a hospital; benefits are available for network dentist charges for covered services performed at a hospital; other associated charges are not covered and should be submitted to your medical carrier for benefit determination);
- Services to the extent you are compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy (for *Arizona* and *Pennsylvania* residents, this exclusion does *not* apply; for *Kentucky* and *North Carolina* residents, this exclusion does *not* apply to services compensated under no-fault auto or insured motorist policies; for *Maryland* residents, this exclusion does *not* apply to services compensated under group medical plans);
- Crowns and bridges used solely for splinting; and
- Resin-bonded retainers and associated pontics.

Except for the limitations listed above, pre-existing conditions are not excluded.

Filing claims

You do not need to file any claims for benefits. However, if benefit payment is denied, you may file an appeal. See “Claims and appeals for the Cigna Dental HMO” on page 210.

Extension of benefits

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

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

Disclosure statement

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

Claims and appeals

This section describes the claims and appeals process for the MetLife PDP and the Cigna Dental HMO.

Claims and appeals for the MetLife PDP

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

Type of claim	Timeline after a claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim[1]
Preservice claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim[1]

Type of claim	Timeline after a claim is filed
Urgent care claims (for services requiring precertification of services where a delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

[1] The time period allowed to make a decision is suspended pending receipt of additional information.

You have the right to request a reconsideration of the denied claim by calling or writing to MetLife. Any additional information that you feel would support the claim should be provided to MetLife.

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

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

> An explanation in plain language of why the charges are denied in plain language and

> A reference to the wording from this Plan document that justifies the denial.

The appeal request must be submitted in writing to MetLife within 180 days of receipt of the denial letter. As part of this review, you or your legal representative has the right to review all pertinent documents and submit issues and comments in writing to a committee selected by MetLife. The committee consists of senior representatives of MetLife Dental Claim Management and a Dental Consultant.

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

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, , provided that you file any lawsuit or similar enforcement proceeding, commenced in any forum, 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

Claims and appeals for the Cigna Dental HMO

If you have a concern about your dental office or the Cigna Dental HMO, call **1-800-Cigna24 (1-800-244-6224)** and explain your concern to a Member Services representative. You can also express that concern to Cigna Dental in writing. Most matters can be resolved with the initial telephone call. If more time is needed to review or investigate your concern, Cigna Dental will respond to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

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

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to the Cigna Dental HMO within one year from the date of the initial Cigna Dental decision. You should state the reason why you believe your request should be approved and include any information supporting your request. If you are unable or choose not to write, you can ask Member Services to register your appeal by calling **1-800-Cigna24 (1-800-244-6224)**.

Cigna Dental HMO first-level appeal

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

If your appeal concerns a denied precertification, Cigna Dental will respond with a decision within 15 calendar days after your appeal is received. For appeals concerning all other coverage issues, Cigna Dental will respond with a decision within 30 calendar days after your request is received. If Cigna Dental needs more information to make your first-level appeal decision, it will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

- For *New Jersey* residents: Cigna Dental will respond in writing within 15 working days.
- For *Colorado* residents: Cigna Dental will respond within 20 working days.
- For *Nebraska* residents: Cigna Dental will respond within 15 working days if your complaint involves an adverse determination.

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

Cigna Dental HMO second-level appeal

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

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

Cigna Dental HMO expedited appeal

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

- For *Maryland* residents: Cigna Dental will respond within 24 hours.
- For *Texas* residents: Cigna Dental will respond within one business day.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, provided that you file any lawsuit or similar enforcement proceeding, commenced in any forum, 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.

Cigna Dental HMO independent review

The independent review procedure is a voluntary program arranged by Cigna Dental and is not available in all areas. Call Cigna Dental at **1-800-Cigna24 (1-800-244-6224)** for details.

Appeals to the state

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

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

Vision

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

When you can enroll in and/or make changes to Vision Coverage

You may enroll in the Vision Plan as a new hire or during annual enrollment. Your election is generally in effect from your eligibility date through the end of the calendar year. You can change your election during the year if you have a qualified change in status, as described in the “Eligibility and participation” section.

When you enroll in the Vision Plan, you will receive two ID cards in the mail.

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

The Vision Plan is fully insured and 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.

For more information on the vision coverage available, see the Aetna Vision Plan fact sheet.

Contents

Benefits at a glance

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

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 > Standard lenses covered at 100% once every 12-month period > Progressive lenses covered at 100% after $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 > Frames covered at 100% once every 12-month period, up to the frame allowance below – $150 frame allowance; member pays 80% of balance over the $150 plan allowance > Up to a 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 elective 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 > Fit and follow-up covered up to $55 for standard contact lenses and 10% discount for premium contact lenses > Discounts 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
Out-of-network benefit	**Coverage**
Routine eye exam	> Up to $50 once every 12-month period
Frames/lenses	> Frames: Up to $100 > Single-vision lenses: up to $50; bifocals up to $60; trifocals up to $90; and lenticular, up to $125 > Progressive lenses: up to $90
Contact lenses	> Elective contact lenses: Up to $130 > Medically necessary contact lenses: Up to $225 > Fit and follow-up not covered

In-network services

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

In-network providers are licensed physicians 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 physician may apply to join the Aetna provider network by calling EyeMed at **1-800-521-3605**. Membership in the network is not guaranteed.

Using in-network providers

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

- 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 Vision Plan at **1-877-787-5354**. An automated voice response unit (available 24/7) 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 a provider in the Aetna network, call him or her to schedule an appointment and provide the Citi 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 services from in-network providers. However, you must submit a claim if you are receiving services out of network. Visit "Out-of-network benefits" on page 217 for more information on submitting a claim.

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 12-month period; 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
- Up to a 40% discount on additional pairs of glasses at most network providers.

The following products 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 copayment.

Mail-order contact lenses

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

Travel and student coverage

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

Out-of-network benefits

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

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

When you receive services from out-of-network providers, you will need to submit your itemized paid receipts with a Vision Claim Form. You can visit Citi Benefits Online at **www.citibenefitsonline.com** or **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 Vision Plan at **1-877-787-5354**.

Laser vision correction

Laser vision correction is not covered under the Vision 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 is comprised of more than 500 provider locations, including Lasik*Plus* Vision Centers nationwide, and offers a broad choice of the latest technologies in the industry.

The list of physicians and facilities performing laser vision correction is different from the routine vision provider listing. For more information about laser vision correction, call the Vision Plan at **1-877-787-5354** or visit **www.eyemedlasik.com**.

What is not covered

Below is a partial list of exclusions and limitations. For additional details about exclusions and limitations, call the Vision Plan at **1-877-787-5354** or visit **www.aetnavision.com**.

- Special vision procedures, such as orthoptics, vision therapy, or vision training;
- Retinal imaging is excluded but discounts may apply;

- Vision services that are covered in whole or in part under any other part of this plan, under any other plan of group benefits provided by the policyholder, or under any Workers' Compensation law or any other law of like purpose;
- An eye exam that is required by an employer as a condition of employment, 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 another 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 217 for 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 medically 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

Your Citi benefits include programs intended to help you improve your health and reduce health care costs. These programs include:

- The Live Well at Citi Program;
- Citi on-site medical clinics; and
- Citi on-site Health and Fitness Centers.

Contents

The Live Well at Citi Program

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

At a glance

Live Well tools and resources	Description	How to access
Health Advocate	A free, personal support service to help you manage your health care needs, from working through difficult health claims to choosing a doctor to making choices regarding a serious illness.	**1-866-449-9933** from 8 a.m. to 9 p.m. ET on weekdays; after hours and on weekends, leave a message and a representative will return your call the next business day.
Live Well Health Assessment	An interactive health questionnaire, offered through RedBrick Health, which takes about 15 minutes to complete and is your gateway to accessing additional health improvement programs and earning Rewards through the Live Well at Citi Program.	**Employees:** TotalComp@Citi at **www.totalcomponline.com** **Spouses/domestic partners and dependents 18 and over:** Through the RedBrick Portal at **www.redbrickhealth.com**. (Note that first time users will need to create a user name and password.)
Live Well Healthy Lifestyle Programs	A variety of programs that address stress, nutrition, physical activity, weight management, and back pain. You can speak with an expert RedBrick health coach or use online and/or mobile tools to take fun, bite-sized steps to forming healthy habits. This includes the **Live Well Tobacco Cessation Program**.	**Employees:** TotalComp@Citi at **www.totalcomponline.com** **Spouses/domestic partners and dependents 18 and over:** Through the RedBrick Portal at **www.redbrickhealth.com**. (Note that first time users will need to create a user name and password.)
Live Well Chronic Condition Management Programs	Programs for employees and covered dependents enrolled in an Aetna, Anthem BlueCross BlueShield, or Oxford medical plan and who have a chronic health condition, such as heart disease or diabetes.	If you or a covered dependent meet program condition criteria, a nurse from your medical plan may invite you to participate.

Health Advocate

Health Advocate is a free program available to you *and* your family — your spouse/civil union partner/domestic partner, children, parents, and parents-in-law — regardless of your health coverage. You and your family members do not need to be enrolled or eligible to participate in a medical plan offered by Citi to use Health Advocate.

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

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

Health Advocate's Health Cost Estimator+™ (HCE+) Tool

Health Advocate's Health Cost Estimator+ (HCE+) tool, a phone-based resource, is now available.

Many people don't realize that the cost of a medical procedure can vary by over 100 percent, even within the same geographic area. With consumers picking up more of the cost of their healthcare, they need clear, actionable, pre-service information to help project their out-of-pocket costs.

Health Advocate's HCE+ pricing transparency tool compares the cost of hundreds of common healthcare services and procedures, by zip code. This valuable resource is designed to help you in the decision-making process, so you can maximize the value of your healthcare dollars and reduce healthcare costs.

Easy Access

Available free to all Citi employees (regardless of whether you are enrolled in a medical plan), Health Cost Estimator+ can be accessed by calling a Health Advocate representative. The representative you speak with will then act as your personal Health Advocate, perform the research and provide personalized results.

Live Well Health Assessment

The Live Well Health Assessment is a brief, online questionnaire that provides a snapshot of your current health status. After completing the Health Assessment, you will receive recommendations about ways to improve your health.

The Live Well Health Assessment is available to active, benefits-eligible employees. You do not need to be enrolled in a medical plan offered by Citi to participate. Same-gender or opposite-gender spouses/civil union partners/domestic partners may also complete the Live Well Health Assessment but only if they are enrolled in a medical plan offered by Citi.

The Live Well 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.

Live Well Healthy Lifestyle Programs

The Live Well at Citi Program offers a number of resources to help you develop and maintain healthy habits. The Live Well Healthy Lifestyle Programs, offered through RedBrick Health, have a supportive, social approach that can help you achieve your wellness goals. Lifestyle Management Programs include:

- Live Well Tobacco Cessation Programs – offers help to identify the challenges you face when quitting tobacco use and set goals to overcome them.
- RedBrick Journeys® – online wellness programs, tailored to your interests, which can help you make progress on health topics of your choosing by taking small steps towards your goals.
- RedBrick Track™ – an online daily wellness tracker that helps you maintain and expand daily healthy habits.
- Health Coaching – certified experts who will work with you by phone to help answer your health questions, provide support in overcoming obstacles and help you to set health care goals.

If you and your same-gender or opposite-gender spouse/civil union partner/domestic partner are enrolled in Citi medical coverage, you can sign up for any of the Healthy Lifestyle Programs by visiting the RedBrick Portal through TotalComp@Citi (click "Live Well at Citi" under Health and Insurance). Your spouse, civil union partner, domestic partner, or dependents 18 and over can sign up for programs by visiting the RedBrick Portal at **www.redbrickhealth.com**. They should follow the instructions for registering.

Live Well Tobacco Cessation Program

The Live Well Tobacco Cessation Program is available to active, benefits eligible employees and their benefits-eligible spouses/civil union partners/domestic partners (regardless of whether or not they are enrolled in a Citi medical plan).

Your health coach will work with you to identify the challenges you face when quitting and set goals to overcome them. You and your spouse/civil union partner/domestic partner may be eligible for free Nicotine Replacement Therapy (NRT). If you have stopped using tobacco products recently, a health coach can help you keep your commitment to be tobacco-free.

Program representatives may reach out to those who have indicated on their Live Well Health Assessment that they use tobacco products or have stopped using tobacco products within the past 12 months, but you don't need to wait to be invited. To get started, log on to the RedBrick Portal or call **1-855-814-5595**.

You can also complete a Live Well Journey® to stop smoking. See below.

Tobacco Free Attestation

If you and your same-gender or opposite-gender spouse/civil union partner/domestic partner are enrolled in Citi medical coverage for 2015, during annual enrollment, you will have the opportunity to complete the Tobacco Free Attestation on Your Benefits Resources™. If during that time, you indicate that you use tobacco products (including vapor products), or if you fail to complete the Tobacco Free Attestation before your enrollment deadline, you and your covered spouse/partner will each pay a $600 annual penalty on your health care coverage.

If you participate in the Live Well Tobacco Cessation Program in 2015, you'll stop paying the penalty once you complete either the telephonic health coaching program (a minimum of four calls with a health coach), or by completing a tobacco-focused Journey through the RedBrick Portal. You will also be reimbursed for all penalties paid in 2015.

IMPORTANT: Even if you plan to continue with your current Citi medical plan, you **must** complete the Tobacco Free Attestation before your annual enrollment deadline, or you will default to "tobacco user" status and will pay the tobacco penalty in 2015.

Live Well Journeys®

Live Well Journeys are online wellness programs, tailored to your interests, which can help you make progress on health topics of your choosing by taking small steps towards your goals. Journeys can be accessed over the web or via your mobile device.

To get started, select a Live Well Journey and choose the steps you'd like to commit to as part of your journey. Steps may incorporate activities as well as brief videos. You can give feedback on the steps you like and the ones you don't to further personalize your experience. If you are looking for additional encouragement, you can request live support by phone.

Live Well Journeys include Get Strong at Home, Move It and Lose It, Smart Snacking, Dine Out: Take Charge, Make Your Date To Quit, and Stress to Energy Sampler.

RedBrick Track™

RedBrick Track is a daily wellness tracker that spans a spectrum of daily health habits: getting active, eating healthy and living well, yet takes just a minute or two per day. You can access this fun, easy to use tool via web, tablet, mobile phone, or sync up your connected device or partner app.

RedBrick Track helps you maintain and expand your daily healthy habits by reinforcing progress and encouraging you to establish and beat your personal best on the Daily Wellness Meter.

Health coaching

RedBrick Health Coaches are certified experts who will work with you by phone to help answer your health questions, provide support in overcoming obstacles and help set small goals to work on between sessions. Choose from topics including managing blood pressure, cholesterol, diabetes, stress and more.

Live Well Chronic Condition Management Programs

The Anthem BlueCross BlueShield, Aetna, and Oxford medical plans offered by Citi include access to chronic condition management programs for certain members. If you or a covered dependent meet program condition criteria, a nurse from your medical plan may invite you to participate. These programs can help you navigate different care options and manage your treatment plan for many common conditions. Sample management programs include:

- Disease and chronic condition assistance (e.g., breast cancer, COPD, diabetes)
- Health coaching
- Pregnancy care
- Nurseline and more

Specific program details will vary based on your medical plan. Call the number on the back of your medical ID card for details about the chronic condition management programs that may be available to you.

Live Well Rewards

For the 2015 plan year, Citi is offering three different Live Well Rewards plus the Live Well Tobacco Cessation Program that can help tobacco users stop paying the tobacco penalty.

Healthy behavior	Who can participate	How to earn it	Amount for 2015	When you'll receive it
Live Well Health Assessment	Citi benefits eligible employees regardless of whether they're enrolled in Citi benefits; spouses/domestic partners if they're enrolled in Citi medical coverage	Complete the Health Assessment on the RedBrick Portal (accessible through **TotalComp@Citi**) from **October 1 through October 31, 2014**	**$150 Reward** per person	Your Reward will be equally divided among the pay periods in 2015

Healthy behavior	Who can participate	How to earn it	Amount for 2015	When you'll receive it
Tobacco Free Attestation	Only Citi employees and spouses/domestic partners[1] who are enrolled in Citi medical coverage are subject to the tobacco penalty	Complete the Tobacco Free Attestation on YBR™, available through **TotalComp@Citi**, **before your enrollment deadline**; complete the Live Well Tobacco Cessation Program through RedBrick Health in 2015	**$600 penalty** per person	You will pay a $600 penalty on your Citi medical plan coverage if you use tobacco products or if you don't complete the Tobacco Free Attestation
Live Well Healthy Lifestyle Programs	Citi employees and spouses/domestic partners[1] who are enrolled in Citi medical coverage	Complete three online Journeys and three coaching programs for $50 each, up to $300 per person between **October 1, 2014 and September 30, 2015**	**$50 Reward per completed program, up to $300** per person	Starting three to four weeks after you complete your first program, your Reward will be equally divided among the remaining pay periods in 2015
Live Well Chronic Condition Management Programs	Employees and spouses/domestic partners[1] with chronic conditions who are enrolled in a Citi medical plan through Aetna, Anthem BlueCross BlueShield or Oxford	Work with a professional from your health plan on a specific program to address your chronic health conditions. Participants must complete their specific programs by **December 31, 2015** to be eligible for the Reward.	**$300 Reward** per person	Starting the quarter after you complete or graduate from your health plan's program, your Reward will be equally divided among the remaining pay periods in 2015 or extended into the first quarter of 2016 depending on the date you complete the program. (Note: Program requirements vary by health plan.)

[1] "Spouse/domestic partner" includes legal spouse (same or opposite gender), domestic partner, and civil union partner.

Important things to note

> The total amount of Live Well Rewards you can earn is $450 for employee only or $900 for employee plus spouse/domestic partner.

> You may participate in both the Live Well Chronic Condition Management Programs (if invited to participate by your medical plan) and the Live Well Healthy Lifestyle Programs (offered through RedBrick Health). However, you can only earn the Chronic Condition Management Program Reward OR Healthy Lifestyle Program Rewards. You cannot earn Rewards for both programs.

> If you aren't enrolled in a Citi medical, dental, or vision plan, Rewards will be deposited into a Health Care Spending Account (HCSA) for your use in 2015. If you personally contribute to an HCSA, Rewards deposited into your HCSA will not count against your contributions or contribution limit. **Note:** If you establish an HCSA or if one is established on your behalf in connection with your Reward, you'll be ineligible to make contributions to an Health Savings Account (HSA) in the event a subsequent qualified change in status permits you to enroll in a High Deductible Health Plan (HDHP).

- You are eligible for the Health Assessment Reward if you were transferred from a Citi International Business or newly hired before September 25, 2014. You will see the Reward displayed on YBR™ within 48 hours.
- Participants must comply with these deadlines to receive Rewards or avoid the tobacco penalty. (If you are enrolling your spouse/domestic partner in Citi benefits for the first time in 2015, your spouse/domestic partner can earn a Live Well Reward of $150 by completing the Health Assessment between November 10, 2014 and November 21, 2014.)
- If you use tobacco products, you'll stop paying the penalty once you complete the Live Well Tobacco Cessation Program through RedBrick Health, either with a tobacco cessation health coach or online through one of the tobacco-cessation related Journeys. The penalty will be removed as soon as administratively possible. You will receive a full refund of all penalty payments once the program is completed. In order to have your 2015 tobacco penalty payments stopped and earn your $600 refund, you must complete the Tobacco Cessation Program either by working with a health coach or by completing a tobacco-cessation related Journey by September 30, 2015.

Important privacy information

The Live Well at Citi Program was designed to provide for your privacy and to comply with all federal and state privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Personal health information, provided through the Health Assessment, and other information that you provide, is maintained by a third-party vendor (RedBrick Health) and is not maintained on Citi data systems.

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

By enrolling in the Citigroup Health Benefit Plan, you consent to the terms and conditions of the Live Well Program at Citi, as they may be amended from time to time.

Citi on-site medical clinics

Citi operates medical clinics at the following locations: Jacksonville and Tampa, FL; O'Fallon, MO; Jersey City, NJ; Warren, NJ; 399 Park Ave., and 388 Greenwich St., New York, NY; Long Island City, NY; and San Antonio, TX.

The clinics offer the following services:

- Assessment, treatment, recommendations, and/or referral for illness and injury;
- Laboratory blood tests, and EKGs on the order of the employee's physician;
- Ergonomic workstation evaluations;
- Lactation rooms including pumps, refrigerator for milk storage, and attachment kits for purchase;
- Immunizations and consultations for international business travel;
- Periodic medical exams for expatriate staff and spouses;

- Referrals to appropriate medical specialists and other on-ground resources worldwide for expatriate staff and international business travelers; and
- Monitoring of international medical care and emergency medical evacuations coordinated through Travel Health Services and Citi Travel Health Assistance.

Citi on-site Health and Fitness Centers

All Citi Health and Fitness Centers (CHFCs) are staffed by degreed fitness professionals who work closely with employees to create customized exercise programs and work together to plan and achieve individual fitness goals. Employees in locations with on-site CHFCs who desire membership must complete a health and entry screening process that includes two short appointments during which medical history, program policy, safety, goals, and equipment operations are reviewed.

Members are then provided with information and recommendations about frequency, duration, mode, and intensity of an individualized exercise program. Fitness center staff members are available and ready to assist with program updates and changes throughout your visits to the Citi facilities.

All Citi fitness facilities feature strength and cardiovascular equipment, and most offer a variety of group exercise classes at no additional charge.

CHFCs frequently offer motivational or incentive programs; screenings, such as cholesterol, blood pressure, and skin cancer; and site-wide events to educate and motivate employees toward healthy lifestyle changes and maintenance.

Most of the CHFCs offer towel service at no additional charge, and some offer other services, such as massage therapy, nutrition programming, and/or personal training for a fee.

The CHFCs have a fee structure that is very competitive with the surrounding geographic area and that typically is well below market rates for similar operations and facilities. Visit your CHFC for membership fee rates.

Citi operates CHFCs at the following locations:

Getzville (Amherst), Long Island City, and New York, NY; Blue Ash, OH; Meridian (Boise), ID; Elk Grove Village (Chicago), IL; Florence, KY; NC; Hagerstown, MD; Irving and San Antonio, TX; Jacksonville and Tampa, FL; and Warren, NJ. More information is available on Citi For You (intranet only).

Be Well Program

The Be Well Program, formerly known as the Employee Assistance Program (EAP), provided through Harris, Rothenberg International (HRI), Inc., is a confidential counseling service designed to help you and your family members resolve issues that affect your personal life or interfere with your job performance. You can call Be Well 24/7 for help with issues such as sleeping difficulties, anxiety or depression, substance or alcohol abuse, emotional and physical abuse, family and relationship issues, workplace conflict, adopting healthy behaviors, financial concerns, and others.

When you or a family member (spouses/domestic partners*, and dependents) calls Be Well, you will speak with a licensed counselor who will talk with you about your concerns and, if warranted, refer you to an appropriate counselor near your work or home. You can schedule up to three counseling sessions per issue with an HRI licensed counselor, per year, at no cost to you. If you require additional counseling, you will be referred to a counselor near your home or work. The cost for subsequent counseling may be covered by the Citi Medical Plan. Contact your specific plan to confirm coverage details.

All Be Well services are confidential, as required by law. That is, no information will be shared without the written consent of the individual seeking assistance, unless the counselor is legally bound to take action.

The Be Well is a core benefit available to all benefits-eligible employees and their family members. You do not have to enroll or make any contributions to use this benefit.

Employees and their family members can also access HRI's website, which includes many additional resources to help with physical and mental wellness.

*Spouse/domestic partner includes legal spouse (same or opposite sex), domestic partner and civil union partner.

Contact the Be Well Program as follows:

Telephone: **1-800-952-1245**
TTY: **711, then 1-800-952-1245**

Website: **www.harrisrothenberg.net**
Username: resources
Password: for_you

Geriatric Assistance Program

When an older relative's physical or mental health changes or her or his ability to handle routine activities is impaired, the stress on you and your family can be significant, and few people have the expertise to determine which concerns require immediate care. The situation can be even more difficult for those who live at a distance from older relatives.

The Geriatric Assistance Program can provide the following:

- Professional consultation with a highly experienced counselor who can answer common caregiving questions;
- Assistance with care planning, including a full assessment of the adult's health and living situation;
- A review of the quality of care in different facilities; and
- Implementation and coordination of caregiving services to meet the needs of the older adult and family members.

Call the Geriatric Assistance Program through Citi's Be Well or Work/Life Program:

Be Well Program
1-800-952-1245
TTY: **711, then 1-800-952-1245**

Work/Life Program
1-866-449-9933, option #2 for the Work/Life Program

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 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, including parenting/child care, adoption, identity theft, legal wills, and 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**

Spending accounts

Spending accounts allow you to pay for certain health care, dependent day care, and transportation and parking expenses with before-tax contributions from your pay:

- **Health Care Spending Account (HCSA):** Use the HCSA to pay for certain health care expenses for you and your qualified dependents that are not paid by any medical, dental, or vision plan. You are eligible to enroll in the HCSA if you are not enrolled in the High Deductible Health Plan (HDHP). *If you enroll in the HDHP, you cannot enroll in the HCSA. However, if you had an HCSA prior to a qualified change in status (for example, if an HCSA was established for you due to excess Live Well Rewards), then you are permitted to retain the HCSA, even if you elect the HDHP. However, the establishment of the HCSA precludes you from being eligible to establish a Health Savings Account (HSA) for the remainder of the plan year.*
- **Limited Purpose Health Care Spending Account (LPSA):** Use the LPSA if you are enrolled in the HDHP to pay for dental, vision, and/or preventive care medical expenses for you and your qualified dependents that are not paid by any medical, dental, or vision plan or your HSA.
- **Dependent Day Care Spending Account (DCSA):** Use the DCSA to pay for certain dependent day care expenses so that you (and your spouse, if applicable) can work or look for work. **Note:** This account cannot be used to pay for health care expenses for your dependents.
- **Transportation Reimbursement Incentive Program (TRIP):** Use TRIP to pay for the cost of public transportation and parking so you can commute to and from work. **Note:** TRIP is not part of annual enrollment. You can enroll at any time.

Note: For information about the HSA paired with the HDHP, see the “Health Savings Account” in the Medical section.

Your Spending Account™ website

The Your Spending Account™ (YSA™) website makes it easy for you to manage your spending accounts. You can file claims, confirm which expenses are eligible, check your account balance, and more. See the YSA™ Guide for more information.

Contents

How the spending accounts work

Enrolling in the spending accounts

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

For the Transportation Reimbursement Incentive Program (TRIP), you can enroll at any time. Before-tax and, if needed, after-tax payroll contributions will be taken as soon as administratively possible to pay for your transit and/or parking pass, which must be purchased online.

Once enrolled, you can obtain information about your account on Your Benefits Resources™ through TotalComp@Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet. Contributions to the spending accounts from your pay will be available as follows.

If you enroll during the annual enrollment period or as a newly hired employee:

- **HCSA and LPSA:** The entire amount of the 2015 contributions you elect will be posted to your account January 1. You can be reimbursed up to the entire amount of your annual contribution at any time during the plan year for incurred expenses, even if the entire 2015 contribution amount has not yet been deducted from your pay.
- **DCSA:** Contributions will be posted to your account each pay period. You can be reimbursed up to the amount available in your account. The balance of any claim will be paid as additional contributions are deposited into your account.
- **TRIP:** Contributions will be deducted each pay period to purchase transit and/or parking passes you have selected online.

Changing your contribution amounts

You may change your contributions for the HCSA, LPSA, and DCSA only during annual enrollment or as a result of a qualified change in status.

If you elect to change your goal amount as a result of a qualified change in status, there are some things you need to know:

- If you *increase* your spending account goal amount, you *cannot* use the additional money to reimburse yourself for your health care expenses incurred *prior* to the date of this qualified change in status. The additional funds will only be available to reimburse those claims with dates of service incurred *after* the effective date of your qualified change in status.
- If you *decrease* your spending account goal amount, it *will not* result in a refund of deductions withheld by payroll prior to the effective date of the qualified change in status.
- You are not permitted to decrease your goal amount if you have used all of the available funds in your spending account.

Legal requirement: Save your receipts for YSA™ Card use

If applicable, each time you “swipe” the YSA™ Card (described in “Health Care Spending Account (HCSA)” on page 238), be sure to save your receipt in case you are required at a later date to substantiate that your expense was eligible for reimbursement under the Plan. *Per IRS rules, unsubstantiated expenses will be considered taxable income.*

You have until June 30, 2016, to resolve any 2015 transactions that require receipts. Resolution of a transaction includes providing any pertinent documentation to establish that a claim is eligible for reimbursement, which may include providing documentation that a service provided in connection with a claim was medically necessary. If you fail to resolve these transactions with the Citi Benefits Center by the June 30th deadline, the amount of the transaction in dispute, considered an "overpayment," will be added to the amount of your 2016 earnings. Applicable taxes will be withheld and reported on a Form W-2 at the time year-end tax forms are distributed.

Reimbursements

Reimbursements for eligible HCSA/LPSA and DCSA expenses will be deposited directly to your bank account or, if no direct deposit account is on file, sent via check to your address of record. To add direct deposit account information, visit Your Benefits Resources™ (YBR™), available through TotalComp@Citi at **www.totalcomponline.com**.

If your HCSA or LPSA claim is denied, see "Claims and appeals for the Health Care Spending Account (HCSA)/; Limited Purpose Health Care Spending Account (LPSA)" on page 253.

Overpayments

In the event an expense reimbursed by any of the spending accounts is not eligible for reimbursement, you agree to reimburse Citi for any amount owed. In the event that amounts are owed under the HCSA, your privileges under the YSA™ Card may be subject to suspension or termination.

Tax exemptions

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

Spending accounts at a glance

	Health Care Spending Account (HCSA)	Limited Purpose Health Care Spending Account (LPSA)	Dependent Day Care Spending Account (DCSA)	Transportation Reimbursement Incentive Program (TRIP)[1]
Why enroll?	To reduce your taxes by paying for eligible expenses with before-tax dollars			
What is reimbursed?	Health care expenses for you and your family that are not paid by any medical, dental, or vision plan.	Vision, dental, and preventive care medical expenses for you and your family that are not paid by any medical, dental, or vision plan or your Health Savings Account (HSA).	Dependent day care expenses for your qualified dependents so that you (and your spouse, if you are married) can work or look for work.	Eligible transit and parking expenses. **Note:** Your contributions are used to purchase transit/parking passes online. There is no claim-filing process.
Contribution limits	From $120 to $2,500 per year per employee[2]; money is deducted in equal amounts each pay period.	From $120 to $2,500 per year per employee[2]; money is deducted in equal amounts each pay period.	From $120 to $5,000 per year per family; money is deducted in equal amounts each pay period.	**Transit:** Up to $130 per month before tax and up to $1,000 in after-tax dollars. **Parking:** Up to $250 per month before tax and up to $1,000 in after-tax dollars.

	Health Care Spending Account (HCSA)	Limited Purpose Health Care Spending Account (LPSA)	Dependent Day Care Spending Account (DCSA)	Transportation Reimbursement Incentive Program (TRIP)[1]
Forfeiture provisions	You will forfeit any money you contribute but do not use, including disputed amounts, each calendar year.	You will forfeit any money you contribute but do not use, including disputed amounts, each calendar year.	You will forfeit any money you contribute but do not use, including disputed amounts each calendar year.	If your account remains inactive for 12 consecutive months, you will forfeit any remaining contributions.
Changing your election	You can change your election as the result of a qualified change in status; you cannot enroll in December for the current year.	You can change your election as the result of a qualified change in status; you cannot enroll in December for the current year.	You can change your election as the result of a qualified change in status; you cannot enroll in December for the current year.	You can change your online purchase at any time; the change will be effective as soon as administratively possible.
Filing a claim	You must file claims, including pertinent supporting documentation for 2015 expenses so they are resolved no later than June 30, 2016.	You must file claims, including pertinent supporting documentation, for 2015 expenses so they are resolved no later than June 30, 2016.	You must file claims, including pertinent supporting documentation, for 2015 expenses so they are resolved no later than June 30, 2016.	Not applicable **Note:** Parking Cash Reimbursement Option (CRO) claims must be filed within 12 months from the date of service.

1 TRIP is not part of annual enrollment. You can enroll in TRIP at any time.

2 Each partner of a married couple working at Citi can contribute $2,500 to the HCSA or LPSA account.

Health Savings Account (HSA) Information

For information about the HSA paired with the HDHP, see the “Health Savings Account” in the Medical section.

Health Care Spending Account (HCSA)

You can contribute between $120 and $2,500 a year on a before-tax basis to reimburse yourself for eligible out-of-pocket health care expenses. Contributions are taken each pay period before federal and, in most locations, state and local taxes are withheld.

The $2,500 limit applies to each employee electing to participate in the HCSA. If you and your spouse/civil union partner/domestic partner are both Citi employees, you can each contribute up to $2,500 to your own HCSA.

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

If you enroll in the HDHP, you cannot enroll in the HCSA. However, if you had an HCSA prior to a qualified change in status (for example, if an HCSA was established for you due to excess Live Well Rewards), then you are permitted to retain the HCSA, even if you elect an HDHP. However, the establishment of the HCSA precludes you from being eligible for the HSA for the remainder of the plan year.

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

HCSA claims, including any pertinent supporting documentation to establish that a claim is eligible to be reimbursed, must be filed and resolved by June 30 of the calendar year following the calendar year in which the expense was incurred. Generally, you may change or stop your contributions as a result of a qualified change in status.

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

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

If you are a reservist called to active military duty for more than 179 days, you are entitled to receive a taxable distribution of your HCSA balance (contributions less the amount reimbursed) if you request a distribution by the last day of the calendar year in which you made the contributions.

Rules and features

General rules about expenses

Most health care expenses that the IRS considers deductible on your federal income tax return are eligible for reimbursement from the HCSA, provided the expenses are not reimbursed from any other source.

You can be reimbursed for your expenses or those incurred by anyone you can claim as a dependent on your federal tax return, regardless of whether you or your dependent is covered under any Citi medical, dental, or vision plan.

Estimate expenses conservatively. You cannot receive a refund for contributions intended to reimburse yourself for a surgery or procedure that is later canceled.

Examples of eligible health care expenses

- Your share of expenses that are not paid by your medical, dental, and/or vision plan, such as deductibles, coinsurance, and copayments;
- Other charges that exceed what your medical, dental, and/or vision plan will pay, such as charges above maximum allowed amounts or other plan limits;
- Vision care expenses, such as exams, prescription eyeglasses and sunglasses, prescription contact lenses, and laser surgery, that are not covered by your medical or vision plan;
- Hearing care expenses, such as exams, hearing aids, and hearing aid batteries, that are not covered by your medical plan;
- Certain equipment and training for disabled individuals;
- Childbirth classes, such as Lamaze, for up to two people;
- Chiropractic care that is not covered by your medical plan;
- Physical therapy, psychiatric therapy, and counseling that are not covered by your medical plan;
- Cholesterol tests, vaccines, and immunizations that are not covered by your medical plan;
- Prescription contraceptives and infertility treatments that are not covered by your medical plan;
- Smoking cessation programs;

- Certain over-the-counter (OTC) drugs, medicines, and biologicals for which you have a receipt and a prescription (see eligibility requirements below);
- Medicines prescribed by a physician that your medical plan or prescription drug program does not cover; and
- Transportation necessary to obtain certain health care services.

OTC drugs, medicines, and biologicals

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

Note: You cannot use the Your Spending Account™ (YSA™) Card to pay for these items. You will need to pay out of pocket and then submit a paper claim along with your receipt and prescription.

Examples of ineligible health care expenses

- Expenses for which you have been reimbursed from another source, such as Citi's or another employer's medical, dental, and/or vision plan, Medicare, or Medicaid;
- Elective cosmetic surgery or cosmetic dental work;
- Vitamins or minerals taken for general health purposes, including those recommended by your physician;
- Maternity clothes or diaper services;
- Nursing services to care for a healthy newborn;
- Household help or custodial care at home or in an institution, even if recommended by your physician;
- Health club fees, exercise classes, or weight-loss programs for general health purposes, even if recommended by your physician;
- Cosmetics, toiletries, or toothpaste;
- Amounts you pay for medical and dental insurance premiums;
- Over-the-counter items and biologicals for which you do not have a physician's prescription; and
- Long-term care services including insurance premiums for long-term care insurance.

Special rule for orthodontia claims

Generally, a health care service must be provided during the plan year in order for a claim to be incurred and subject to reimbursement. Orthodontic work usually involves a course of treatment that occurs over a number of plan years. In connection with payments made for orthodontic work, IRS guidance provides that if the actual payment is made in advance of a course of orthodontic treatment, the claim is deemed to be incurred at the time of the advance payment and subject to reimbursement at the time the payment is made without regard to when the actual treatment is provided. If the actual payment is not made in advance, the claim is incurred when the services are provided.

For more information

For more information about eligible expenses, see *IRS Publication 502: Medical and Dental Expenses* at **www.irs.gov** or contact your tax adviser. You can also call the IRS at **1-800-829-1040**.

Note: The IRS publication is a guideline for use in preparing tax returns; it is not a description of the Citi Plan.

Your Spending Account™ (YSA) Card

When you enroll in the HCSA, you may elect to receive a YSA™ Card to use at any provider that accepts Visa as a form of payment. **Note:** The YSA™ Card is not available for use with any of the other spending accounts. Once you elect to receive a YSA™ Card, the automatic claims submission feature, described below, will be turned off automatically.

You may be requested to provide substantiation for YSA™ Card transactions. If the amount you are required to substantiate is $100 or more and you do not provide substantiation within 30 days of the transaction, your card will be shut off until the substantiation is provided. For details, see the YSA™ guide.

Automatic claims submission

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

- Aetna ChoicePlan 500 and Anthem BlueCross BlueShield ChoicePlan 500;
- Oxford Health Plans PPO;
- Aetna Vision;
- Express Scripts Prescription Drug Program; and
- MetLife Preferred Dentist Program (PDP).

However, if you elect to receive a YSA™ Card, the automatic claims submission feature will be turned off and used only to substantiate purchases made with the YSA™ Card. You will then need to file a claim for any eligible expenses for which you do not use your YSA™ Card.

If you do not want to be reimbursed for your claims automatically, you may cancel automatic reimbursement or you may elect to receive a YSA™ Card, which will turn off the automatic claims submission feature. You may change your election one time during the plan year on the YSA™ website.

You may access the YSA™ website through Your Benefits Resources™ through TotalComp@Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet.

Paying for your expenses out of pocket

You can choose to pay out of pocket for eligible expenses and submit a claim online on the YSA™ website or you can submit a paper claim to YSA™ using the HCSA/LPSA Claim Form. The claim-filing instructions are on the YSA™ website and the HCSA/LPSA Claim Form. In order for your claim to be reimbursed, you must provide any pertinent documentation to establish that an expense is eligible to be reimbursed. If such information is not provided by the deadline noted below, the funds in your HSCA/LPSA that are in dispute, are subject to forfeiture.

Reimbursements

At any time, up until June 30 of the following plan year, you may be reimbursed for eligible expenses up to the total amount you elected to contribute for the plan year. In order for a claim to be deemed an eligible expense to be reimbursed, you must provide any pertinent documentation to establish that a claim is eligible for reimbursement, which may include providing documentation that a service provided in connection with a claim was medically necessary.

If you increase your contributions during the year because of a qualified change in status, you may be reimbursed from the increased amount only for expenses incurred *after* the date of the qualified change in status.

Using HCSA during an unpaid leave or after your termination of employment

You can continue your HCSA coverage under COBRA through the end of the calendar year in which you take an unpaid leave of absence or your employment is terminated. If you do not continue coverage under COBRA, you cannot use the account for expenses incurred beyond the start date of your leave or your termination date, respectively. However, you will have until the following June 30 to submit your claims, including any pertinent supporting documentation to establish that a claim is eligible to be reimbursed, for services incurred before the start date of your leave or your termination date.

To continue your HCSA coverage under COBRA, contact the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. Then select the "health care including COBRA" option. For TDD and international assistance, please see the "For More Information" section.

Effect on other benefits

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

Effect on taxes

You receive a tax advantage by paying for eligible health care expenses through the HCSA *or* by claiming a federal income tax deduction for eligible expenses that exceed 10% of your adjusted gross income (7.5% of adjusted gross income is applicable to taxpayers who are age 65 for the 2013 through the 2016 tax year; thereafter, the threshold increase to 10% as well). However, you cannot claim a deduction for an expense on your federal tax return if you have been reimbursed for the same expense through the HCSA.

Social Security

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

Filing a claim

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

Generally, you will have until June 30 following the year in which you incur the eligible expense to file a claim for reimbursement. If you are required to substantiate a claim, either in connection with the YSA card or a submitted claim, in order for a claim to be deemed an eligible expense to be reimbursed, you must provide any pertinent documentation to establish that a claim is eligible for reimbursement, which may include providing documentation that a service provided in connection with a claim was medically necessary. All such documentation must be submitted and the claim must be resolved by the June 30 deadline to avoid the amount being subject to tax (YSA card) or subject to forfeiture.

You may access the Your Spending Account™ (YSA™) website through a link on the Your Benefits Resources™ (YBR™) website. To access YBR™, visit TotalComp@Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet.

Follow these steps to submit an online claim from the YSA™ home page:

1. Select the appropriate tab: HCSA/LPSA or DCSA (Note: you will use the HCSA tab for both HCSA and LPSA claims.)
2. Go to the drop down and select "Create Health Care Claim" or "Create Dependent Care Claim."

3. Choose the method (Upload/Fax/Mail) for submitting documentation and enter your claim detail information. Select “Continue” at the bottom of the page.
4. Review the claim information and click “Continue” if it is accurate. Otherwise, select “Make Changes” or “Cancel.”
5. If “Upload” was selected as the submission method, upload the necessary documentation and click “Submit Claim.” The next screen will confirm that the claim was successfully submitted.
6. If “Fax/Mail” was selected as the submission method, select “Create Cover Sheet” to continue with the claim submission process. Print the cover sheet and fax it with the claim form and receipt(s) to Your Spending Account™ at **1-888-211-9900**.

If your HCSA claim is denied, see “Claims and appeals for the Health Care Spending Account (HCSA)/; Limited Purpose Health Care Spending Account (LPSA)” on page 253.

For more information

Call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “health and welfare benefits” option and then the “spending accounts” option. For TDD and international assistance, please see the “For More Information” section.

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

Limited Purpose Health Care Spending Account (LPSA)

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

Rules and features

You can contribute between $120 and $2,500 a year on a before-tax basis to reimburse yourself for eligible out-of-pocket dental, vision, and preventive care medical expenses. Contributions are taken each pay period before federal and, in most locations, state and local taxes are withheld.

The $2,500 limit applies to each employee electing to participate in the LPSA. If you and your spouse/civil union partner/domestic partner are both Citi employees, you can each contribute up to $2,500 to your LPSA.

Because the LPSA is intended to be used in conjunction with a HDHP/ Health Savings Account (HSA), eligible expenses are limited to dental, vision, and preventive care medical expenses that are not already covered. Other medical care expenses should be paid from your Health Savings Account (HSA).

OTC drugs, medicines and biologicals

You may be reimbursed for over-the-counter medicines and biologicals through your LPSA only in instances when a physician has prescribed the medicine or biologicals or if the medicine is insulin.

Examples of eligible health care expenses

- Your share of expenses that are not paid by your dental and/or vision plan, such as deductibles, coinsurance, and copayments and charges that exceed maximum allowed amounts or other plan limits;
- Vision care expenses, such as exams, prescription eyeglasses and sunglasses, prescription contact lenses, and laser surgery, which are not covered by your medical or vision plan;

- Preventive care medical expenses not already covered by the Plan; and
- Screening services including routine cancer, heart disease, and infectious disease screening.

Because network preventive care is covered at 100% in the HDHP, you will not need this account to reimburse yourself for network preventive medical care expenses. However, if you obtain preventive care from an out-of-network doctor, the HDHP will cover 100% of maximum allowed amount only. As a result, not all preventive care charges may be covered.

Examples of ineligible health care expenses

- Expenses for which you have been reimbursed from another source, such as Citi's or another employer's medical, dental, and/or vision plan, Medicare, Medicaid, or your HSA;
- Non-preventive care medical expenses;
- Elective cosmetic surgery or cosmetic dental work;
- Vitamins or minerals taken for general health purposes, including those recommended by your physician;
- Maternity clothes or diaper services;
- Nursing services to care for a healthy newborn;
- Household help or custodial care at home or in an institution, even if recommended by your physician;
- Health club fees, exercise classes, or weight-loss programs for general health purposes, even if recommended by your physician;
- Cosmetics, toiletries, or toothpaste;
- Amounts you pay for medical and dental insurance premiums; and
- Long-term care services including insurance premiums for long-term care insurance.

For more information

For more information about eligible expenses, see *IRS Publication 502: Medical and Dental Expenses* at **www.irs.gov** or contact your tax adviser. You also can call the IRS at **1-800-829-1040**.

Note: The IRS publication is a guideline for use in preparing tax returns; it is not a description of the Citi Plan.

Is the LPSA for you?

The LPSA is for employees who enroll in the HDHP.

Generally, employees who enroll in the HDHP and establish an HSA can also enroll in an LPSA to pay for eligible health care expenses with before-tax dollars. ("Establish" an account means you apply for an account, which is approved because you meet certain credit and customer identity validation requirements. If your account is not established, you cannot receive the employer contribution.) However, you may enroll in an LPSA even if you are not enrolled in an HSA (as long as you are enrolled in the HDHP).

Note: Employees who enroll in the High Deductible Health Plan generally are *not* eligible to enroll in an HCSA.

Plan your LPSA contributions accordingly

Because network preventive care is covered at 100% in the HDHP, you will not need this account to reimburse yourself for network preventive medical care expenses. However, if you obtain preventive care from an out-of-network physician, the HDHP will cover 100% of maximum allowed amount only. As a result, not all preventive care charges may be covered.

To participate in the LPSA each plan year, you must actively enroll. Your enrollment does not carry over from year to year.

You can be reimbursed for expenses incurred only during the time you are enrolled. The amount of your payroll contributions will appear on your Form W-2 Wage and Tax Statement for the year in which you were enrolled.

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

Paying for your expenses out of pocket

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

- HDHP (preventive care only);
- Dental; and
- Vision.

However, you must pay for eligible expenses out of pocket and submit qualified expenses for reimbursement using the HCSA/LPSA Claim Form. You can submit a claim online on the YSA™ website or you can submit a paper claim to YSA™ using the HCSA/LPSA Claim Form (Form 316). The claim-filing instructions are on the YSA™ website and the HCSA/LPSA Claim Form.

Reimbursements

At any time, up until June 30 of the following plan year, you may be reimbursed for eligible expenses up to the total amount you elected to contribute for the plan year. In order for a claim to be deemed an eligible expense to be reimbursed, you must provide any pertinent documentation to establish that a claim is eligible for reimbursement, which may include providing documentation that a service provided in connection with a claim was medically necessary.

If you increase your contributions during the year because of a qualified change in status, you may be reimbursed from the increased amount only for expenses incurred *after* the date of the qualified change in status.

Using LPSA after your termination of employment

You can continue your LPSA coverage under COBRA through the end of the calendar year in which you take an unpaid leave of absence or your employment is terminated. If you do not continue coverage under COBRA, you cannot use the account for expenses incurred beyond the start date of your leave or your termination date, respectively. However, you will have until the following June 30 to submit and resolve your claims, including pertinent supporting documentation, for services incurred before the start date of your leave or your termination date.

Effect on other benefits

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

Effect on taxes

You receive a tax advantage by paying for eligible health care expenses through your LPSA *or* by claiming a federal income tax deduction for eligible expenses that exceed 10% of your adjusted gross income (7.5% of adjusted gross income is applicable to taxpayers who are age 65 for the 2013 through the 2016 tax year; thereafter, the threshold increase to 10% as well). However, you cannot claim a deduction for an expense on your federal tax return if you have been reimbursed for the same expense through the LPSA.

Social Security

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

Filing a claim

See “How to file a claim” in the “Eligibility and participation” section.

Generally, you will have until June 30 following the year in which you incur the eligible expense to file and resolve a claim for reimbursement. In order for a claim to be deemed an eligible expense to be reimbursed, you must provide any pertinent documentation to establish that a claim is eligible for reimbursement, which may include providing documentation that a service provided in connection with a claim was medically necessary. All such documentation must be submitted and received by the June 30 deadline to avoid the amount being subject to forfeiture.

You may access the Your Spending Account™ (YSA™) website through a link on the Your Benefits Resources™ (YBR™) website. To access YBR™, visit TotalComp@Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet.

Follow these steps to submit an online claim from the YSA™ home page:

1. Select the appropriate account page: HCSA/LPSA or DCSA
2. Select “Submit Claims”
3. Enter your claim detail information
4. Select “Review Claims” at the bottom of the page
5. Create a fax cover sheet
6. Fax the claim form and receipt(s) to Your Spending Account™ at **1-888-211-9900**.

If your LPSA claim is denied, see “Claims and appeals for the Health Care Spending Account (HCSA)/; Limited Purpose Health Care Spending Account (LPSA)” on page 253.

For more information

Call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “health and welfare benefits” option. For TDD and international assistance, please see the “For More Information” section.

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

Dependent Day Care Spending Account (DCSA)

You can contribute between $120 and $5,000 a year on a before-tax basis to reimburse yourself for day care expenses for qualified dependents so that you (and your spouse, if you are married) can work or look for work. See "Qualifying individuals" on page 248.

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

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

In accordance with IRS guidelines:

- The Plan Administrator, in its discretion, may reduce the rate of contribution by certain participants during the year to ensure that the DCSA is not deemed to discriminate in favor of highly compensated employees.
- Eligible expenses submitted via paper claim with future dates of service will not be reimbursed prior to the last day of the billing period.

Quick tip: You cannot use the DCSA to reimburse yourself for your dependent childrens' health care expenses; use the HCSA or LPSA for that purpose.

Rules and features

Examples of eligible dependent day care expenses

- Care at a licensed nursery school, day camp (including specialty camps), or day care center; the facility must comply with state and local regulations, serve more than six individuals, and receive fees for services;
- Services from individuals who provide dependent day care inside or outside your home, unless the provider is your spouse, your own child under age 19, or any other dependent (these individuals must provide their Social Security numbers to you);
- After-school care for children under age 13;
- Household services related to the care of an elderly or disabled adult who lives with you;
- A care provider's expenses for the transportation between your house and the place that provides day care services;
- Your portion of FICA and other taxes that you pay for a care provider; and
- Any other services that qualify as dependent day care under IRS rules.

Examples of ineligible dependent day care expenses

- Expenses for food, clothing, or education;
- Your expenses for transportation between your house and the place that provides day care services;
- Expenses for dependent day care when either you or your spouse is not working;
- Charges for convalescent or nursing home care for a parent or disabled spouse;
- Overnight camp expenses;

- Expenses for dependent day care that enables you or your spouse to do volunteer work;
- Payments made to your spouse, your own child under age 19, or any other dependent; and
- Expenses for which you take the federal child care tax credit.

For more information

For more information about eligible dependents and expenses, see *IRS Publication 503: Child and Dependent Care Expenses* at **www.irs.gov** or contact your tax adviser. You also can call the IRS at **1-800-829-1040**.

Note: The IRS publication is a guideline for use in preparing tax returns; it is not a description of the Citi Plan.

Qualifying individuals

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

- Your child under age 13 who must share your residence for more than half the year and who must not provide more than half of his or her own support;
- Your spouse who is physically or mentally unable to care for himself or herself and resides with you for more than half the year; and
- A dependent who is mentally or physically unable to care for himself or herself and resides with you for more than half the year.

Marital status and your DCSA contribution

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

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

If your spouse does not work: In general, you cannot use the DCSA if your spouse does not work, unless he or she is a full-time student for at least five months during the calendar year, is looking for work, or is disabled. In such a case, for purposes of determining the maximum contribution, your spouse is considered to earn $250 a month if you have one qualified dependent or $500 a month if you have two or more qualified dependents. For Plan purposes, count only the months that your spouse is either in school or disabled.

These limits are subject to change.

Paying for your expenses out of pocket

You can submit a claim for eligible expenses online on the YSA™ website or you can submit a paper claim to Your Spending Account™ (YSA™) using the DCSA Claim Form. The claim-filing instructions are on the YSA™ website and the DCSA Claim Form.

Reimbursements

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

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

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

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

Effect on other Citi benefits

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

Effect of DCSA participation on Social Security

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

Using DCSA after your termination of employment

You may submit claims for eligible expenses incurred after your termination date but incurred within the 2015 plan year. You must submit any eligible 2015 claims, including any pertinent supporting documentation to establish that the claim is eligible to be reimbursed, no later than June 30, 2016.

DCSA subsidy

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

Note: To obtain the DCSA subsidy you must elect it; it is not automatic.

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

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

You must enroll for the subsidy during your annual enrollment period. You cannot receive the subsidy through any other process. You must elect the full amount that you want to use to reimburse yourself for eligible expenses. The deductions from your pay will be the amount of the election minus the amount of the subsidy.

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

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

If your benefits-eligible pay is[1]:	Your DCSA subsidy will be:	
	For full-time employees	**For part-time employees**
Up to $25,000	30% of your DCSA contribution; maximum subsidy is $1,500	22-1/2% of your DCSA contribution; maximum subsidy is $1,125
$25,001-$35,000	20% of your DCSA contribution	15% of your DCSA contribution
$35,001-$45,000	15% of your DCSA contribution	11-1/4% of your DCSA contribution
$45,001-$90,000 if you are the sole financial provider of your dependents	15% of your DCSA contribution	11-1/4% of your DCSA contribution

[1] Your total household income and benefits eligible pay cannot exceed $90,000 at the time you enroll.

If you are rehired

If you terminate employment with Citi and are rehired in the same plan year, you must re-enroll to have DCSA coverage. If you re-enroll in the DCSA, you are not eligible for the subsidy, because your subsidy was credited during your employment earlier in the same plan year. (Subsidies are credited during the first quarter if you enroll during annual enrollment or within 31 days if you enroll as a new hire or are newly eligible for benefits.)

Filing a claim

Generally, you will have until June 30 following the year in which you incur an eligible expense to file and resolve a claim for reimbursement. In order for a claim to be deemed an eligible expense to be reimbursed, you must provide any pertinent documentation to establish that a claim is eligible for reimbursement. All such documentation must be submitted and the claim must be resolved by the June 30 deadline to avoid forfeiture. For example, you will have until June 30, 2016, to file claims for reimbursement of expenses incurred in 2015.

For more information, see “How to file a claim” in the “Eligibility and participation” section.

Note: You cannot submit claims for services that have not yet been rendered. Claims submitted in advance will be denied as ineligible and you will need to resubmit them to be reimbursed after the services have been provided.

For more information

Call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “health and welfare benefits” option and then the option for “spending accounts.” For TDD and international assistance, please see the “For More Information” section.

Transportation Reimbursement Incentive Program (TRIP)

TRIP allows you to purchase transit and parking passes online so you can commute to and from work. TRIP is not for business travel (for example, to use public transportation to attend a business meeting).

The first $130 of the cost of your transit and/or $250 of your parking pass will be deducted from your pay before taxes are withheld. Any amount of your transit pass that exceeds $130 or parking pass that exceeds $250 will be deducted from your pay after taxes are withheld. By enrolling in TRIP and paying transit and parking pass expenses with before-tax dollars, you lower your taxable income and, as a result, pay less in federal and FICA taxes and, in most locations, state and local taxes.

You can set up or change your online purchase at any time. Your enrollment or change will be effective as soon as administratively possible.

Are you eligible to enroll in TRIP?

You are eligible to enroll in TRIP if:

- You commute to work by public transportation (bus, subway, train, ferry, or van pool) or you commute to work by car and have out-of-pocket parking expenses; or
- You do *not* participate in another Company-sponsored parking or mass transit program.

If you enroll in TRIP and later begin participating in another Company-sponsored parking or mass transportation program, you must cancel the purchase of your online transit or parking pass.

Quick tip

You do not need to wait until annual enrollment to enroll in TRIP. The deadline to enroll or change your TRIP participation is the 10th of every month for participation that begins the 1st of the following month. If you miss the deadline, your enrollment/change will be effective the following month.

Note for rail commuters using the Long Island Rail Road and Metro North Railroad: The deadline to enroll or change your TRIP participation is the 4th of every month.

How the program works

TRIP is made up of two accounts:

- *A Transit Account* to pay for eligible transit expenses. The Internal Revenue Code defines transit expenses as those for bus, subway, train, ferry, and Metro passes, as well as van pooling. A van must be a "licensed commuter highway vehicle" with seating capacity for six or more adults, excluding the driver.
- *A Parking Account* to pay for parking on or near Citi's business premises or near a location from which you commute to work by mass transit, vanpool, or carpool.

You can enroll to purchase both a transit and a parking pass, two types of transit media (pass, token or ticket), or two types of parking media (parking permit or parking garage) online, depending on what is required for your commute to and from work. When enrolling, you can set up a recurring purchase or you can arrange to purchase your pass each month. The pass will be mailed to your address of record with the TRIP provider in time for use beginning the 1st of the following month.

Your card will be updated prior to the beginning of each month for monthly purchases and it will be valid for up to one year or as long as you continue to have a monthly order. If you do not change the order for a particular month, a new card will be mailed to your address of record following your next order.

The deadline to enroll or change your TRIP participation is the 10th of every month for participation the 1st of the following month. If you miss the deadline, your enrollment/change will be effective the following month.

Once enrolled, you can cancel or suspend your online purchase at any time. If you cancel or suspend your purchase by the 10th of any month (the monthly purchase deadline), a pass will not be purchased for you for the following month.

Note for rail commuters using the Long Island Rail Road (LIRR) and Metro North Railroad (MNR): An earlier deadline applies to you. Your orders and cancellations must be placed by the 4th of the month.

If you:	Order:	Receive:
Enroll to purchase a transit and/or parking pass on the Your Spending Account™ (YSA™) website, available as a link from Your Benefits Resources™	No later than the 10th of any month; for LIRR and MNR commuters, no later than the 4th of any month	Your pass will be purchased and mailed to your address of record with the TRIP provider so you have it before the 1st of the following month

Cash reimbursement option

The cash reimbursement option for parking expenses is a solution intended to cover situations when you are unable to participate in the TRIP Parking Account using the parking voucher, the parking debit card, or the pay-the-provider-directly option. This may work for you if you pay for your parking on a quarterly basis or a year in advance. To be reimbursed in cash, you must submit a claim for eligible expenses online on the Your Spending Account™ (YSA™) website or you can submit a paper claim to YSA™. Be sure to include your itemized receipts with the claim.

To be reimbursed in cash, you must submit a paper claim to YSA™ with your itemized receipts. For more information about the cash reimbursement option, see the Transportation Reimbursement Incentive Program claim form or visit the YSA™ website through TotalComp@Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet.

Examples of eligible expenses	
Parking Account	**Transit Account**
> Parking at or near your work location; and > Parking at or near a location from which you commute to work by mass transportation, carpool, or other means	> Transportation passes; > Any pass, token, fare card, ticket, or similar item that entitles you to ride public transportation to and from work; and > Transportation between work and your residence in a “commuter highway vehicle” that: – Seats six or more adults excluding the driver; – Is used 80% or more (based on mileage) for transporting employees between work and home; and – Includes at least three commuters, excluding the driver, on each trip.

Examples of ineligible expenses	
Parking Account	**Transit Account**
> Non-work-related parking expenses; > Parking at or near your residence; > Parking for which you receive a before-tax benefit; > Parking paid for by your employer; > Parking expenses incurred by family members; and > Expenses eligible to be reimbursed from the Transit Account.	> Carpooling and/or vanpooling in a vehicle seating fewer than six passengers, excluding the driver; > Taxi fares; > Highway, bridge, or tunnel tolls; > Expenses incurred for business travel (such as traveling from the office to a business or client meeting); > Gas or mileage expenses; > Transit expenses incurred by family members; and > Expenses eligible to be reimbursed from the Parking Account.

Changing your TRIP pass election

Once enrolled, you can change your online purchase at any time; the change will be effective as soon as administratively possible. For example, let’s say you are enrolled to purchase a parking pass and a train pass, but you relocate so you require a bus pass only. If, by May 10 (for example), you cancel the train and parking pass purchase and enroll for a bus pass, your new bus pass will be mailed to your address of record with the TRIP provider for use as of June 1.

To enroll in TRIP or to change your election once enrolled, visit the YSA™ website through the Your Benefits Resources™. Visit TotalComp@Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet.

If your employment is terminated/transferred

If your employment is terminated or if you transfer to an entity that is nor eligible to participate in TRIP, your payroll deductions will stop and your account will be closed as of your termination or transfer date. You will forfeit the before-tax balance in your account.

For more information

Call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option and then the option for "spending accounts." For TDD and international assistance, please see the "For More Information" section.

Claims and appeals for the Health Care Spending Account (HCSA)/; Limited Purpose Health Care Spending Account (LPSA)

If you are denied a benefit under the HCSA/LPSA, you should proceed in accordance with the following procedures:

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

Step 2: Once you have received your notice from the Citi Benefits Center, review it carefully. The notice will contain:

- The reasons for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit to submit the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures;
- A right to request all documentation relevant to your claim; and
- A statement explaining your rights to bring civil action under Section 502(a) of ERISA after an adverse benefit determination upon review.

Step 3: If you disagree with the processing of your claim, contact the Citi Benefits Center for assistance. If you are still unable to resolve your issue and have your claim approved, you may file a first-level appeal. You may obtain a first-level appeal form from the Citi Benefits Center spending account team. Complete and return the form along with any additional documentation supporting why you believe your claim should be approved.

You must file your appeal no later than 180 days after receipt of the notice described in Step 1. Mail your appeal to the Citi Benefits Center at the address below (the address is also on the first page of the appeal form). Be sure to submit all information identified in the Denial Notice as necessary to perfect your claim and any additional information that you believe would support your claim.

Your Spending Account™
Claims and Appeals Management
P.O. Box 1444
Lincolnshire, IL 60069-1444

Note: The Plan can be administered only in accordance with its terms.

Step 4: The Denial Notice is received from the claims reviewer. If the claim is again denied, you will be notified in writing. The notice will be mailed by the Citi Benefits Center no later than 90 days after receipt of the first-level appeal (180 days, if special circumstances apply and you are notified of the extension in writing within the initial 90-day period, including the anticipated decision date).

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

Step 6: If you still do not agree with the Citi Benefits Center's decision, you may file a written second-level appeal with Citi at the address listed below within 60 days after receiving the latest Denial Notice from the Citi Benefits Center. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

Claim review process

You have the right to appeal a denied claim. To do so, you must file an appeal of the denied claim to the Committee within 180 days of the receipt of the denial letter. Send your appeal to the following address:

Citigroup Inc.
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

Appeals review process

The Committee will conduct a full and fair review of your appeal. You and/or your representative may review Plan documents and submit written comments with your appeal. Appeals that are filed at least 30 days prior to the Committee's next quarterly meeting will be decided at that meeting (and appeals filed within 30 days will be decided at the following meeting). If special circumstances apply, you will be notified of an extension and the date the Committee will reach a determination with respect to your appeal. Your appeal will be decided no later than by the third quarterly meeting that follows the receipt of your appeal.

Legal action

No suit or action for benefits under the Plan shall be sustainable in any court of law or equity, unless you complete the appeals procedure, and unless your suit or action is commenced within 12 consecutive months after the Committee's final decision on appeal, or if earlier, within two years from the date on which the claimant was aware, or should have been aware, of the claim at issue in the proceeding. The two-year limitation shall be increased by any time a claim or appeal on the issue in under consideration by the appropriate fiduciary.

Disability coverage

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

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 Disability Plan.

For complete details about your coverage under the LTD benefit, see the insurance certificate, which is also part of the Disability Plan, at Citi Benefits Online. 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 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 to when you became disabled.

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. For TDD and international assistance, please see the "For More Information" section.

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

For purposes of the Disability Plan, your years of service are based on your actual time providing services to Citi as an employee. You are credited with service from your hire date, or if you have had one or more breaks in service, from your adjusted service date. You will have a year of service for this purpose for each 12 months of service, counting any part of a month in which you provided service.

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

Managed Disability Brochure

To learn more about how to report a disability and what happens to your benefits coverage while you are on a leave of absence, see the Managed Disability brochure.

Contents

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 MetLife, Citi's disability 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. For TDD and international assistance, please see the "For More Information" section. You also can call MetLife directly at **1-888-830-7380**.

For a description of your responsibilities and those of MetLife when you report a disability, see the Managed Disability brochure.

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 and rehired employees (regardless of prior service), there is a 90-day waiting period before disability benefits are payable (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

STD schedule of benefits – 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			
Years of service	**Minimum benefit (% of benefits eligible pay)**	**Plus additional benefit**	**Maximum benefit (% of benefits eligible pay)**
Less than 90 days	0	0	0
90 days to less than 3 years	60%	Commissions	100%
3 years to less than 7 years	70%	Commissions	100%
7 or more years	80%	Commissions	100%

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	0	0	0
90 days to less than 1 year	1	12	13
1 or more years	13	0	13

Paid Pregnancy Leave – 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			
Years of service	**Minimum benefit (% of benefits eligible pay)**	**Plus additional benefit**	**Maximum benefit (% of benefits eligible pay)**
Less than 90 days	0	0	0
90 days to less than 1 year	70%	Commissions	100%
1 or more years	80%	Commissions	100%

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 six 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 six-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 at work. "Actively at work" means that you are regularly scheduled to work in the office or at home. You must be able to perform all of the activities of your job. 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. You will be eligible to receive an STD benefit for the balance of your STD period of up to 13 weeks (for a reduced period to reflect the STD benefits paid during the prior absence) and may qualify for Long-Term Disability (LTD).

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 state benefits, including Worker's Compensation and Social Security disability benefits. However, the Disability 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 state law).

For employees who work in California

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

If you are covered by the VDI Plan, you are not eligible to file a claim with the state. You must report your disability to MetLife. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu choose the "disability" option. For TDD and international assistance, please see the "For More Information" section. You also can call MetLife directly at **1-888-830-7380**.

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 Short-Term Disability (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 disability insurance certificate at Citi Benefits Online constitutes your benefits eligible pay (as defined by the Disability 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 state disability plan, Social Security, and the LTD portion of the Disability 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 when your benefits eligible pay exceeds $50,000.99 for the next plan year (or as a new hire with the requisite benefits eligible pay), 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[1] 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.

[1] If your benefits eligible pay increases above $50,000.99 for benefits purposes for the following plan 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 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

LTD BENEFITS	
Age when total disability begins (when LTD becomes effective)	**Date monthly LTD benefits will stop**
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 the “Eligibility and Participation” section.

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 Disability 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 Disability 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.

Converting your coverage

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

The maximum benefit of this individual policy is $3,000 per month. To obtain conversion information, call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “health and welfare benefits” option. For TDD and international assistance, please see the “For More Information” section.

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. Refer to the insurance certificate at Citi Benefits Online for additional details.

If you have consecutive, concurrent, or continuous disabilities, related or unrelated, which continue 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 yourself 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.

Your LTD benefit won't be offset for any SSDI cost-of-living adjustments. If you're approved for SSDI retroactively and receive a lump-sum SSDI award, you're required to submit any overpayment of benefits to MetLife. Any other income you receive while you're receiving LTD benefits may be used to offset your LTD benefit as described in the LTD insurance certificate at Citi Benefits Online. This is not applicable to Individual Disability Insurance Plans (IDIs).

While on an LTD leave, MetLife will send you instructions on how to apply for SSDI benefits, tax information, benefits continuation information, and relevant forms.

Claims and appeals

You should file a Short-Term Disability (STD) claim as soon as you know you will be out of work for more than seven consecutive calendar days due to a non-work related illness. If you are unable to file the claim yourself, someone may file the claim on your behalf.

To file a claim, call MetLife, the Claims Administrator for STD benefits, at **1-888-830-7380**; for text telephone service, call **1-877-503-0327**. You can also call ConnectOne at **1-800-881-3938**; from the main menu, choose the "disability" option and follow the prompts to report a disability. For TDD and international assistance, please see the "For More Information" section. The Claims Administrator will provide the appropriate forms and can help you file for state disability benefits, where applicable.

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

- Name, address, telephone number, and GEID;
- Manager's/supervisor's name, telephone number, e-mail address, and mailing address;
- Your health care provider'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. Benefits are approved for a fixed period of time, as determined by the Claims Administrator. The initial approval period is an estimate of how long it would take a regular person to recover from your disabling condition and may be adjusted based on medical information or other extenuating circumstances.

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 Disability 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 Disability Plan, to decide questions of eligibility for coverage or benefits under the Disability 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 Disability 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 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; the Long-Term Disability (LTD) benefit 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 Disability 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 the denied benefit.

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 Disability 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 Disability 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 Disability 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 Disability 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 Disability 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 Disability 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 1/1/12).

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.

Did you know?

If you're enrolled in GUL coverage, you receive Will Preparation and Estate Resolution services at no cost when you work with an in-network attorney. Call Hyatt Legal Plans at **1-800-821-6400** and provide the Citi group number 1137000 to get more information.

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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 Internal Revenue Code (the "Code"). The Basic Life insurance benefit that exceeds $50,000 for tax purposes is treated as income to you and is called "imputed income." This imputed income is taxable income to you and is shown on your pay statement and Form W-2 Wage and Tax Statement for the year in which coverage was effective. Imputed income is taxable pay based on your age and 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 have imputed income or be subject to the related tax; however, 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 increases to $200,000 or above

Once your benefits eligible pay is equal to or exceeds $200,000, you are no longer eligible for Basic Life and Basic AD&D. As a result, you may have the opportunity to enroll in Group Universal Life (GUL) coverage (you can enroll in Supplemental AD&D at any time without providing evidence of insurability) equal to one times your benefits eligible pay up to $500,000 *without providing evidence of insurability,* 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 or $5 million — you are not eligible to increase GUL coverage. You can convert your Basic Life and AD&D benefits into individual policies. Refer to "Continuing Basic Life and Basic AD&D on an individual basis" on page 268.

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. For TDD and international assistance, please see the "For More Information" section;
- 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 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 this is received, you may call MetLife directly at **1-877-275-6387** within 31 days after you become ineligible.

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 Citi group rate. If you have any questions about continuing your AD&D on an individual basis, please call MetLife directly at **1-888-252-3607**.

If you become ineligible for Basic Life and 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 insurability, by calling MetLife within 31 days after you become ineligible.

Note that the rates for continuing your Basic Life and/or Basic AD&D insurance may be higher than the Citi group rate.

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 (capped at $500,000) or $1.5 million, you must provide evidence of insurability 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. 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 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 insurability 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 by paying premiums directly to MetLife. MetLife will send you information regarding the continuation of your GUL coverage once notified of your termination or retirement. MetLife will bill you at a higher rate than the Citi group rate. The rate will become effective the month following your termination of employment.

If you are receiving disability benefits from the Citigroup Disability Plan at the time your employment terminates and you are enrolled in GUL coverage, MetLife will bill you at the active employee rate for the same length of time you pay active employee rates for medical coverage, based on your years of service in connection with your disability. Afterwards, MetLife will bill you at a higher rate than the Citi group rate. The rate will become effective the month after you are no longer eligible to pay active employee rates for medical coverage. If you have any questions on continuing your coverage, call MetLife directly at **1-888-830-7380**.

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 and do not pay the GUL premiums or notify MetLife that you wish to discontinue the GUL coverage, premiums for the 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.

Did you know?

If you’re enrolled in GUL coverage, you receive Will Preparation and Estate Resolution services at no cost when you work with an in-network attorney. Call Hyatt Legal Plans at **1-800-821-6400** and provide the Citi group number 1137000 to get more information.

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 applicable charges.

Accelerated benefits are not payable if:

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

Cash Accumulation Fund (CAF)

When you enroll in GUL coverage, you can participate in the Cash Accumulation Fund (CAF). The CAF allows you to save money that earns an interest rate at a guaranteed minimum of 4% 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 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 your GUL coverage 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. 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;
- 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** to name or change a beneficiary.

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 yourself 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 insurability.

If you enroll in GUL coverage at any other time, your spouse/civil union partner/domestic partner must provide evidence of insurability 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 CAF 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 Citi group rate. The rate will become effective the month following your termination of employment, divorce, or termination of your civil union or domestic partnership.

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 available 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 on the day the child reaches the maximum age of 27, 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. For TDD and international assistance, please see the "For More Information" section.

Unless you have designated a beneficiary — other than yourself — 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
- Your estate, if the dependent dies 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 Accidental Death & Dismemberment (AD&D) insurance for you and your dependents

You may enroll in Supplemental AD&D coverage, provided by MetLife, at any time without providing evidence of insurability. You may choose from 1 to 10 times your benefits eligible pay (capped at $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 yourself 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 anytime without providing evidence of insurability.

Once you or your spouse/civil union partner/domestic partner have enrolled, your eligible children may be enrolled in Supplemental AD&D coverage in increments of $5,000 to a maximum of $20,000 at any time without evidence of insurability. Coverage for a child generally ends on the day the child reaches the maximum age of 27, 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 Citi group 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 Accidental Death & Dismemberment (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;
- 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 $10,000.

Additional Supplemental AD&D benefits

Child care center benefit

If you die as a result of an accidental injury and MetLife pays a benefit, you will receive an additional Child Care benefit if:

- This benefit is in effect on the date of the injury; and
- MetLife receives proof that on the date of your death a child was enrolled in a Child Care Center; or within 12 months after the date of your death a child was enrolled in a Child Care Center.

A Child Care Center is a facility operated and licensed according to the law of the jurisdiction where it is located. The facility must provide care and supervision for children in a group setting on a regularly scheduled and daily basis.

Benefit Amount

For each child who qualifies for this benefit, MetLife will pay an amount equal to the Child Care Center charges incurred for a period of up to 4 consecutive years, not to exceed an annual maximum of $10,000; and an overall maximum of 5% of the Principle Sum.

MetLife will not pay for Child Care Center charges incurred after the date a child attains age 13.

MetLife may require proof of the child's continued enrollment in a Child Care Center during the period for which a benefit is claimed.

Benefit Payment

MetLife will pay this benefit quarterly when MetLife receives proof that Child Care Center charges have been paid. Payment will be made to the person who pays such charges on behalf of the child.

If this benefit is in effect on the date you die and there is no child who could qualify for it, MetLife will pay $1,000 to your beneficiary in one sum.

Child Education benefit

If you die as a result of an accidental injury and MetLife pays a benefit, MetLife will pay an additional Child Education benefit if:

> This benefit is in effect on the date of the injury; and

> MetLife receives proof that on the date of your death a child was enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level; or at the 12th grade level and, within one year after the date of your death, enrolls as a full-time student in an accredited college, university or vocational school.

Benefit Amount

For each Child who qualifies for this benefit, MetLife will pay an amount equal to the tuition charges incurred for a period of up to four consecutive **academic years, not to exceed** an academic year maximum of $10,000; and an overall maximum of 20% of the Principle Sum.

MetLife may require proof of the child's continued enrollment as a full-time student during the period for which a benefit is claimed.

Benefit Payment

MetLife will pay this benefit semi-annually when MetLife receives proof that tuition charges have been paid. Payment will be made to the person who pays such charges on behalf of the child.

If this benefit is in effect on the date you die and there is no child who could qualify for it, MetLife will pay $1,000 to your beneficiary in one sum.

Spouse education benefit

If you die as a result of an accidental injury and MetLife pays a benefit, MetLife will pay an additional Spouse Education benefit if:

> This benefit is in effect on the date of the injury; and

> MetLife receives proof that on the date of your death, your spouse was enrolled as a full-time student in an accredited school; or within 3 years after the date of your death, your spouse enrolls as a full-time student in an accredited school.

Benefit Amount

MetLife will pay an amount equal to the tuition charges incurred for a period of up to one academic year, not to exceed an academic year maximum of $10,000; and an overall maximum of 3% of the Principle Sum.

MetLife may require proof of the spouse's continued enrollment as a full-time student during the period for which a benefit is claimed.

Benefit Payment

MetLife will pay this benefit semi-annually when MetLife receives proof that tuition charges have been paid. Payment will be made to your spouse. If this benefit is in effect on the date you die and there is no spouse who could qualify for it, MetLife will pay $1,000 to your beneficiary in one sum.

Hospital Confinement Benefit

If you die as a result of an accidental injury and MetLife pays a benefit, MetLife will pay an additional Hospital Confinement benefit if:

- This benefit is in effect on the date of the injury; and
- MetLife receives proof that you or a dependent are confined in a hospital as a result of an accidental injury which is the direct result of such confinement independent of other causes.

Benefit Amount

MetLife will pay an amount for each full month of Hospital Confinement equal to the lesser of 1% of the Principle Sum and $2,500. MetLife will pay this benefit on a monthly basis beginning on the fifth day of confinement, for up to 12 months of continuous confinement. This benefit will be paid on a pro-rata basis for any partial month of confinement.

MetLife will only pay benefits for one period of continuous confinement for any accidental injury. That period will be the first period of confinement that qualifies for payment.

Benefit Payment

Benefit payments will be made monthly. Payment will be made to you. This additional benefit provides insurance only for accidents. It does not provide basic hospital, basic medical or major medical insurance, as defined by the New York State Insurance Department.

Common Carrier Benefit

If you die as a result of an accidental injury and MetLife pays a benefit, MetLife will pay an additional Common Carrier benefit if:

- This benefit is in effect on the date of the injury; and
- MetLife receives proof that the injury resulting in the deceased's death occurred while traveling in a Common Carrier.

Benefit Amount

The Common Carrier Benefit is an amount equal to the Principle Sum.

Benefit Payment

For loss of your life, MetLife will pay benefits to your beneficiary. For a loss of a dependent's life, MetLife will pay benefits to you.

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:

- Service in the armed forces or unit Auxiliary thereto;
- Aviation, other than a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline;
- War, whether declared or undeclared; or act of war, participation in a felony, riot, or insurrection
- Suicide or attempted suicide;
- Intentionally self-inflicted injury;
- 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;
  - Loss caused by or contributed to by voluntary actions such as 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;

MetLife will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

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 MetLife 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 Supplemental AD&D coverage once you lose eligibility

When you are no longer eligible for group coverage, you or your dependents can continue your Supplemental AD&D insurance by paying premiums directly to MetLife. 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.

Business Travel Accident/Medical (BTA/BTM) 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 their 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 designated for your Basic Life 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 Accidental Death & Dismemberment (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 the 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 Accidental Death & Dismemberment (AD&D), Group Universal Life (GUL), Supplemental AD&D, and Business Travel Accident/Medical (BTA/BTM) 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. For TDD and international assistance, please see the “For More Information” section.

If proper notice, as indicated, is not given in that time, the claim will not be invalidated or reduced if it is shown that proper notice was 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, email) 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 after it receives notice of a potential claim (this may be longer if additional documentation is required), 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.

Long-Term Care (LTC) insurance

Effective January 1, 2012, no new participants will be permitted to enroll into the Citigroup Long-Term Care (LTC) Plan. Participants who enrolled on or before December 31, 2011 may continue to be participants under the LTC Plan.

If you enrolled in 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 become insured. Family members who have 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 LTC 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[1]	$115	$175	$230	$290	$345	$405
Community-based professional care DMB[2]	$86.25	$131.25	$172.50	$217.50	$258.75	$303.75

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Informal care DMB	$28.75	$43.75	$57.50	$72.50	$86.25	$101.25
Informal care calendar-year maximum[3]	$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

[1] If you are a Kansas resident, the alternate care facility DMB benefit varies slightly. Call John Hancock at **1-800-222-6814** for details.

[2] Community-based professional care includes adult day care (Washington state refers to this as adult day health care) and the following services provided in your home: Home health care, hospice care, and homemaker services provided by a person certified or employed through a licensed home health care agency.

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

Stay-at-home benefit

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

The stay-at-home benefit amount is the most the LTC 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 LTC 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: Automatic Benefit Increase (ABI) or future purchase option

You also had the option of including the 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 LTC 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%

Age	Percentage of premium returned upon death
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 LTC 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 LTC 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 LTC 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 LTC Plan contains a coordination of benefits provision that may reduce or eliminate the benefits otherwise payable under the LTC 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, copayment, or deductible provisions under Medicare; or for treatment specifically provided for detoxification or rehabilitation for alcohol or drug addiction.

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

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

Tax implications

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

Subject to specified dollar limits that vary depending on your age, you may be able to include your premium in your itemized deductions on your federal income tax return if your total medical expenses, including the allowable portion of your premium, exceed 7.5% of adjusted gross income, if you are age 65 or older. The allowable dollar limits are reviewed each year by the U.S. Treasury and adjusted accordingly. The benefits you receive under the policy generally are not considered taxable income. Consult your tax adviser if you have any questions or need details.

For more information

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 file a claim for benefits under the Life Insurance, Business Travel Accident/Medical, GUL, Supplemental AD&D, or the Long-Term Care Insurance Plans, your claim generally will be administered in accordance with the timetable outlined below. For additional details on the specific claims and appeals procedures, contact the applicable Claims Administrator.

Notice of adverse benefit determinations

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

> 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), if applicable.

Appeals

You have a right to appeal a denied claim for benefits by filing a written request for review of your claim with the Claims Administrator within 180 days after receipt of the notice informing you that your claim has been denied. In the case of a disability claim, you have 180 days following receipt of the notification in which to appeal the decision.

The Claims Administrator will conduct a full and fair review of your claim and appeal. You or your representative may review Plan documents and submit written comments with your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The Claims Administrator's review will take into account all comments, documents, and other claim-related information that you submit regardless of whether that information was submitted or considered in the initial benefit determination.

The Claims Administrator will reach a determination regarding your appeal 60 days after its receipt (120 days if the Claims Administrator determines that special circumstances require an extension and, before the expiration of the initial 60 days you are notified in writing of the circumstances warranting the extension and the anticipated determination date).

In the case of a claim for disability benefits, the Claims Administrator will reach a determination regarding your appeal 45 days after its receipt (90 days if the Claims Administrator determines that special circumstances require an extension and, before the expiration of the initial 45 days, you are notified in writing of the circumstances warranting the extension and the anticipated determination date).

Notice of benefit determination on appeal

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

- 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, if applicable, 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.

Administrative information

This section contains general information about the administration of the Citi Plans, the Plan Sponsors, and Claims Administrators.

Contents

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 290 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 also known as Protected Health Information (“PHI”) 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 HIPAA Privacy Rule defines “PHI” to include any individually identifiable health information (1) that is created or received by a health care provider, health plan, employer, insurance company, or health care clearinghouse; (2) that relates to the past, present, or future physical or mental health or condition of such individual; the provision of health care to such individual; or payment for such provision of health care; and (3) that is in the possession or control of an entity covered by the HIPAA Privacy Rule (called “covered entities”), including a group health plan. 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 PHI 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 PHI 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 PHI 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 PHI that is inconsistent with the uses or disclosures provided for herein of which it becomes aware.

The Plans shall make PHI available to individuals in accordance with 45 C.F.R. sec. 164.524. The Plans shall make PHI available to these Plans for purposes of amending the Plans and shall incorporate any amendments to PHI in accordance with 45 C.F.R. sec. 164.526. The Plans shall make PHI available 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 PHI to be disclosed, including those employees or persons who receive PHI 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 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 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 referred to in this section as an "Organized Health Care Arrangement" and each individually referred to in this section as a "Component Plan") may use and disclose your PHI.

This notice also sets out Component Plans' legal obligations concerning your PHI and describes your rights to access and control your PHI. 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. For TDD and international assistance, please see the "For More Information" section. 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 295.

Component Plans' responsibilities

Each Component Plan is required by law to maintain the privacy of your PHI. The HIPAA Privacy Rule defines "PHI" to include any individually identifiable health information (1) that is created or received by a health care provider, health plan, employer, insurance company, or health care clearinghouse; (2) that relates to the past, present, or future physical or mental health or condition of such individual; the provision of health care to such individual; or payment for such provision of health care; and (3) that is in the possession or control of an entity covered by the HIPAA Privacy Rule (called "covered entities"), including a group health plan. The Component Plans were required to limit the use, disclosure, or request for PHI 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 PHI. Component Plans must abide by the terms of this notice. If any of the Component Plans use or disclose PHI for underwriting purposes, the Component Plan will not use or disclose PHI 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 PHI. 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 PHI 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 PHI to fulfill their responsibilities for coverage and provide benefits as established under their governing documents. For example, Component Plans may disclose your PHI 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 PHI 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 PHI (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 PHI 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 PHI with each other to carry out payment and health care activities.

Other covered entities: Component Plans may use or disclose your PHI 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 PHI to a health care provider when needed by the provider to render treatment to you. Component Plans may disclose PHI 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 PHI 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 PHI to the extent required by federal, state, or local law.

Public health activities: Each Component Plan may use or disclose your PHI 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 PHI, 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 PHI 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 PHI 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 PHI in response to a subpoena, a discovery request, or other lawful process.

Abuse or neglect: Component Plans may disclose your PHI 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 PHI to a government entity authorized to receive such information.

Law enforcement: Under certain conditions, Component Plans may also disclose your PHI 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 PHI to a coroner or medical examiner when necessary to identify a deceased person or determine a cause of death. Component Plans may also disclose PHI to funeral directors as necessary to carry out their duties.

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

Research: Component Plans may disclose your PHI 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 PHI 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 PHI 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 PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military: Under certain conditions, Component Plans may disclose your PHI 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 PHI to the foreign military authority.

National security and protective services: Component Plans may disclose your PHI 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 PHI 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 PHI 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 PHI 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 PHI 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 294. Component Plans may also disclose your PHI 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 PHI, 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 PHI 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 PHI when you request access to this information. Component Plans will disclose your PHI 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 PHI 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 PHI upon receipt. However, the revocation will not be effective for information that such Component Plan has used or disclosed in reliance on the authorization.

Contacting you

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

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

Your rights

The following is a description of your rights regarding your PHI. 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 295.

Right to request a restriction: You have the right to request a restriction on the PHI 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 PHI 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 295.

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 PHI 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 PHI 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 PHI 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 295.

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 PHI 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 PHI could endanger you.

Right to request access: You have the right to inspect and copy PHI 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 PHI, 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 PHI if it is maintained in an electronic health record. In addition, you may request a copy of all electronic PHI 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 PHI 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 PHI subject to law that prohibits access to PHI. 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 PHI held by a Component Plan if you believe that information is incorrect or incomplete. If you request an amendment of your PHI, your request must be submitted in writing, using the contact information in “Contact information” on page 295, 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 PHI, 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 PHI. You may request an accounting using the contact information in "Contact information" on page 295. 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 295.

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 295. 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 PHI 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 Global 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** **Health Care Spending Account** **Limited Purpose Health Care Spending Account** ***Note:** If you are enrolled in an HMO, call your HMO.	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, Puerto Rico, and Canada:** Call **1-888-809-8455**. 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.

Important notices about your Citi prescription drug coverage and Medicare

Citi has determined that prescription drug coverage provided through the medical options it offers is "creditable" under Medicare. See "For more information about Medicare" under "Creditable Coverage Disclosure Notice".

Creditable Coverage Disclosure Notice

For employees and former employees enrolled in Citi medical plan

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

Keep this notice. If you enroll in Medicare prescription drug coverage, you may be asked to present this notice to prove that you had "creditable coverage" and, therefore, are not required to pay a higher premium than the premiums generally charged by the Medicare Part D Plans. You may receive this notice at other times in the future, for example, before the next period in which you can enroll in Medicare prescription drug coverage and/or if your Citi prescription drug coverage changes such that the coverage ceases to be "creditable coverage." You may request another copy of this notice by calling the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. For TDD and international assistance, please see the "For More Information" section.

* Citi is required by law to distribute this notice to both current employees and former employees who are enrolled in Citi coverage and who may be Medicare eligible. Generally, you become eligible for Medicare at age 65 or as a result of a disability as determined by the Social Security Administration.

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 might also offer more coverage for a higher monthly premium.

‘Creditable coverage’

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

Understanding the basics

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

- You *have* prescription drug coverage under your current Citigroup Health Benefit Plan. Your prescription drug coverage under the Citigroup Health Benefit Plan is considered primary to Medicare, if you are a current employee of Citi. This means that your Citi Plan pays benefits first. Although you can choose to join a Medicare prescription drug plan in addition to your enrollment in the Citigroup Health Benefit Plan, you should consider how Citi coverage would affect the benefits you receive under the Medicare prescription drug plan.
- If you drop your Citi prescription drug coverage and enroll in a Medicare prescription drug plan, you may not be able to get your Citi coverage back at a later date. You should compare your current coverage carefully — including which drugs are covered — with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.
- Your existing Citi coverage is, on average, *at least as good* as standard Medicare prescription drug coverage (this is your “creditable” coverage). As a result, you can keep your current Citi coverage and *not* pay extra if you decide you want to join a Medicare prescription drug plan. People can enroll in a Medicare prescription drug plan when they first become eligible for Medicare. In addition, people with Medicare have the opportunity to enroll in a Medicare prescription drug plan during an annual enrollment period from October 15-December 7 for coverage effective the first day of the following year.
- If you drop or lose your coverage with Citi and do not immediately enroll in a Medicare prescription drug plan after your current coverage ends, you may pay more to enroll in a Medicare prescription drug plan later. If you lose your prescription drug coverage under the Citigroup Health Benefit Plan, through no fault of your own, you will be eligible for a 60-day Special Enrollment Period (SEP) to enroll in a Medicare prescription drug plan.

In addition, if you lose or decide to terminate your coverage under the Citigroup Prescription Drug Program you will be eligible to enroll in a Medicare prescription drug plan at that time under the SEP as well. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare’s prescription drug coverage, your monthly premium will increase at least 1% for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay for the same coverage. You must pay this higher premium percentage as long as you have Medicare coverage. In addition, you may have to wait until the next annual enrollment period to enroll.

For more information about Medicare

More detailed information about Medicare Plans that offer prescription drug coverage is in the "Medicare & You" handbook (available at www.medicare.gov). Each year Medicare will mail a copy of the handbook to Medicare-eligible individuals. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare drug coverage, in addition to the "Medicare & You" handbook:

> Visit **www.medicare.gov**.

> Call your State Health Insurance Assistance Program (See your copy of the "Medicare & You" handbook for the telephone number).

> Call 1-800-MEDICARE (**1-800-633-4227**); for TDD users, call **1-877-486-2048**.

Your income may affect your Medicare premium

Some people may have to pay an extra amount because of their yearly income. If you have to pay an extra amount, Social Security—not your Medicare plan—will send a letter telling you what the extra amount will be and how to pay it. The extra amount will be withheld from your Social Security or Office of Personnel Management benefit check. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. If you have any questions about this extra amount, contact Social Security at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TDD users should call **1-800-325-0778**.

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

You can obtain Medicare's income level and asset guidelines by calling 1-800-MEDICARE (**1-800-633-4227**). If you qualify for assistance, visit the Social Security website at **www.socialsecurity.gov** or call **1-800-772-1213** to request an application.

For more information about this notice

Call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

For TDD users: Call the Telecommunications Relay Service at 711. Then call ConnectOne as instructed above.

Note: You will receive this notice each year, before the next period you can join a Medicare prescription drug plan, and if this coverage through Citi changes. You may also request a copy by calling the Citi Benefits Center as instructed immediately above.

ERISA information

As a participant in Citi Health and Welfare Plans subject to ERISA (which excludes HSA, DCSA and TRIP), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

You may examine all documents governing the Plans (including group insurance policies, where applicable) and copies of all documents filed with the U.S. Department of Labor (and available at the Public Disclosure Room of the Employee Benefits Security Administration) such as annual reports (Form 5500 Series). Upon written request to the Plan Administrator, you may obtain copies of documents governing the operation of the Plans, including insurance contracts, a copy of the latest annual report (Form 5500), and the current summary plan description. The Plan Administrator will mail these documents to your home free of charge. You may also receive a copy of the Plan's annual financial report. The Plan Administrator will furnish each participant with a copy of the Summary Annual Report.

If there is a loss of medical coverage as a result of a qualifying event, you may continue health care coverage for yourself, spouse (same- or opposite-gender/civil union partner/domestic partner, or eligible dependents. You or your dependents may have to pay for such coverage. Review this Plan/SPD and all other documents governing the Plans for 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 “Claims and appeals” on page 303.

Under ERISA, you can take steps to enforce the rights described above. For example, if you request materials from the Plan(s) 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 Plan(s), contact the Plan Administrator listed under “Plan administration” on page 311.

If you have any questions about this Handbook 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**.

Recovery provisions

Refund of overpayments

Whenever payments have been made by any of the Citigroup Health and Welfare 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(s) the applicable Overpayment and help the Plan(s) 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 Plan(s), Overpayment recovery will not be more than the amount of the payment. An Overpayment also occurs when payment is made from the Plan(s) that should have been made under another group plan. In that case, the Plan(s) 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 Plan(s) 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 Plan(s) (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 for Citigroup Health Benefit Plan

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 the Plan to the extent necessary to reimburse the 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.

For information on the Plan's funding status visit the "Plan information" section.

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.

For information on the Plan's funding status visit the" "Plan Information" section.

Aetna ChoicePlan 500 and Aetna HDHP only:

In addition to the above, the following also applies:

The Plan also has a right of subrogation. 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.

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he/she receives any payment from any Third Party as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

The Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition for which Third Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person; the Covered Person's representative or agent; Third Party; Third Party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Third Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to the payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that the Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Third Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained.

The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify any Third Party. The Plan reserves the right to notify Third Party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

For information on the Plan's funding status visit the "Plan information" section.

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, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan or the Health Care Spending Account/Limited Purpose Health Care Spending Account (HCSA/LPSA) who is an alternate recipient under a QMCSO will be considered as having a right to dependent coverage under the Citigroup Health Benefit Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan or the Health Care Spending Account/Limited Purpose Health Care Spending Account (HCSA/LPSA).

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

To receive, at no cost, a detailed description of the procedures for a QMCSO, or if you have a question about filing a QMCSO, call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. For TDD and international assistance, please see the "For More Information" section.

You can file your QMCSO by mailing it to:

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

Phone: **1-800-881-3938**, "health and welfare benefits" option
Fax: **1-847-442-0899**

Claims and appeals

Claims must be submitted in order to receive reimbursement for charges you incur when you seek care under the Plans. Many times, claims are submitted electronically to the Claims Administrator without your intervention needed. However, you may be required to manually submit claims for expenses to be paid or approved for reimbursement. For example, if you see an out-of-network physician, you will be required to manually submit a claim. Listed below are the forms needed to claim benefits that may not be reimbursed automatically or paid directly. Claims should be sent to the Claims Administrators as detailed under "Claims Administrators" on page 315.

To file an eligibility or enrollment-related claim or appeal, for example, if enrollment in Citi Health and Insurance benefits has been denied in whole or in part, see "Eligibility and enrollment claims" on page 309 .

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

- Medical, dental, and vision claims must be filed within two years of the date of service.
- Prescription drug claims must be filed within one year of the date of service.
- HCSA/LPSA/DCSA claims must be filed and resolved by June 30 of the calendar year following the Plan year in which the expense was incurred.
- TRIP parking cash reimbursement option claims must be filed within 12 months from the date of service.

How to file a claim	
Medical	
> For the ChoicePlan 500, Oxford PPO and High Deductible Health Plan (HDHP) (non-HMOs)	Use one of the following forms, available in the Find forms section of Citi Benefits Online at **www.citibenefitsonline.com**, to file a claim for a covered out-of-network expense: > Aetna claim form (for ChoicePlan 500 and HDHP participants) > Anthem BlueCross BlueShield claim form (for ChoicePlan 500 and HDHP participants) > Oxford Health Plan claim form
> HMO participants	> Call your HMO for any claim-filing information.
Prescription Drugs	
> Express Scripts (prescription drug program related to all non-HMO medical plans including the ChoicePlan 500, HDHP, and Oxford Health Plan)	Use one of the following forms, available in the Find forms section of Citi Benefits Online at **www.citibenefitsonline.com**, to file a claim for a covered out-of-network expense or home delivery: > Express Scripts Retail Pharmacy claim form > Express Scripts Home Delivery
Dental	
> MetLife Preferred Dentist Program (PDP)	> MetLife Dental claim form, available in the Find forms section of Citi Benefits Online at **www.citibenefitsonline.com**.
> Cigna Dental Care DHMO	> There are no claim forms to file under this Plan.
Vision	
> Aetna Vision	> Aetna Vision Plan claim form, available in the Find forms section of Citi Benefits Online at **www.citibenefitsonline.com**. > Call the Aetna Vision Plan at **1-877-787-5354**.
Employee Assistance Program	
	> Call Harris Rothenberg at **1-800-952-1245** or visit **www.harrisrothenberg.net** User ID: resources Password: for_you
Health Care Spending Account (HCSA) and Limited Purpose Health Care Spending Account (LPSA)	
	> If you do not use a Your Spending Account™ (YSA™) card for an eligible HCSA purchase, or if you are participating in an LPSA, you can file a claim by using the Health Care Spending Account/Limited Purpose Health Care Spending Account claim form, available in the Claim Forms section of Citi Benefits Online at **www.citibenefitsonline.com**, or submit a claim online via the YSA™ website. You may access the YSA™ website through a link on the Your Benefits Resources™ (YBR™) website. You can access YBR™ through TotalComp@Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet.
Dependent Day Care Spending Account (DCSA)	
	> DCSA Reimbursement Request Form, available in the Claim Forms section of Citi Benefits Online at **www.citibenefitsonline.com**.

How to file a claim	
Transportation Reimbursement Incentive Program (TRIP)	
> For TRIP parking participants enrolled in the Cash Reimbursement Option **only**	> Transportation Reimbursement Incentive Program (TRIP) claim form, available in the Find forms section of Citi Benefits Online at **www.citibenefitsonline.com**. **For TRIP parking participants enrolled in the Cash Reimbursement Option only.**
Short-Term Disability (STD)	
	> To file a claim, call MetLife, the Claims Administrator for the STD Plan, at **1-888-830-7380**; for text telephone service, call **1-877-503-0327**. You can also call ConnectOne at **1-800-881-3938**; from the main menu, choose the "disability" option and follow the prompts to report a disability. For TDD and international assistance, please see the "For More Information" section.
Basic Life and Basic AD&D insurance	
	> To file a claim, your beneficiary may call the Citi Benefits Center at **1-800-881-3938**. From the ConnectOne main menu, choose the "pension, retiree health and welfare, and survivor support" option. For TDD and international assistance, please see the "For More Information" section.
GUL and Supplemental AD&D insurance	
	> To file a claim, your beneficiary may call the Citi Benefits Center at **1-800-881-3938**. From the ConnectOne main menu, choose the "pension, retiree health and welfare, and survivor support" option. For TDD and international assistance, please see the "For More Information" section.

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

If you do not receive a benefit to which you believe you are entitled under any Citigroup Health and Welfare Plans subject to ERISA, which excludes HSA, DCSA and TRIP, or if your application for benefits is denied, in whole or in part, you may file a claim with the Plan Administrator or Claims Administrators, as applicable. For more information about the Plan Administrator and Claims Administrators, see "Plan administration" on page 311 and the list of Claims Administrators under "Claims Administrators" on page 315.

Please note that the health savings account ("HSA") associated with the HDHP benefit options is an account owned by each participant who establishes an HSA. The Citi HSA is not a plan and is designed to be exempt from ERISA.

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 one of the Citigroup Health and Welfare Plans, you must first go through the Citigroup Health and Welfare Plan's appeals procedures.

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

Detailed procedures governing claims for benefits, applicable time limits, and remedies available under the Citigroup Health Benefit Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan, the Health Care Spending Accounts (HCSA/LPSA) and the Citigroup Disability Plan for the redress of denied claims are included in this Handbook.

Medical care claims

There are four categories of claims for medical benefits, each with somewhat different claims and appeal rules. The primary difference is the time frame within which claims and appeals must be determined.

1. **Pre-service claim:** A claim is a pre-service 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 as being subject to pre-service authorization (also called prior authorization).

2. **Urgent care claim:** A claim involving urgent care is any pre-service claim for medical care or treatment to which the application of the time periods that otherwise apply to pre-service claim 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 pre-service request, the Claims Administrator will determine whether it involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim review 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 pre-service claim or an urgent care claim.

4. **Concurrent care claim:** A concurrent care decision occurs when the Claims Administrator approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims:

   (a) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and

   (b) where an extension is requested beyond the initially approved period of time or number of treatments.

Deciding initial medical benefit claims

A post-service claim must be filed within 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 and in no event (except in the case of legal incapacity of the claimant) later than two years after the date of receipt of the service, treatment, or product to which the claim relates.

These claims procedures do not apply to any request for benefits that is not made in accordance with these procedures or other procedures prescribed by the Claims Administrator except that, (a) in the case of an incorrectly filed pre-service 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 pre-service claim within a reasonable time appropriate to the medical circumstances but no later than 15 days after receipt of the claim.

The Claims Administrator will decide an initial urgent care claim as soon as possible, taking into account the medical urgencies but no later than 72 hours after receipt of the claim.

However, if a claim is a request to extend a concurrent care decision (defined above) involving urgent care and if the claim is made at least 24 hours prior to the end of the initially approved period of time or number of treatments, the claim will be decided within no more than 24 hours after the receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable time frames for pre-service, urgent care, or post-service claims.

A decision by the Claims Administrator to reduce or terminate an initially approved course of treatment is an adverse benefit decision that may be appealed by the claimant, as explained below. Notification to the claimant of a decision to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow you to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.

An initial post-service claim shall be decided within a reasonable time but no later than 30 days after the receipt of the claim.

Despite the specified time frames, nothing prevents you from voluntarily agreeing to extend the above time frames. In addition, if the Claims Administrator is not able to decide a pre-service 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 pre-service or post-service claim is incomplete, the Claims Administrator may deny the claim or may take an extension of time, as described above. If the Claims Administrator takes an extension of time, the extension notice shall include a description of the missing information and shall specify a time frame, no less than 45 days, in which the necessary information must be provided. The time frame for deciding the claim shall be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided to the Claims Administrator. If the requested information is provided, the Plan shall decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

Notification of initial benefit decision by Plan

You will receive written notification of an adverse decision on a claim, and it will include the following:

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

- If the decision involves scientific or clinical judgment, disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical circumstances or (b) a statement that such explanation will be provided at no charge upon request; and
- In the case of an urgent care claim, an explanation of the expedited review methods available for such claims.

Written notification of the decision on a pre-service or urgent care claim will be provided to you whether or not the decision is adverse. Notification of an adverse decision on an urgent care claim may be provided orally, but written notification will be furnished no later than three days after the oral notice.

Appeals

You have the right to appeal an adverse decision under these claims procedures. The appeal of an adverse benefit decision must be filed within 180 days following your receipt of the notification of adverse benefit decision, except that the appeal of a decision to reduce or terminate an initially approved course of treatment (see the definition of concurrent care decision under “Claims and appeals” on page 303) 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 and all required information to conduct the review 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 (30 days for Anthem) after receipt of the appeal.

The appeal of a decision to reduce or terminate an initially approved course of treatment (see the definition of concurrent care decision under “Claims and appeals” on page 303) 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 pre-service, 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;
- If an internal rule or guideline was relied on in making the adverse determination, either the specific rule or guideline, or a statement that such a rule or guideline was relied on in making the adverse determination and that a copy of such rule or guideline will be provided free of charge on request; and
- 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 appeals

- The external appeals process is different for each medical benefit option provided under the Plan. For details on the external appeals process as it relates to the benefit option you are enrolled in, visit the Medical and Prescription drug sections.

Eligibility and enrollment claims

If you believe your application to enroll in or change any of the health and insurance plans subject to ERISA was incorrectly denied, you may file a claim with the Plans Administration Committee of Citigroup Inc. (the "Committee") to have your case reviewed. 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 below. Use the Citigroup 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. You can speak with a representative from 8 a.m. to 8 p.m. ET Monday through Friday, excluding holidays. For TDD and international assistance, please see the "For More Information" section. Follow the instructions on the form and return the form to the Committee:

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**

All Other Benefit Claims

In addition, if you file a claim for benefits under the Citigroup Disability, Life Insurance, Business Travel Accident/Medical, GUL, Supplemental AD&D, or the Long-Term Care Insurance Plans, your claim generally will be administered in accordance with the timetable outlined below. For additional details on the specific claims and appeals procedures, contact the applicable Claims Administrator.

Notice of adverse benefit determinations

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

- 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), if applicable.

Appeals

You have a right to appeal a denied claim for benefits by filing a written request for review of your claim with the Claims Administrator within 180 days after receipt of the notice informing you that your claim has been denied. In the case of a disability claim, you have 180 days following receipt of the notification in which to appeal the decision.

The Claims Administrator will conduct a full and fair review of your claim and appeal. You or your representative may review Plan documents and submit written comments with your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The Claims Administrator's review will take into account all comments, documents, and other claim-related information that you submit regardless of whether that information was submitted or considered in the initial benefit determination.

The Claims Administrator will reach a determination regarding your appeal 60 days after its receipt (120 days if the Claims Administrator determines that special circumstances require an extension and, before the expiration of the initial 60 days you are notified in writing of the circumstances warranting the extension and the anticipated determination date).

In the case of a claim for disability benefits, the Claims Administrator will reach a determination regarding your appeal 45 days after its receipt (90 days if the Claims Administrator determines that special circumstances require an extension and, before the expiration of the initial 45 days, you are notified in writing of the circumstances warranting the extension and the anticipated determination date).

Notice of benefit determination on appeal

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

- 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, if applicable, 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 Plan(s). Notwithstanding any provision of the Plan(s) 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(s), that period will apply to suits against the insurer.

Future of the Plans and Plan amendments

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

Citigroup Inc. (or its affiliate, if appropriate) has the right to amend, modify, suspend, or terminate any Plan, policy, or program in whole or in part, at any time, for any reason. Plan amendments shall be adopted and executed by the Senior Human Resources Officer of Citigroup Inc., a Committee of the Board of Directors of Citigroup Inc., or any officer of Citigroup Inc. authorized to adopt plan amendments or sign other documents on behalf of Citigroup Inc., and may include amendments to insurance contracts or administrative agreements.

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

Plan administration

The Plan Administrator, the Plans Administration Committee of Citigroup Inc., is responsible for the general administration of the Plans and has the full discretionary authority and power to control and manage all the administrative aspects of the Plans, except to the extent such authority has been delegated to the Claims Administrator.

In accordance with such delegation, the Plan Administrator and the Claims Administrator have the full discretionary authority to construe and interpret the provisions of the Plans and make factual determinations regarding all aspects of the Plans and their benefits including the power and discretion to determine the rights or eligibility of employees and any other persons and the amounts of their benefits under the Plans and to remedy ambiguities, inconsistencies, or omissions. Such determinations shall be binding on all parties.

The Plan Administrator has designated other organizations or persons to fulfill specific fiduciary responsibilities in administering the Plans including, but not limited to, any or all of the following responsibilities:

- To administer and manage the Plans, including the processing and payment of claims under the Plans and the related recordkeeping, according to the terms of an administrative services or claims administration agreement;
- To prepare, report, file, and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency or to prepare and disclose to employees or other persons entitled to benefits under the Plans; and
- To act as Claims Administrator and to review claims and claim denials under the Plans to the extent an insurer or administrator is not empowered with such responsibility.

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

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.

Compliance with law

The Plans shall be construed and administered in compliance with federal and state law mandates governing the Plans, including ERISA, COBRA, USERRA (Uniformed Services Employment and Re-employment Rights Act), HIPAA, the Code, the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act of 1996, as amended, the Women's Health and Cancer Rights Act of 1998, and the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Compliance with Section 125 of the Internal Revenue Code

This Handbook describing the Citigroup Health Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan and the applicable spending accounts under the Citigroup Spending Account Plan and documents governing participant elections generally are, when read together, intended to comply with the requirements of Section 125 of the Internal Revenue Code of 1986, as amended, and constitute a cafeteria plan. Eligible participants are authorized to make contributions to their HSAs under the cafeteria plan, pursuant to IRS guidance. All such documents are incorporated by reference to constitute a single plan, in accordance with applicable Treasury regulations.

As stated previously in this document, all participants are entitled to make their benefit elections under the foregoing Plans through salary reduction arrangements so that the participant's premium payments or health care spending account contributions can be made on a before tax basis.

This Handbook describes the benefits available, authorizes employees to enter into salary reduction arrangements to pay their portion of the health care premiums on a before tax basis and authorizes employees to contribute amounts under the Health Care Spending Account, Limited Purpose Health Care Spending Account, the Dependent Day Care Spending Account, and the Health Savings Accounts on a before tax basis with respect to subsequent expenses that will be incurred and later reimbursed.

Changes in such elections (except for the HSA) are available only in limited circumstances described in the Eligibility and Participation section. The change in coverage must be consistent with the change in status. For example, if a dependent is added, the coverage should increase (not decrease). In addition to the foregoing, the Plans permit election changes based on the special enrollment rights under HIPAA.

Pursuant to the Code and related guidance, eligibility requirements and contribution limits for the HSAs are determined on a monthly basis. As such, although HSA contributions can be made under a Section 125 cafeteria plan, HSA contributions are not subject to the change in status rule and participants are permitted to change their elections at any time. The HSA changes are effective as soon as administratively practicable.

Plan information

Item	Details
Plan sponsor	Citigroup Inc. 750 Washington Boulevard, 9th Floor Stamford, CT 06901
Employer Identification Number	52-1568099
Participating Employers	Citigroup Inc. and any of its U.S. subsidiaries in which at least an 80% interest is owned.
Plan Administrator	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** **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. Call **1-888-809-8455**. Press 1 when prompted. From the ConnectOne main menu, choose the "health and welfare benefits" option. For TDD users: Call the Telecommunications Relay Service at 711. Then call ConnectOne as instructed above.
Type of Administration	The Plans are administered by the Plans Administration Committee of Citigroup Inc. through agreements entered into with the Claim Administrators. However, final decision on the payment of claims rest with the Claim Administrators.
Agent for Service of Legal Process	General Counsel Citigroup Inc. 399 Park Avenue, 2nd Floor New York, NY 10043
Plan Year (for all Plans)	January 1 — December 31
Plan Names and Numbers	
Medical Plans (self-funded ChoicePlan 500, High Deductible Health Plan, and Oxford PPO) including prescription drugs; Health Savings Accounts (HSAs), and medical clinics	Citigroup Health Benefit Plan Plan number 508
Dental Plans (fully-insured MetLife PDP and Cigna DHMO)	Citigroup Dental Benefit Plan Plan number 505
Vision Plan (fully-insured Aetna Vision)	Citigroup Vision Benefit Plan Plan number 533
Health Care Spending Account/Limited Purpose Health Care Spending Account	Citigroup Flexible Benefits Plan Plan number 512

Item	Details
Employee Assistance Program	Citigroup Employee Assistance Program Plan number 521
Dependent Day Care Spending Account (DCSA)	Not applicable (DCSA is not subject to ERISA)
Transportation Reimbursement Incentive Program (TRIP)	Not applicable (TRIP is not subject to ERISA)
Basic Life, Basic AD&D, GUL, and Supplemental AD&D insurance	Citigroup Life Insurance Benefits Plan Plan number 506
Business Travel Accident/Medical insurance	Citigroup Business Travel Accident/Medical Plan Plan number 510
Long-Term Care insurance	Citigroup Long-Term Care Insurance Plan Plan number 535
Short-Term Disability and Long-Term Disability	Citigroup Disability Plan Plan number 530
For fully insured HMOs	Call the Citi Benefits Center at 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. Plan number 508
Funding	
> Medical Plan > Dental Plan	The Medical Plan and Dental Plan are funded through insurance contracts, the general assets of Citigroup, or a trust qualified under Section 501(c)(9) of the Code on behalf of the Plans. The cost of medical and dental coverage is shared by Citigroup and the participant. The following Plans are self-insured, and thus are not subject to state laws: > ChoicePlan 500 (administrated by Aetna and Anthem BlueCross BlueShield) > High Deductible Health Plan (administrated by Aetna and Anthem BlueCross BlueShield) > Oxford PPO The following Plans are fully-insured and are subject to state laws: > Health maintenance organizations (HMOs) > MetLife Preferred Dentist Program (MetLife PDP) > Cigna Dental HMO (dental health maintenance organization)
> Vision Plan > Employee Assistance Program > Health Care Spending Account (HCSA) > Limited Purpose Health Care Spending Account (LPSA)	The cost of the Vision Plan and medical spending accounts is provided by employee contributions. Citigroup pays for the Employee Assistance Program. The Vision Plan is funded through an insurance contract. The medical spending accounts and the Employee Assistance Program are funded from the general assets of Citigroup.
> Basic Life insurance > GUL insurance > Basic and Supplemental AD&D insurance > Business Travel Accident/Medical insurance	Basic Life, Basic AD&D, GUL, Supplemental AD&D, and Business Travel Accident/Medical insurance are fully-insured. Benefits are provided under insurance contracts between Citigroup and the Claims Administrator. The Claims Administrator, not Citigroup, is responsible for paying claims. Basic Life, Basic AD&D, and Business Travel Accident coverage is provided through employer contributions; GUL and Supplemental AD&D is provided through employee contributions.

Item	Details
> Disability Plan	STD benefits are paid from the general assets of the Company. STD coverage is provided by Citigroup; 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. 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 Plan, namely, those provisions of the Plan Documents that apply to the participant and are administered by that particular Claims Administrator. Since TRIP, DCSAs and HSAs are not subject to ERISA, neither the Claims Administrator listed below nor the Plans Administration Committee is a fiduciary under ERISA for these arrangements.

Plan	Administrator contact information
Medical Plan And Prescription Drug Coverage	
ChoicePlan 500	Aetna Citigroup Claims Division P.O. Box 981106 El Paso, TX 79998-1106 **1-800-545-5862** Anthem BlueCross BlueShield P.O. Box 105187 Atlanta, GA 30348-5187 **1-855-593-8123** **Note:** Anthem does not underwrite or assume any financial risk for claims liability.
High Deductible Health Plan	Aetna Citigroup Claims Division P.O. Box 981106 El Paso, TX 79998-1106 **1-800-545-5862** Anthem BlueCross BlueShield P.O. Box 105187 Atlanta, GA 30348-5187 **1-855-593-8123**

Plan	Administrator contact information
Health Savings Account (HSA)	ConnectYourCare **1-888-846-6414** **www.connectyourcare.com**
Oxford Health Plans PPO	Oxford Health Plans, LLC P.O. Box 29139 Hot Springs, AR 71903 **1-800-396-1909** Appeals and Grievances Oxford Health Plans Issue Resolution Department P.O. Box 29135 Hot Springs, AR 71903 Oxford Grievance Review Board P.O. Box 29134 Hot Springs, AR 71903 Oxford Health Plans Clinical Appeals Department P.O. Box 29139 Hot Springs, AR 71903
For fully insured HMOs	Call the HMO directly at the telephone number on your ID card.
Prescription Drug Program	
Paper claims address	Express Scripts, Inc. P.O. Box 66583 St. Louis, MO 63166 **1-800-227-8338**
Home delivery service	Express Scripts Pharmacy P.O. Box 66566 St. Louis, MO 63166-6566 **1-800-227-8338**
Dental Plan	
MetLife Preferred Dentist Program (PDP)	Metropolitan Life Insurance Co. MetLife Dental Claims Unit P.O. Box 981282 El Paso TX 79998-1282 **1-888-830-7380** To submit an appeal: MetLife Group Claims Review P.O. Box 14589 Lexington, KY 40512-4093

Plan	Administrator contact information
Cigna Dental HMO	Cigna Dental HMO / Member Services 1571 Sawgrass Corporate Parkway Suite 140 Sunrise, FL 33323 **1-800-244-6224**
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**
Spending Accounts	
> Health Care Spending Account > Limited Purpose Health Care Spending Account > Dependent Day Care Spending Account > Transportation Reimbursement Incentive Program	Your Spending Account™ (YSA™/Plans Administration Committee of Citigroup Inc. [HCSA/LPSA]) P.O. Box 785040 Orlando, FL, 32828-5040 Call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “health and welfare benefits” option and then the option for spending accounts, including transit and parking. For TDD and international assistance, please see the “For More Information” section.
Other Insurance	
Basic Life	Metropolitan Life Insurance Co. 200 Park Ave. New York, NY 10166 **1-800-638-6420**
Basic and Supplemental Accidental Death and Dismemberment (AD&D)	Metropolitan Life Insurance Co. 200 Park Ave. New York, NY 10166 **1-800-638-6420**
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**
Group Universal Life	Metropolitan Life Insurance Co. 200 Park Ave. New York, NY 10166 **1-800-638-6420**

Plan	Administrator contact information
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**
Short-Term Disability *Long-Term Disability*	Metropolitan Life Insurance Co. P.O. Box 14590 Lexington, KY 40511-4590 **1-888-830-7380**

Glossary

Definitions of certain terms used in the Citigroup Health and Insurance Benefits 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 80% of certain covered expenses, coinsurance for these expenses is 20%.

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

Custodial care: Services and supplies furnished to a person mainly to help him or her in the activities of daily life (such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods). These services include room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard:

- To whom they are prescribed;
- To whom they are recommended; or
- To who performs them.

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

Goal amount: The total annual amount a participant elects to contribute on a before-tax basis to a Health Care Spending Account, Limited Purpose Health Care Spending Account, or Dependent Day Care Spending Account. The annual contribution elected will be divided by the number of pay periods in the plan year and deducted from the employee's pay. For elections made during the plan year, the annual contribution amount will be divided by the number of remaining pay periods in the plan year and deducted from the employees pay.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A U.S. law designed to, among other things, ensure the portability of health insurance coverage and the ability to add family members to health coverage, as well as protect the privacy and security of health information.

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;
- Not be primarily scholastic, vocational, educational, developmental, experimental or investigational in nature; and
- 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.

Network provider: A health care provider on a list of providers contracted with the claims administrator. Coinsurance or copayments are discounted when plan members utilize network providers and facilities.

Non-occupational disease: A disease that does not:

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

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

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

Non-occupational injury: An accidental bodily injury that does not:

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

Notification: A requirement that a participant calls his or her health plan 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 (includes copays, deductibles and coinsurance) toward eligible expenses that a covered person pays for himself or herself and/or dependents as defined by the applicable Plans.

Once the maximum out-of-pocket amount has been met, the Plan will pay 100% of maximum allowed amount (MAA) charges. For out-of-network services, when expenses incurred are higher than the MAA, the individual receiving the service is responsible for paying the difference between the provider's charge and the allowed amount, even if the out-of-pocket maximum has been reached.

Precertification/Prior Authorization: A requirement that a participant calls his or her health plan option to coordinate any inpatient surgery, hospitalization and certain outpatient diagnostic/surgical procedures. Precertification determines medical necessity and 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.

Obtaining a precertification means that the administrator has confirmed medical necessity of the service, but it does not guarantee coverage. Plan participants should contact member services to determine coverage.

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. Note: Citi plans are not subject to pre-existing conditions.

Preventive care: Routine care exams based on:

- Guidelines from the American Medical Association and the United States Preventive Care Task Force;
- Guidelines from the Advisory Committee on Immunization Practices that have been adopted by the director of the Centers for Disease Control and Prevention,
- The Comprehensive Guidelines Supported by the Health Resources and Services Administration, and
- Physician recommendations.
- Covered expenses include routine physical exams (including well-woman and well-child exams), routine cancer screenings, and immunizations. See "Preventive care" in the Medical section of the Citigroup Health and Insurance Benefits Handbook.

Provider: 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, institution, facility, primary care center, patient-centered medical home, clinic, ambulatory surgical center, outpatient center, urgent care center, or pharmacy.

Recognized charge: See "Maximum allowed amount (MAA)."

Wellness services: See "Preventive care."

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 center, with a staff of doctors, that:

- Is licensed as required;
- Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
- Gives treatment by or under the supervision of doctors, and nursing services when the patient is in the center;
- Does not have Inpatient accommodations; and
- Is not, other than incidentally, used as an office or clinic for the private practice of a doctor or other professional provider.

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 exams, 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, with each record containing prenatal history, a 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.

Chiropractic care: Skeletal adjustments, manipulations, or other treatments 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 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: Aetna, Anthem BlueCross BlueShield, Oxford PPO Health Plans, Express Scripts 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 to provide for the carrying out of such policies by a full- or part-time physician;
  - It has a requirement that every patient be under the care of a physician; and
  - It is established and operates in accordance with the applicable licensing and other laws.

Controlled Substance Classes: Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) are divided into five classes. An updated and complete list of the classes is published annually in Title 21 Code of Federal Regulations (C.F.R.) §§ 1308.11 through 1308.15. Substances are placed in their respective classes based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused. Some examples of the drugs in each class are listed below.

- **Class I Controlled Substances:** Substances in this class have no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse. Some examples of substances listed in Class I are: heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), peyote, methaqualone, and 3,4-methylenedioxymethamphetamine (“Ecstasy”).
- **Class II Controlled Substances:** Substances in this class have a high potential for abuse which may lead to severe psychological or physical dependence. Examples of Class II narcotics include: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®, Percocet®), and fentanyl (Sublimaze®, Duragesic®) and hydrocodone containing products (Zohydro ER®, Vicodin®). Other Class II narcotics include: morphine, opium, and codeine.

- Examples of Class II stimulants include: amphetamine (Dexedrine®, Adderall®), methamphetamine (Desoxyn®), and methylphenidate (Ritalin®).
- Other Class II substances include: amobarbital, glutethimide, and pentobarbital.
- **Class III Controlled Substances:** Substances in this class have a potential for abuse less than substances in Class I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.
- Examples of Class III narcotics include: products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with Codeine®), and buprenorphine (Suboxone®).
- Examples of Class III non-narcotics include: benzphetamine (Didrex®), phendimetrazine, ketamine, and anabolic steroids such as Depo®-Testosterone.
- **Class IV Controlled Substances:** Substances in this class have a low potential for abuse relative to substances in Class III. Examples of Class IV substances include: alprazolam (Xanax®), carisoprodol (Soma®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®).
- **Class V Controlled Substances:** Substances in this class have a low potential for abuse relative to substances listed in Class IV and consist primarily of preparations containing limited quantities of certain narcotics.
- Examples of Class V substances include: cough preparations containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams (Robitussin AC®, Phenergan with Codeine®), and ezogabine.

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; the employee's qualified legal spouse (same or opposite sex), domestic partner, or civil partner; and/or dependent children who are covered under the Plan.

DEA Number: A DEA number is a number assigned to a health care provider (such as a medical practitioner, dentist, or veterinarian) by the U.S. Drug Enforcement Administration allowing them to write prescriptions for controlled substances. Legally, the DEA number is solely to be used for tracking controlled substances. It is often used by the industry, however, as a general "prescriber number" that is a unique identifier for anyone who can prescribe medication.

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 room care: The definition varies depending on your applicable Claims Administrator as follows.

Aetna:

- The treatment given in a hospital's emergency room to evaluate and treat an emergency medical condition. An emergency medical condition is a recent and severe medical condition, including, but not limited to, severe pain that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:
  - Placing your health in serious jeopardy;
  - Serious impairment to bodily function;

- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Anthem BlueCross BlueShield:

- The treatment of a medical or behavioral condition of sudden onset that manifests itself by symptoms of sufficient severity (including severe pain) that a prudent layperson 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.

Oxford:

- Medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain. The symptoms must be severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:
  - The patient's health would be placed in serious jeopardy;
  - Bodily function would be seriously impaired; and
  - There would be serious dysfunction of a bodily organ or part.
  - Emergency care includes immediate mental health and chemical dependency treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons

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 Pharmacopeia 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 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 drugs: Equivalent medications that contain 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 an 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 all 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 an 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 to 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 diagnoses 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.

Infertile or infertility: The condition of a presumably healthy covered person who is unable to conceive or produce conception. The Citi plans cover infertility treatments with a lifetime maximum.

Injury: Accidental physical harm 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 lifesaving 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 are 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. For *Aetna, Oxford* and *Anthem Plans*, the BMI is greater than 40 kilograms per meter squared or equal to or greater than 35 kilograms per meter squared, respectively, with a co-morbid medical condition, including but not limited to hypertension; a cardiopulmonary condition; sleep apnea; or diabetes. Please contact your Plan Administrator for additional information.

Network pharmacy: A registered and licensed pharmacy, including a mail-order pharmacy that participates in the network.

Network provider: A provider that participates in the health plan network in which you enrolled.

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:

- Is licensed by a board of nursing as an 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:

- Is licensed by a board of nursing as an 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, a 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).

Care provided by Christian Science practitioners is covered as an out-of-network benefit under the ChoicePlan 500, but is not covered by Oxford.

Plan: The benefits (the "Citigroup Health and Insurance Plans"; or collectively, the "Plans"; and individually, a "Plan") described in this Benefits Handbook are:

- Citigroup Health Benefit Plan
  - Aetna ChoicePlan 500;
  - Aetna High Deductible Health Plan;
  - Anthem BlueCross BlueShield ChoicePlan 500;
  - Anthem BlueCross BlueShield High Deductible Health Plan;
  - Oxford Health Plans PPO (a UnitedHealthcare company);
  - Fully insured health maintenance organizations (HMOs);
  - Citigroup Prescription Drug Program administered by Express Scripts; and
  - On-site medical clinics;
- Citigroup Dental Benefit Plan:
  - Cigna Dental HMO; and
  - MetLife Preferred Dentist Program (PDP);
- Citigroup Vision Benefit Plan;
- Citigroup wellness benefits;
- Citigroup Employee Assistance Program;
- Citigroup Work/Life Program;
- Citigroup Disability Plan;
- Health Savings Account (HSA);
- Spending accounts;
  - Health Care Spending Account (HCSA);
  - Limited Purpose Health Care Spending Account (LPSA);
  - Dependent Day Care Spending Account (DCSA); and
  - Transportation Reimbursement Incentive Program (TRIP)
- Life insurance
  - Basic Life insurance;
  - Accidental Death and Dismemberment (AD&D) insurance;

  - Group Universal Life (GUL); and
  - Supplemental AD&D insurance;
- Citigroup Business Travel Accident/Medical Insurance; and
- Citigroup Long-Term Care Insurance Plan (if elected coverage prior to January 1, 2012).

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 their 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 physician's prescription. The following will be considered prescription drugs:

- Federal legend drugs, which are any medicinal substances 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:

- Is licensed or certified as a psychologist or
- Is 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: Housing and meals, 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. Does not include 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: Such a facility, if approved by Medicare, is covered by the Citigroup Health 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 devoted 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, 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; and
- 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 hospitals are covered as hospitals and not as treatment centers.

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: The definition varies depending on your Claims Administrator:

- **Aetna:** A hospital to which you are admitted by a physician due to:
  - The onset of or change in an illness;
  - The diagnosis of an illness; or
  - An injury.
  - **Note:** The condition, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within two weeks from the date the need for the confinement becomes apparent.
- **Anthem BlueCross BlueShield:** 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.
- **Oxford:** A medical care facility that provides care for a condition that needs immediate attention to minimize the severity and prevent complications but is not a medical emergency. Urgent care facilities are covered in or out of the service area. Precertification is not required for Plan urgent care treatment when provided by facilities that are specifically contracted by Oxford as urgent care providers. Members should contact the number on their ID cards for instructions.

Utilization review: A review and determination as to the medical necessity of services and supplies.

For more information

By Phone

Call the Citi Benefits Center via ConnectOne: **1-800-881-3938**. When prompted, enter your user ID and PIN. If you don't have a ConnectOne PIN, follow the prompts to designate a PIN. Once you designate a PIN, you can use ConnectOne immediately,

- From outside the United States, Puerto Rico, Canada and Guam: Call HR Shared Services (HRSS) at **1-888-809-8455**.
- If you are hearing impaired and use a TDD in the United States: Call the Telecommunications Relay Service at 711. Then call ConnectOne as instructed above.
- If you are hearing impaired and use a TDD in Puerto Rico: Call **1-866-280-2050** and then call ConnectOne as instructed above.

Online

Access Your Benefits Resources™ (YBR™) through the TotalComp@Citi website at **www.totalcomponline.com**, available from the Citi intranet and the Internet. From the main page, click on "Want to get somewhere fast" and then select the "Health and Insurance" option that appears under Your Benefits Resources. You will then be linked to the Your Benefits Resources home page.

Keep in mind that if you are an active employee and visit the TotalComp@Citi website from outside the Citi network, you'll need to use Multi-Factor Authentication (MFA) to view your benefits information. You'll be prompted to enter a one-time password that you'll receive by text message, automated voice call or by using a Remote Access SafeWord/Mobile Pass card.

This process ensures that your personal data as an employee has the same level of security that applies to our banking customers. For more information on MFA, please visit the TotalComp@Citi website and click the MFA link on the login page.

If you are no longer employed by Citi, you will need to visit the TotalComp@Citi website and access the appropriate link. You will be asked to provide the last 4 digits of your social security number as well as your date of birth and zip code. As a first time user, you will be prompted to create a user ID and password before setting up several security questions. Once completed, the computer will be registered and further attempts to log in will just require the user id and password you have created.

For information about these topics, plans, or programs	Contact	Telephone number/website
Beneficiary designations for:		
> Basic Life insurance, Basic AD&D insurance, Citigroup 401(k) Plan, Citibuilder 401(k) Plan for Puerto Rico, and Citigroup Pension Plan	Citi Benefits Center	Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "pension, retiree health and welfare, and survivor benefits" option. Visit YBR™ through TotalComp@Citi at **www.totalcomponline.com**.
> Group Universal Life (GUL) and Supplemental AD&D insurance	MetLife	Call MetLife at **1-888-830-7380**. Visit the MetLife MyBenefits website through TotalComp@Citi at **www.totalcomponline.com**.

For information about these topics, plans, or programs	Contact	Telephone number/website
Benefits (health and insurance)	Citi Benefits Center	Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. Visit YBR™ through TotalComp@Citi at **www.totalcomponline.com**.
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. Visit YBR™ through TotalComp@Citi at **www.totalcomponline.com**.
Dental Plans	Cigna Dental HMO	**1-800-244-6224** **www.myCigna.com** (participants only) **1-800-244-6224** (pre-enrollment information)
	MetLife Preferred Dentist Program (PDP)	**1-888-830-7380** Visit the MetLife MyBenefits website through TotalComp@Citi at **www.totalcomponline.com**.
Dependent Day Care Spending Account (DCSA)	Citi Benefits Center	Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu choose the "health and welfare benefits" option. Visit YBR™ through TotalComp@Citi at **www.totalcomponline.com**. On YBR™, click "Your Spending Account" under "Other Benefits."
Disability To report a disability or apply for a Family Medical Leave	MetLife	Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu choose the "disability" option, or; Contact MetLife directly at **1-888-830-7380**. Visit the MetLife MyBenefits website through TotalComp@Citi at **www.totalcomponline.com**.
Employee Assistance Program (EAP)	Harris, Rothenberg International (HRI), owned by Humana	**1-800-952-1245** **711 (TDD) then, 800-952-1245** Outside the United States, call collect to **212-422-8847**. **www.harrisrothenberg.net** User ID: resources Password: for_you
General information Eligibility, enrollment, general information about health and welfare benefits, qualified changes in status, and continuing coverage after a termination of employment or while on a leave of absence	Citi Benefits Center	Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. Visit YBR™ through TotalComp@Citi at **www.totalcomponline.com**.

For information about these topics, plans, or programs	Contact	Telephone number/website
Group Universal Life (GUL)	MetLife	**1-888-830-7380** Visit the MetLife MyBenefits website through TotalComp@Citi at **www.totalcomponline.com**.
Health and insurance coverage verification for: > Child support > Medicaid or other premium assistance > Medicare > Social Security Administration > Etc.	Citi Benefits Center	Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.
Health Care Spending Account (HCSA)	Citi Benefits Center	Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu choose the "health and welfare benefits" option. Visit YBR™ through TotalComp@Citi at **www.totalcomponline.com**. On YBR™, click "Your Spending Account" under "Other Benefits."
Health Savings Account (HSA)	ConnectYourCare	**1-888-846-6414** **www.connectyourcare.com**
Insurance > Basic Life > Basic Accidental Death and Dismemberment (AD&D) > Business Travel Accident/Medical	Citi Benefits Center	Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. Visit YBR™ through TotalComp@Citi at **www.totalcomponline.com**.
Limited Purpose Health Care Spending Account (LPSA)	Citi Benefits Center	Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. Visit YBR™ through TotalComp@Citi at **www.totalcomponline.com**. On YBR™, click "Your Spending Account" under "Other Benefits."
Live Well at Citi Program	Health Advocate, RedBrick Health and medical carriers	**1-866-449-9933** Visit www.citibenefitsonline.com then Live Well at Citi **1-855-814-5595 (RedBrick)** Visit TotalComp@Citi at www.totalcomponline.com, then click "want to get somewhere fast" then Live Well at Citi-RedBrick.
Long-Term Care (LTC) insurance	John Hancock Life Insurance Company (U.S.A.)	**1-800-222-6814**
Medical (HMOs)	Various sources	Refer to the list at **https://www.handbook.citibenefitsonline.com/cit-1d1-health-medical-eds-web-ai.html.**

For information about these topics, plans, or programs	Contact	Telephone number/website
Medical (non-HMO plans)	Aetna (ChoicePlan 500, High Deductible Health Plan)	**1-800-545-5862** **1-800-628-3323** (TDD) **www.aetna.com**
	Anthem BlueCross BlueShield (ChoicePlan 500, High Deductible Health Plan)	**1-855-593-8123** **www.anthem.com**
	Oxford Health Plan (PPO plans in CT, NJ, and NY tri-state area only)	**1-800-396-1909** **https://www.oxhp.com/Member/MemberPortal/**
Prescription drug program (ChoicePlan 500, High Deductible Health Plan, and Oxford PPO) To refill an Express Scripts Home Delivery prescription using the automated system, for instructions on how your physician can fax your prescription to the Express Scripts Pharmacy, and to arrange credit card payment for all your Express Scripts Home Delivery pharmacy service orders	Express Scripts	**1-800-227-8338** **1-800-899-2114** (TDD) **https://member.express-scripts.com/preview/citigroup2014** (public site for Citi employees or prospective members) **www.express-scripts.com** (participants only)
For prior authorization		**1-800-224-5498**
Supplemental AD&D insurance	MetLife	**1-888-830-7380** Visit the MetLife MyBenefits website through TotalComp@Citi at **www.totalcomponline.com**
Transportation Reimbursement Incentive Program (TRIP)	Citi Benefits Center	Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. Visit YBR™ through TotalComp@Citi at **www.totalcomponline.com**. On YBR™, click "Transportation Reimbursement Incentive Program (TRIP)" under "Health and Insurance."
Vision Plan For Plan information and laser vision correction providers/arrangements	Aetna	**1-877-787-5354** Non-Members: **www.AetnaVisionOE.com/avp1** Members: **www.aetnavision.com**
Workers' Compensation	Constitution State Services Co.	**1-800-243-2490**
Work/Life Program	Health Advocate	**1-866-449-9933,** select option #2 **www.healthadvocate.com/citiworklife** (no password required)

CITI ON-SITE MEDICAL CLINICS	
Jacksonville, FL	
14000 Citicards Way	**904-954-8262**
Medical emergency number	**904-954-8911**
Tampa, FL	
Citibank Center, Bldg. C	**813-604-4333**
Medical emergency number	**611**
Jersey City, NJ	
480 Washington Blvd., 8th Floor	**201-763-1111**
Medical emergency number	**201-763-0263**
Warren, NJ	
283 King George Road, Bldg. C	**908-563-5400**
Medical emergency number	**908-563-5412**
New York City	
399 Park Ave., Level A/Zone 11, New York City	**212-559-3981**
Medical emergency number	**212-559-4357 (5-HELP)**
111 Wall St., 23rd Floor, Zone 12, New York City	**212-657-7478**
Medical emergency number	**212-657-4357 (6-HELP)**
388 Greenwich St., 5th Floor, New York City	**212-816-1460**
Medical emergency number	**212-816-1300**
One Court Square, 9th Floor, Zone 7, Long Island City	**718-248-2709**
Medical emergency number	**718-248-4357 (4-HELP)**
San Antonio, TX	
100 Citibank Drive, Bldg. 3	**210-357-8275**

CITI HEALTH AND FITNESS CENTERS	
Florida	
14000 Citicards Way, Bldg. A, Jacksonville	**904-954-2630**
3800 Citibank Center, Tampa	**813-604-4348**
Warren, NJ	
283 King George Road	**908-563-9533**
New York City	
388 Greenwich St., 5th Floor, New York City	**212-816-0523**
One Court Square, 5th Floor, Long Island City	**718-248-9571**
Getzville, NY	
580 CrossPoint Pkwy.	**716-730-7926**
Texas	
100 Citibank Drive, San Antonio	**210-677-6991**
6400 Las Colinas Blvd, Irving	**972-653-8890**
Blue Ash, OH	
9997 Carver Road	**574-993-1032**
Meridian, ID	
2200 South Cobalt Way	**208-822-2331**
Elk Grove Village, IL	
50 Northwest Point Blvd	**224-222-2509**
Florence, KY	
4600 Houston Road	**859-283-3882**
Hagerstown, MD	
14700 Citicorp Drive	**301-714-5738**
Sioux Falls, SD	
701 East 60th St. N	**605-331-1922**