Health and Insurance Benefits Handbook

For coverage effective January 1, 2025

Benefits Handbook

Health and Insurance Benefits Handbook

The health and insurance benefits plans information in this Benefits Handbook is broken up into sections, including:

- About this Benefits Handbook;
- Eligibility and Participation;
- Health Care Benefits;
- Supplemental Medical Plans;
- Spending Accounts (including the Transportation Reimbursement Incentive Program [TRIP]);
- Disability Coverage;
- Life & Accident Insurance Benefits;
- MetLife Legal Plan;
- Administrative Information;
- Glossary; and
- For More Information.

The Benefits Handbook contains the official documents for your Citi health and insurance benefits plans. It describes these benefits available effective January 1,2025.

For More Information

Administrative details and procedures for Citi's health and insurance benefit plans can be found in the *Administrative Information* section. (Administrative information about the Citi Retirement Savings Plan is included within the *Citi Retirement Savings Plan SPD*.)

If you have questions about the information in this Benefits Handbook, you can contact the Citi Benefits Center via ConnectOne at 1 (800) 881-3938

Health Advocate

The Live Well at Citi Program offers you free health care support from Health Advocate. Health Advocate is not affiliated with insurance carriers or health care providers and does not share your information with Citi. You and your entire family can use Health Advocate, regardless of whether you are enrolled in a Citi health plan. 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.

Expatriates

If you are on an Expatriate assignment and eligible for the Citi Expatriate Benefits Plan, see the Expatriate Health and Insurance Benefits Enrollment Handbook for information about coverage effective January 1, 2025.

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About this Benefits Handbook

This 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"), effective January 1, 2025. An SPD is a legally required document that provides a comprehensive description of benefits plans and their provisions. Citi reserves the right to change or discontinue, at any time, any or all of the benefits coverage or programs described here. 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 In-Network Only Plan;
  - Aetna Choice Plan;
  - Aetna High Deductible Plan with HSA;
  - Anthem BlueCross BlueShield In-Network Only Plan;
  - Anthem BlueCross BlueShield Choice Plan;
  - Anthem BlueCross BlueShield High Deductible Plan with HSA;
  - Fully insured health maintenance organizations (HMOs);
  - Citigroup Prescription Drug Program administered by CVS Caremark;
- Citigroup Supplemental Medical Plans;
  - Accident Plan;
  - Critical Illness Plan; and
  - Hospital Indemnity Plan;
- Citigroup Dental Benefit Plan:
  - Cigna Dental HMO; and
  - MetLife Preferred Dentist Program (PDP);
- Citigroup Vision Benefit Plan;
- Citigroup Wellness Benefits;
- Citigroup Be Well Program;
- Citigroup Disability Plan;
- Citigroup Spending Accounts Plan:
  - Health Care Spending Account (HCSA);
  - Limited Purpose Health Care Spending Account (LPSA);
  - Dependent Day Care Spending Account (DCSA); and
  - Transportation Reimbursement Incentive Program (TRIP);
- Citigroup Life Insurance Benefits Plan:
  - Basic Life insurance;
  - Basic Accidental Death and Dismemberment (AD&D) insurance;
  - Group Universal Life (GUL) insurance; and
  - Supplemental AD&D insurance;
- Citigroup Business Travel Accident/Medical Insurance Plan; and
- Citigroup Legal Benefits Plan (MetLife Legal Plans).

Medicare Eligible?

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

This Benefits Handbook is intended to comply with the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA), and other applicable laws and regulations. In addition, this Benefits Handbook is designed to comply with the requirements of a cafeteria plan under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code").

This Benefits Handbook has been written, to the extent possible, in nontechnical language to help you understand the basic terms and conditions of the health and insurance benefits plans described.

The Plans are subject to the provisions of ERISA, except for DCSA and TRIP (under the Citigroup Spending Accounts Plan) and the health savings accounts ("HSAs") (under the High Deductible Plan with HSA option of the Citigroup Health Benefit Plan). This Benefits Handbook serves as the Plan document and Summary Plan Description (SPD) for the Plans subject to ERISA and the Code, as applicable. The terms and conditions of these Plans may be further described in insurance policies, the provisions of which, as may be amended from time to time, are hereby incorporated by reference.

Notwithstanding any other provision in this SPD, Citigroup intends to operate the Plan in compliance with the transparency, surprise billing and other applicable requirements in the relevant provisions of the Consolidated Appropriations Act, 2021 ("CAA") and the Transparency-In-Coverage Regulations as they become effective, based on a good faith, reasonable interpretation of the statute, existing regulations and other official guidance. As additional guidance becomes available and applicable, Citigroup will modify this SPD accordingly and/or provide a Summary of Material Modifications.

If you do not have access to the Citi intranet or the Internet, you can request a copy of the Benefits Handbook at no cost to you by speaking with a Citi Benefits Center representative. Call the Citi Benefits Center via ConnectOne at 1 (800) 881-3938. See the *For More Information* section for detailed instructions.

This Benefits Handbook provides no guarantee that you are eligible to participate in every benefit or program described. Each Plan may have its own eligibility requirements, so be sure to review individual eligibility requirements carefully. In addition, Citi in no way guarantees the payment of any benefit that may be due or becomes due to any person under the Plans.

Non-Assignment of Benefits

Plan participants cannot assign, sell, transfer, pledge, borrow against, or otherwise promise any benefit payable under the Plans described in this Benefits Handbook or the right to assert legal rights, including an administrative claim or lawsuit against any of the following: the Plans, the Plan Administrator, a Claims Administrator, or any Plan fiduciary, or the Company and any Participating Employers, or their officers, shareholders, or employees. For example, Plan participants may not assign their right to receive Plan benefits and legal rights relating to the Plans to any health care provider—such assignment is not permitted and is void. The Plan Administrator or Claims Administrator may make payment directly to the Plan participant or, at its discretion, directly to a doctor, hospital, or other provider of care. When payment is made directly to a doctor, hospital or other provider of health care, such direct payments are solely at the discretion of the Plan Administrator or Claims Administrator—such payments do not create any enforceable assignment of benefits or the right to assert any legal rights or to bring any administrative claim or lawsuit by any doctor, hospital, or other provider of care against the Plans (or the Plan Administrator, Claims Administrator, or any Plan fiduciary, or the Company and Participating Employers, or officers, shareholders or employees thereof).

The Plans will, when required by law or applicable guidance, recognize an assignment of benefits to a state Medicaid program.

Tax Information

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

For information on how applicable tax law may apply to your personal situation, consult your tax adviser.

No Right to Employment

Nothing in this document represents or is considered an employment contract, and neither the existence of the Plans nor any statements made by or on behalf of Citi shall be construed to create any promise or contractual right to employment or to the benefits of employment 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 Citigroup Inc. ("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 In-Network Only Plan, Choice Plan, High Deductible Plan with HSA and HMOs);
- Prescription Drug;
- Dental (including MetLife Preferred Dentist Program (PDP) and Cigna Dental HMO);
- Vision;
- Wellness Benefits;
- Supplemental Medical Plans (Accident Plan, Critical Illness Plan and Hospital Indemnity Plan);
- Spending Accounts;
- Be Well Program;
- Disability Coverage;
- Insurance Benefits (including Basic Life, Basic Accidental Death and Dismemberment (AD&D), Group Universal Life (GUL), and Supplemental AD&D)
- Business Travel Accident and Business Travel Medical
- MetLife Legal Plans.

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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;
- 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 Chubb USA, of up to five times your salary to a maximum benefit of $2 million while traveling on behalf of Citi; and medical coverage related to covered accidents and/or sickness while traveling outside your home or assigned country on behalf of Citi;
- Be Well Program, administered by TELUS Health (formerly Life Works); a 24/7, 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; including therapy services provided through text messaging.
  - Work/Life Program, part of the Be Well program administered by TELUS Health; helps employees save time as they face common everyday challenges; services include helping employees find child and elder care, providing up to 30 minutes of free legal assistance, helping with identity theft, and more.
- Live Well at Citi Program, administered by Health Advocate and Personify Health (formerly Virgin Pulse); Citi's comprehensive health and wellness program provides you and your family with tools and resources designed to assist you in managing your health care and achieving your health goals;

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 Plan with HSA ;
  - 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:
  - Supplemental Medical Plans: Accident Plan, Critical Illness Plan and Hospital Indemnity Plan;
  - Long Term Disability (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
  - MetLife Legal Plans.

Eligibility

Citi provides benefits coverage for you, your spouse/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 Citi 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 Plans 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.

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.

A “participating employer” is Citi 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.

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.

If Both You and Your Spouse/Partner Are Citi Employees

If both you and your spouse/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 Plans as an individual and be claimed as your spouse's/partner's dependent.

Plan	Applicable Rules
Medical, dental and vision	Each of you may be covered under the medical, dental and vision 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 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. If your partner's children are not your tax dependents, as noted above, your partner, as a Citi employee, can contribute to his/her own HCSA.
Limited Purpose Health Care Spending Account (LPSA)	If you or your spouse enroll in the Citi High Deductible Plan with HSA, either of you may contribute to an LPSA, but you may not file more than once for reimbursement of the same eligible expense. You may use the LPSA to be reimbursed only for dental, vision or preventive medical care expenses that are not already covered by the Plan. Neither of you can enroll in the HCSA. Your 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 partner's children are not your tax dependents, as noted above, your partner, as a Citi employee, can contribute to his/her own LPSA.
Health Savings Account (HSA)	The maximum amount that can be contributed to an HSA for the 2025 calendar year is $4,300 for individual and $8,550 for all other coverage levels. This does not mean that both family members can contribute $8,550 each; it is a combined contribution amount. Citi makes up to a $500 annual contribution for individual coverage and up to a $1,000 annual contribution for employees with family coverage (other than individual). Citi's contribution to your HSA counts toward your annual contribution maximum. Once HSA is established, if you are age 55 or older, you can make an additional catch-up contribution of up to $1,000. You are permitted to elect a contribution (up to the Code maximum) or change your election amount at any time during the plan year. If your partner's children are not your tax dependents, as noted above, your partner, as a Citi employee, can establish his/her own HSA if he or she has enrolled in a High Deductible Plan with HSA.
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. You and your spouse/partner cannot contribute more than $5,000 per year to a DCSA combined. Your 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 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/partners, as Citi employees, must 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 Medical Plans	Each of you may be covered under the Supplemental Medical 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.
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: All employees can earn the $100 Live Well Reward for the Health Assessment as long as they were hired (or transferred from a Citi international business) by October 1, 2024 and complete their Health Assessment within the required time frame annually. If your spouse/partner is also a Citi employee, he/she can earn the $100 Reward as well. If your spouse/partner is not a Citi employee, he/she can only earn the $100 Reward if he/she is enrolled in a Citi medical plan. If both you and your spouse/partner are Citi employees and you are not enrolled in a Citi medical plan, you both will earn your Live Well Rewards that can be redeemed for gift cards in the Home tab of your Personify Health (formerly Virgin Pulse) account at https://landing.personifyhealth.com/LiveWell/ or through the Personify Health (formerly Virgin Pulse) app. If both you and your spouse/partner are Citi employees who are enrolled in the Citi medical plan and both complete the Health Assessment, the $200 premium discount will be applied to the employee who has medical coverage for the couple, if applicable. If you both elect individual coverage, the premium discount of $100 will be applied to each individual's coverage. Tobacco Penalty: The tobacco penalty is applied per adult with Citi medical coverage per year, regardless of whether both adults work for Citi or not. See "Live Well Tobacco Cessation Program" under the *Wellness* section for details.
Be Well Program	You and your household members are covered under this program.
MetLife Legal Plans	If either of you enrolls, the spouse/partner and dependent children are also covered.

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 to 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. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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 Plans or receiving benefits for a specific condition or illness.

For Dependents

When you add a spouse/partner or new dependent to your coverage, you will be required to submit proof of eligibility for the coverage (for example, a marriage license, partnership registration, domestic partner registry certificate or birth certificate). Note that domestic partners and spouses are offered all the same benefits and treated the same in all ways. Any requirements for proof of relationship or waiting periods for registered domestic partnerships are also applied to marriages.

Your eligible dependents must live in the United States and generally are:

- Your lawfully married spouse or 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/partner is *not* an eligible dependent unless mandated by state law; at any time, you cannot cover more than one person as your spouse/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 non-registered domestic partners.
  - When you add a spouse/partner or new dependent to your coverage, you will be required to submit proof of eligibility for the coverage (for example, a marriage license, partnership registration, certification of domestic partnership or birth certificate). Note that domestic partners and spouses are offered all the same benefits and treated the same in all ways.
- Your domestic partner;
- Your civil union/domestic partner's ("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 children 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 before age 26 the dependent child became incapable of self-sustaining employment due to a disability, in which case the dependent may be eligible for coverage beyond such age.

Note: Dependent children up to age 27 may be covered under the GUL.

To enroll your disabled adult child age 26 or older, 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 to determine eligibility for adding him or her to your health care coverage.

Keep in mind, except as otherwise described for disabled adult child(ren), your children, regardless of marital status, are eligible for healthcare coverage under your Plan until the end of the plan year in which they turn age 26 (end of the month in which they turn age 26 for supplemental medical plans). The Plan however, does not provide coverage for any spouse of your children or their dependent children (i.e., your grandchildren).

Note: Not all HMOs cover civil union partners/domestic partners and/or their children. For more specific information, contact your HMO directly.

*Except as otherwise described for disabled adult child(ren), 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 and for supplemental medical plans, 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 30.

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 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 when eligible 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 lives in the United States 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.

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. If your domestic partnership is not registered, you will need to complete a form that certifies the following:

- You have lived together for at least six consecutive months prior to enrollment; if you are (were) married, legally separated or getting a divorce, the six months (to enroll your domestic partner) are 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 six months from the date your divorce is final or from the date you report your divorce to the Citi Benefits Center, whichever is later;
- 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; 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.

In order for you 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. See the *For More Information* section for detailed instructions, including TDD and international assistance. You must wait six months from the time your termination attestation form is received before you can add a new domestic partner, unless your domestic partnership is registered.

The children of your domestic partner are eligible for coverage if they live in the United States, 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; or
- Any other children 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 before age 26 the child became incapable of self-sustaining employment due to a disability, in which case the dependent may be eligible for coverage beyond such age.

To enroll your domestic partner's disabled adult child you must have a letter from the SSA declaring your domestic partner's child as disabled; if you do not have such a letter, your Citi health plan will evaluate the child to determine eligibility for 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 30.

HMO Eligibility

Note: 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 In-Network Only Plan, Choice Plan, High Deductible Plan with HSA or other non-insured (self-funded) programs. This applies to the following plans:

1. Health Plan Hawaii Plus (HMSA);
2. Kaiser FHP of California—Northern; and
3. Kaiser FHP of California—Southern.

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/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 41 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 after the date you first become eligible, during the Annual Enrollment period or within 31 days after the date 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/partner only;
- Employee Plus Children: Coverage for you and your eligible children including the eligible children of your spouse/partner; and
- Employee Plus Family: Coverage for you, your spouse/partner, your eligible children and your spouse's/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/partner has medical coverage from his or her employer and "Employee Plus Spouse/Partner" for dental coverage if your spouse's/partner'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 20. 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.

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.* The individual penalty for not having health coverage under the Affordable Care Act is no longer applicable; however, certain states impose such a penalty for not having health coverage. 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 benefits, described in “Benefits Overview” on page 9.

Dependent Verification

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 13, under “Eligibility” beginning on page 10.

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. Note: 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.
- 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. Note: You generally have 31 days from the date of a qualified change in status to enroll in or change your coverage in connection with the qualified change in status See “Changing Your Coverage” beginning on page 24 for more information.

You are not permitted to add, drop or change coverage in the MetLife Legal Plans mid-year due to a qualified change in status.

The individual penalty for not having health coverage under the Affordable Care Act is no longer applicable; however, certain states impose such a penalty for not having health coverage.

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. Benefit changes must be made within 31 days of the qualified change in status. See “Changing Your Coverage” beginning on page 24 for more information.

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 Your Benefits Resources™, available through My Total Compensation and Benefits at 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 (LPSA), 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 Plan with HSA option under the medical plan to be potentially eligible to establish an HSA. To 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. To receive the full Citi contribution ($500 individual; up to $1,000 all other coverage) to your HSA, all requirements must be met by the end of the year (as of December 31) prior to the coverage becoming effective in the following year. If in a previous plan year, you elected coverage under the High Deductible Plan with HSA option, and established an HSA, and you do not elect an annual contribution amount during annual enrollment, you will only receive Citi's contribution; no additional contributions will be made to your HSA.

Supplemental Medical Plans

You can enroll each year during Annual Enrollment (or as a new hire) to have coverage. Midyear changes are permitted under the plan if you have a Qualified Status Change that allows you to change other Citi benefits.

Once you are enrolled, your participation will continue as long as you remain eligible, unless you elect to drop coverage during a subsequent Annual Enrollment period.

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 or increase your 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 continue your Basic Life and AD&D coverage 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 will 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 will 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.

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

MetLife Legal Plans

You can enroll each year during Annual Enrollment (or as a new hire) to have coverage. Midyear changes are not permitted under the plan, even if you have a Qualified Status Change that allows you to change other Citi benefits.

Once you are enrolled, your participation will continue as long as you remain eligible, unless you elect to drop coverage during a subsequent Annual Enrollment period.

After You Enroll or Default

Confirmation of Enrollment

A confirmation of enrollment listing your benefits will be mailed to your preferred address of record.

- If you enroll by telephone: Review this confirmation statement carefully for accuracy and retain it as proof of your enrollment. If you find an error, to correct it, immediately call the Citi Benefits Center through ConnectOne at 1 (800) 881-3938. See the *For More Information* section for detailed instructions, including TDD and international assistance.
- If you enroll online, you will receive a confirmation of enrollment email: If you find an error, to correct it, immediately call the Citi Benefits Center through ConnectOne at 1 (800) 881-3938. See the *For More Information* section for detailed instructions, including TDD and international assistance.

Confirmation of Default

If you do not enroll, you will have the "default" coverage shown on the Your Benefits Resources™ website, available through My Total Compensation and Benefits at 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 preferred address of record 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 My Total Compensation and Benefits at 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. See the *For More Information* section for detailed instructions, including TDD and international assistance. Speak with a Citi Benefits Center representative to name a beneficiary for Basic Life and Basic AD&D insurance and Business Travel Accident/Medical (BTA) insurance.

If you enroll in Group Universal Life (GUL) insurance 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 My Total Compensation and Benefits at www.totalcomponline.com, available from the Citi intranet and the Internet. Note that Supplemental Medical plans pay the estate in the event of a death before benefits are distributed.

If you are enrolled in the HSA, we encourage you to be sure you have a beneficiary selected by signing into your online HSA and Select "Beneficiaries" from the home page. A beneficiary can be one or more individuals (i.e., spouse, children, relatives and friends). If you do not assign a beneficiary, your HSA funds will default to your legal surviving spouse, if applicable , or alternatively, to your estate. If your HSA is left to your estate, it may face heavier taxation. For those reasons, it's important to keep your beneficiary information up to date.

If you retire, the beneficiary you designated while an employee will be carried over to any Company-provided retirement plans you may have until or unless you have otherwise designated such 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 2025 are shown below.

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

- $30,000 or less;
- $30,001 – $40,000;
- $40,001 – $50,000;
- $50,001 – $75,000;
- $75,001 – $100,000;
- $100,001 – $150,000;
- $150,001– $200,000;
- $200,001 – $500,000; and
- $500,001 +.

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. See "Definition of Benefits Eligible Pay" on page 21.

Note: If your coverage begins during a pay period, your contributions will not be prorated based on having coverage for only part of the pay period.

Before-Tax Contributions

Contributions for medical (including the Health Savings Account [HSA]), dental, vision 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 Wage and Tax Statement. 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) benefit and, where applicable, LTD contributions;
- Basic Life insurance benefit;
- Basic Accidental Death and Dismemberment (AD&D) insurance benefit;
- Group Universal Life (GUL) insurance and costs;
- Supplemental AD&D insurance and costs;
- Eligibility for the Dependent Day Care Spending Account (DCSA) subsidy; and
- Short-Term Disability (STD) benefit for U.S. Consumer Wealth Management employees who hold the title of Senior Wealth Advisor or its equivalent.

Definition of Benefits Eligible Pay

Enrolling During the Annual Enrollment Period

If you are enrolling during the Annual Enrollment period for coverage effective January 1, 2025, your benefits eligible pay for purposes of benefits enrollment is made up of the following:

1. Annual base pay of current year as of June 30, 2024;
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, 2023, will be used for the 2025 Annual Enrollment calculations;
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, 2023, excluding the cash portion of the annual discretionary incentive award/retention package dated January 2023, will be used for the 2025 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 2024 will be used for the 2025 Annual Enrollment calculations; and
5. Short-Term Disability (STD) benefits paid from January 1 – December 31, 2023, for employees paid commissions only.

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, 2024) 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 above.

Note: Your benefits eligible pay does not necessarily equal the amount reported as your salary and wages on your Form W-2 Wage and Tax Statement ("Form W-2").

If You Become Disabled

In the event that you go out on a disability, if your leave extends beyond the benefits eligible pay calculation period for purposes of annual enrollment for the 2025 plan year or beyond, your benefits eligible pay will be recalculated for annual enrollment after you return from the disability leave. Your benefits eligible pay will not change while you are out on a disability leave.

Partner Benefits

Citi offers benefits coverage to your certified or registered domestic partner, regardless of gender or gender identity. (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 and his or her eligible dependents.

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

- Medical;
- Dental;
- Vision;
- Health Care Spending Account (HCSA), provided your 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: 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 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 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 partners and life insurance for children.

You may enroll your partner and his or her eligible children in the medical and/or dental plan in which you enroll. You may enroll your partner in spousal 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 partner in the Plan or from your partner receiving benefits for a specific condition or illness.

When You Can Enroll Your Partner

You can enroll your 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. See "Changing Your Coverage" beginning on page 24 for more information.

Examples of qualifying events that will allow you to enroll your 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 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, if applicable. See the *For More Information* section for detailed instructions, including TDD and international assistance.

For information on domestic partner eligibility, see "For Domestic Partners" on page 14 under "Eligibility" beginning on page 10.

Cost of Partner Benefits

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

If your 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 partner medical, dental and/or vision coverage will be taken on a before-tax basis. However, if your partner and his or her child(ren) do not qualify as dependents for federal income tax purposes as described above, you will pay for their medical, dental and/or vision coverage with after-tax dollars.

Tax Implications

According to federal tax law, your taxes may be affected when you enroll your partner in Citi coverage. This Benefits Handbook does not address state and local tax treatment. For information on how 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.

If Your Partner Qualifies as a Tax Dependent

If your 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 partnership benefits will affect your taxes and those of your 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 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 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 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 additional $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 Partner Coverage

To terminate partner coverage, you must complete a form attesting that your partnership has ended or submit a document showing the termination of your partner registration, as applicable. To request the form, call the Citi Benefits Center through ConnectOne at 1 (800) 881-3938. See the *For More Information* section for detailed instructions, including TDD and international assistance. Taxes paid on the imputed income are not refundable.

Your 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/partners and other covered dependents. See "COBRA" beginning on page 37 for more information.

If You and Your 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 within 31 days 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. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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), Group Universal Life (GUL) insurance and Supplemental Medical Plans.

Please note that the qualified change in status rules do not apply to enrollment in the MetLife Legal Plans. If you enroll during annual enrollment, you will not be able to make a change in your coverage until the next annual enrollment.

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 28.

Exceptions to the 31-day rule are legal separation, annulment or divorce, the loss of Medicaid or Children's Health Insurance Program (CHIP) coverage, and the start of eligibility for state premium assistance. For these three 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/partner or child coverage under this program, respectively, is available if you marry, establish an eligible 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, annulment or divorce;
2. Meeting the eligibility to qualify as a 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/partner's or other employer's plan;
6. The death of a spouse/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 Plans, as long as you and your dependents are eligible but not already enrolled in the

Plans. 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 generally allow you to change your elections within 31 days of the occurrence of the qualified change in status (as long as you meet the consistency requirements, as described below). Exceptions to the 31-day rule are legal separation, annulment or divorce. For those events, you have 60 days to report the change. Note that a HIPAA special enrollment event includes loss of eligibility for another group health plan or health insurance that you or your dependents are enrolled in and gaining an eligible dependent through a birth, marriage, or adoption.

- Legal marital status: Certain events that change your legal marital status, including marriage, divorce, death of a spouse, legal separation or annulment. Note: in the event of a divorce, annulment or legal separation, you will have 60 days from the event to change your elections;
- 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/partner’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; and
- Residence: A change in the place of residence for you, your spouse/partner, 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).

The following are rules that are applicable to a qualified change in status. Any change in benefits request, including the ones discussed below, in connection with a qualified change in status must be made within 31 days of the occurrence of the qualified change in status, except as otherwise indicated.

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/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 change in status and is consistent with the qualified change in status.

Coverage and Cost Events

In some instances, you can make changes to your benefits coverage for other qualifying events, such as midyear events affecting your cost or coverage, as described below. To change your coverage, the qualifying event must be reported within 31 days; 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 mid-year, 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 midyear 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 change in status, 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 alternative 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/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 partner coverage: The events qualifying you to make a midyear election change described in this section also apply to events related to a 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 partner, generally that change must be made on an after-tax basis, unless your 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 Plans. 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, 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 Plans, as long as you and your dependents are eligible but not already enrolled in the Plans.

How to Report a Qualified Change in Status Event

Generally, you have 31 days from the date of the event (60 days in the event of legal separation, annulment or divorce, 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. See "Changing Your Coverage" beginning on page 24 for more information.

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 through ConnectOne at 1 (800) 881-3938. See the *For More Information* section for detailed instructions, including TDD and international assistance.
- Visit Your Benefits Resources™, available through My Total Compensation and Benefits at www.totalcomponline.com.
- To enroll in Group Universal Life (GUL) insurance or Supplemental AD&D insurance, call MetLife at 1 (888) 830-7380 or access the MetLife MyBenefits website available through My Total Compensation and Benefits at 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 Benefits 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 change in status to the Citi Benefits Center within 31 days of the child's birth to add the child to your coverage.

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

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

- Extension of benefits; and
- Continuation of coverage.

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

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.

The LTD portion of 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; or
- 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.

Health Savings Account (HSA)

You must be enrolled in the High Deductible Plan with HSA 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 must be received by the tenth of the month (for LIRR and MNR commuters, no later than the 4th of any month) to be applied to the following benefit month. For example, changes must be completed by 12/10 in order to be applied in January.

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 yourself and your eligible dependents. Coverage and contributions will be retroactive to your eligibility begin date (often your date of hire).
You enroll for yourself and your eligible dependents during the Annual Enrollment period,	Coverage will begin on January 1 of the following year.
You enroll in coverage for yourself and/or a new dependent within 31 days of a qualified event; However, if you experience a qualified change in status that is a HIPAA special enrollment event, Note that a HIPAA special enrollment event includes loss of eligibility for another group health plan or health insurance that you or your dependents are enrolled in and gaining an eligible dependent through a birth, marriage, or adoption,	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 with you for adoption. Note: Exceptions to the 31-day rule are legal separation, annulment or divorce, the loss of Medicaid and/or the Children's Health Insurance Program (CHIP) coverage, and the start of eligibility for state premium assistance. For these three events, you have 60 days to report the change.
You enroll in coverage for yourself and/or a new dependent as part of a mid-year enrollment change,	Coverage will begin on the date you elect coverage.

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. on 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 have attained age 65, your coverage will end at 11:59 p.m. on 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; or
- Upon a finding of fraud or intentional misrepresentation related to a claim for eligibility or benefits under the Citigroup Health Benefits 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), Transportation Reimbursement Incentive Program (TRIP), and the MetLife Legal Plan end on the date your employment is terminated.

You can continue Group Universal Life (GUL) and Supplemental AD&D coverage or convert your Business Travel Accident (BTA) coverage to an individual AD&D policy 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.

You can continue coverage through portability under the Supplemental Medical Plans by paying Aetna directly. You must apply for portability within 30 days after you are no longer eligible under the group plan. Rates will be comparable to the Citi employee rates.

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

- 11:59 p.m. on the day in which your employment is terminated, unless you have attained age 65. If you have attained age 65, your coverage will end at 11:59 p.m. on 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 (except the MetLife Legal Plan);

- The date you become legally separated or divorced, submit a partnership termination form or submit other legal documents showing your termination of the relationship to your spouse/partner (except the MetLife Legal Plan);
- 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 Insurance Plans;
- The date the eligible dependent is covered as the dependent of another employee under the Citigroup Health and Insurance 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 37.

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;
- You have attained age 50 and have at least five years of Citi service; and
- You are eligible for coverage under the Citigroup Health Benefit Plan, regardless of whether you are enrolled. Please note if coverage is lost under the Citigroup Health Benefit Plan due to failure to pay premiums, you will be ineligible for retiree health coverage.

Note: If you are eligible for retiree health coverage and you have attained age 65, you will be assisted by Via Benefits, a Willis Towers Watson Company, to enroll in Medicare exchange health care coverage. For information on Via Benefits and health plan and premium options, call Via Benefits at 1 (888) 427-8835.

If you are eligible for retiree health coverage and you have not attained age 65, you may be eligible to continue health coverage through COBRA while you wait to be eligible to enroll in retiree medical, prescription drug, dental and vision plans through Via Benefits, a private Medicare plan exchange that has partnered with Citi to ensure you receive support as you transition to retiree health plans available directly with insurance companies. Enrolling in COBRA coverage will not impact your eligibility to later enroll in coverage through Via Benefits. See “COBRA” for more information on how COBRA coverage works

Medicare

For employees who may be close to attaining age 65, the eligibility age for Medicare coverage, and may be thinking about how Medicare impacts your Citi benefits if you continue to be actively employed at Citi upon or after attaining age 65, please note that if you remain actively employed at age 65 and enrolled in the medical plan, your Citi medical coverage will be your primary coverage for you and your spouse and qualified dependents even if you enroll in Medicare. You may enroll in Medicare when you are eligible, as noted below, and Medicare might reimburse expenses the Citi plan did not cover; however, due to the extent of the Citi coverage, it is unlikely Medicare will pay much as secondary coverage. Once your benefit coverage as an active Citi employee ends after you have attained age 65, Medicare, if enrolled, will automatically be considered your primary coverage and will be required to pay benefits first.

If you have not enrolled in Medicare upon attaining age 65 as an active employee or you have become automatically eligible for Medicare upon attaining age 65 because you commenced receipt of Social Security benefits, you will be required to enroll in Medicare upon retiring to avoid penalties for late enrollment. As noted above, once your active employment coverage terminates, Medicare pays primary, regardless of whether you are eligible for retiree health coverage or elect COBRA continuation of health coverage

If your covered partner attains age 65 while you are actively employed with Citi, under the Medicare rules, your partner is required to enroll in Medicare when initially eligible to avoid late enrollment penalties and Medicare pays primary benefits for your partner. If you are considering or are close to retiring, you should enroll in Medicare so that there are no gaps in your coverage once you retire.

Medicare Benefits

Medicare consists of several parts: Part A is Hospital Insurance, Part B is Supplementary Medical Insurance, and Part D is Prescription Drug Insurance.

If you enroll in Medicare Part A, you are automatically enrolled in Medicare Part B. Generally, there is no premium associated with Medicare Part A. However, a monthly premium is required for Medicare Part B coverage. You should contact your local Social Security office for information about Medicare when you are approaching your 65th birthday, if you are considering retiring.

Note: If you are enrolled in Medicare Part A or B, you are not eligible for an HSA. However, if you previously had an HSA and have a remaining balance, you may use the funds to pay for eligible expenses even if you receive Medicare benefits. Neither you nor Citi are permitted to contribute to your HSA after you enroll in Medicare.

If you are Medicare eligible, but do not enroll, you are permitted to have an HSA and may continue to contribute until the month after you enroll in Medicare.

Medicare Part D provides prescription drug benefits and requires you to pay a separate monthly premium. As a participant in a Citi medical plan, you do not need to enroll for Medicare Part D coverage because the Citi prescription drug coverage is expected to pay out as much as the standard Medicare prescription drug coverage benefits ("creditable coverage"). As long as you have creditable coverage through the Citi medical plan, you will have a special enrollment period in which to enroll in Medicare Part D prescription drug coverage after your Citi prescription drug coverage ceases without penalty. Annually, you receive a "Notice of Creditable Coverage" from Citi which describes this process.

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 do not 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 you 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 you are eligible for the retiree health plans on your termination date, you must choose between electing retiree health coverage, as currently available, or continuing health coverage through COBRA. If you elect COBRA, you won't be able to elect retiree health coverage at a later 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 will be assisted by Via Benefits 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 may 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 colspan="2">Coverage Provisions</th></tr>
<tr><td>Medical</td><td colspan="2">Coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions.
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 the 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 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 Plan rules. In no event will the time between your periods of Citi service be counted.</td></tr>
<tr><td></td><td>Years of Citi service (as of the LTD effective date)</td><td>Medical continuation period after week 52 (the termination of your employment)</td></tr>
<tr><td></td><td>Less than two years</td><td>Six months</td></tr>
<tr><td></td><td>Two years to less than five years</td><td>Equal to your length of service</td></tr>
<tr><td></td><td>Five years or more</td><td>As long as you are deemed disabled and eligible for LTD benefits under the Plan</td></tr>
<tr><td></td><td colspan="2">At the end of the medical continuation period, shown above, you may continue coverage through COBRA, if applicable. The above continuation period is considered part of the COBRA period.</td></tr>
<tr><td></td><td colspan="2">If you became disabled on or after January 1, 2014, and
You commence short-term disability benefits;
You receive disability benefits for 52 weeks (including LTD benefits); and
Your employment is terminated,
you will be eligible to pay the same rate that active employees pay for medical coverage for up to 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.
Regardless of the commencement of your disability, the following applies:
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, who did not enroll in or declined automatic enrollment 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 Parts 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 under the Citi medical coverage because Citi will pay benefits as if you are enrolled in Medicare Parts A and B. In addition, you may incur penalties if you enroll in Medicare Part B after you are initially eligible.</td></tr>
<tr><td>Dental</td><td colspan="2">Coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. Then you may continue coverage under COBRA.</td></tr>
<tr><td>Vision</td><td colspan="2">Coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. Then you may continue coverage under COBRA.</td></tr>
</table>

<table>
<tr><th>Plan</th><th colspan="2">Coverage Provisions</th></tr>
<tr><td>Basic Life and Basic AD&D insurance</td><td colspan="2">Coverage stops after 52 weeks, but you can continue your Basic Life or Basic AD&D. You'll receive information in the mail on how to continue your coverage from the Citi Benefits Center.</td></tr>
<tr><td rowspan="5">GUL insurance</td><td colspan="2">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 below:</td></tr>
<tr><td>Years of Citi service (as of the LTD effective date)</td><td>GUL continuation period after week 52 (the termination of your employment)</td></tr>
<tr><td>Less than two years</td><td>Six months</td></tr>
<tr><td>Two years to less than five years</td><td>Equal to your length of service</td></tr>
<tr><td>Five years or more</td><td>As long as you are deemed disabled and eligible for LTD benefits under the Plan</td></tr>
<tr><td colspan="2">Afterward, MetLife will bill you at a higher rate than the Citi group rate. The higher rate will become effective the month following the termination of your active rate coverage based on your years of Citi service noted above. MetLife will send you information regarding the continuation of these coverages when you are required to pay the higher rate.</td></tr>
<tr><td>Supplemental AD&D insurance</td><td colspan="2">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) 252-3607.</td></tr>
<tr><td>Business Travel Accident/Medical (BTA/BTM) insurance</td><td colspan="2">Coverage stops after 52 weeks, but you can convert your BTA coverage to an individual Accidental Death and Dismemberment (AD&D) policy if you are under age 70 by calling the administrator, Chubb at 1 (800) 336-0627. 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.</td></tr>
<tr><td>Health Savings Account (HSA)</td><td colspan="2">If you establish an HSA in connection with your High Deductible Plan with HSA 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 Optum Financial. Such contributions up to the permissible limit are tax-deductible. Any remaining balance in your HSA 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.</td></tr>
<tr><td>Health Care Spending Account (HCSA)</td><td colspan="2">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.</td></tr>
<tr><td>Limited Purpose Health Care Spending Account (LPSA)</td><td colspan="2">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.</td></tr>
<tr><td>Dependent Day Care Spending Account (DCSA)</td><td colspan="2">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.</td></tr>
<tr><td>Transportation Reimbursement Incentive Program (TRIP)</td><td colspan="2">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.</td></tr>
<tr><td>Supplemental Medical Plans</td><td colspan="2">You can continue your Supplemental Medical coverage through portability by paying Aetna directly. Call their Member Services at 1 (800) 607-3366 to find out your rates within 30 days of becoming ineligible.</td></tr>
<tr><td>MetLife Legal Plans</td><td colspan="2">Your MetLife Legal Plans coverage will continue until the last day of the month in which you have received your 52nd week of disability benefits, including the 13-week period of STD. You must pay premiums directly to the Citi Benefits Center in order to continue MetLife Legal Plans coverage while on LTD (up to 39 weeks). After your 52nd week of disability, you have the option to enroll in individual legal coverage with automatic monthly payments made from your bank account. Learn more by visiting MetLife.com/individual-legal-plans or calling MetLife Legal Plans at 1 (800) 821-6400.</td></tr>
</table>

Coverage for Surviving Spouse/Partner and/or Dependents

When an active employee dies, the surviving spouse/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

After a death is reported to the Citi Benefits Center, the surviving spouse/partner and/or dependent children will automatically be enrolled in six months of free medical and/or dental coverage. Before the end of the six-month period, your surviving spouse/partner and/or dependent children will receive a COBRA notification package. They must elect, if they want to continue, the COBRA continuation coverage by signing and returning the election form to the Citi Benefits Center within the election period. See "COBRA" beginning on page 37.

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 can either 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/partner 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/partner, child or parent who has a serious health condition; or for your child's birth or placement with you for adoption or foster care.

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/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.

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 insurance 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 insurance 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.

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. See the *For More Information* section for detailed instructions, including TDD and international assistance. 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 Paid 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 Benefits 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 (USERRA), 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. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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 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 Benefits 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 coverage similar to COBRA to 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 60 days applies to the payment of the regularly scheduled contribution.

Note: You may have options other than the COBRA continuation of health benefits available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. The day after your employment terminates and you are ineligible for coverage under the Citi health plan, there is a 60-day special enrollment period during which you can enroll for coverage in the Health Insurance Marketplace. If you are considering enrolling for coverage under the Exchange, be mindful of this enrollment deadline.

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/partner of an employee and are covered by the Citigroup Health Benefit Plan, the Citigroup Dental Benefit Plan or the Citigroup Vision Benefit Plan (or your claims can be reimbursed through your spouse's/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/partner;
2. The termination of your spouse's/partner's employment (for reasons other than your spouse's/partner's gross misconduct) or a reduction in your spouse's/partner's hours of employment;
3. Divorce or legal separation from your spouse or the termination of your partnership; or
4. Your spouse's/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/partner or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. A spouse/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. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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/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/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. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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.

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/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
PO 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 60 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 60 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
PO Box 785004
Orlando, FL 32878-5004

You may also call the Citi Benefits Center through ConnectOne at 1 (800) 881-3938. See the *For More Information* section for detailed instructions, including TDD and international assistance.

Coordination of Benefits

The Citigroup Health Benefits 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, maximum allowed amount 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 Claims 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 and Anthem BlueCross BlueShield: 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/partner, if your spouse/partner 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 (other than your domestic partner or partner's eligible dependents) are eligible for 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 eligible for Medicare;
- Dependent spouses age 65 and over who participate in the Citi Plan on the basis of the current employment status of the employee and who are eligible for Medicare; 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). After this initial 30-month period, the Citi Plan is secondary to Medicare.

Note: The Citi Plan will pay as secondary for your domestic partner who is eligible to enroll in Medicare, even if your domestic partner does not enroll in Medicare.

If you or a covered family member enrolls in Medicare after a COBRA election is made, COBRA coverage for that individual may end. If Medicare eligible, Medicare is the primary plan for a qualified beneficiary enrolled in COBRA.

Note: If you are enrolled in Medicare Part A or B, you are not eligible to make contributions to an HSA, if you are enrolled in a High Deductible Plan with HSA. Additionally, you ceased to be eligible for the Citi contribution as well. However, if you have an HSA with a remaining balance, you may use the funds to pay for eligible expenses even if you receive Medicare benefits.

If you are Medicare eligible, but do not enroll, you are permitted to make contributions to your HSA, as a participant in the High Deductible Plan with HSA. You may continue to contribute until the month after you enroll in Medicare. Please note: If you enroll in Medicare upon retiring after attaining age 65, if you are eligible for free Medicare Part A, which more than likely you are, you will have coverage that is retroactive up to six-month after you attain age 65. If you are making HSA contributions after attaining age 65, it is advisable to stop HSA contributions (including Citi contributions) six months before retiring. Due to the retroactive Medicare coverage, such contributions would be deemed ineligible, and would need to be refunded from your HSA by the time you file your tax return following the year of your retirement to avoid the excise taxes on the excess HSA contributions .

Medicare Part D provides prescription drug benefits and requires you to pay a separate monthly premium. As a participant in a Citi medical plan, you do not need to enroll for Medicare Part D coverage because the Citi prescription drug coverage is expected to pay out as much as the standard Medicare prescription drug coverage benefits ("creditable coverage"). As long as you have creditable coverage through the Citi medical plan, you will have a special enrollment period in which to enroll in Medicare Part D prescription drug coverage after your Citi prescription drug coverage ceases without penalty. Annually, you receive a "Notice of Creditable Coverage" from Citi which describes this process.

Delaying enrollment in Medicare beyond initial eligibility may result in the assessment of penalties or late fees in the following situations:

- You or your dependent is eligible for Medicare and you are no longer an active employee (COBRA coverage is not considered coverage based on current employment);
- You domestic partner is eligible for Medicare (even if you are still an active employee).

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 and Anthem BlueCross BlueShield: 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.

Cross-Plan Offsets

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive (an "Overpayment"), the Plan has the right to be repaid. The Plan has the right to reduce by the amount of the Overpayment, any future benefit payment made to you or your dependents. The Plan may also recover Overpayments by reducing future payments to a provider by the amount of the Overpayment under a process referred to as a "cross-plan offset." These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator(s) ("TPA"). Under this process, the TPA reduces future payments to providers by the amount of the Overpayments they received, and then credits the recovered amount to the plan that made the overpayment.

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. Keep in mind that you cannot submit medical, dental, vision, HCSA, LPSA or DCSA claims for services or expenses incurred prior to the effective date of your coverage.

Need Help Resolving a Claim Issue?

Health Advocate can help: call 1 (866) 449-9933. For more information about Health Advocate, visit Live Well at Citi.

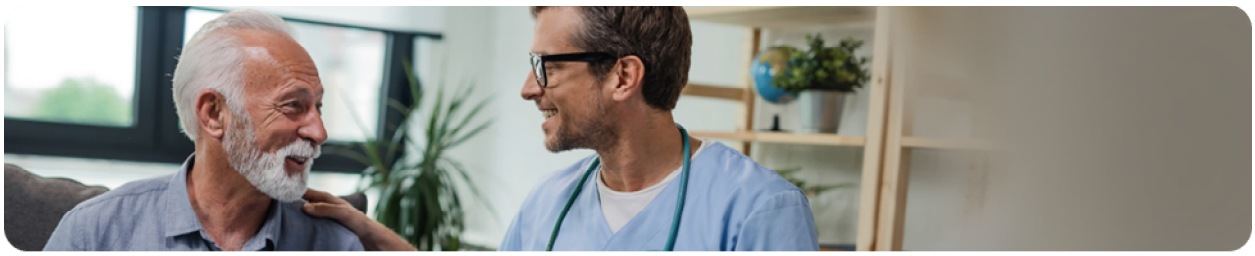
Listed below are the forms needed to claim benefits that may not be reimbursed automatically or paid directly. Claims should be sent to the Claims Administrators as detailed under "Claims Administrators" in the *Administrative Information* section. If you do not receive benefits to which you believe you are entitled, see the applicable "Claims and Appeals" subsection in the section of this Benefits Handbook that describes each plan.

Name of Plan	Name/Form Number and When to Use the Form	How to Obtain a Form
Aetna • Choice Plan (CP) • High Deductible Plan with HSA (HDPH)	Aetna Medical Benefits Request form Use the form to file a claim for covered out-of-network expenses.	Visit Forms and Claims at Citi Benefits Online at www.citibenefits.com Or Visit Your Benefits Resources™ through My Total Compensation and Benefits at www.totalcomponline.com
Anthem BlueCross BlueShield • CP • HDPH	Anthem BlueCross BlueShield 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 see the *For More Information* section.	
CVS Caremark (Prescription drug coverage for CP and HDHP)	CVS Caremark Prescription Drug Claim form Use the form to file a claim for covered out-of-network expenses.	Visit Forms and Claims on Citi Benefits Online at www.citibenefits.com Or Visit Your Benefits Resources™ through My Total Compensation and Benefits at www.totalcomponline.com Or Call CVS Caremark at 1 (844) 214-6601 or visit www.caremark.com
MetLife Dental PDP	MetLife Dental Claim form Use the form to file a claim for covered dental expenses.	Visit Forms and Claims on Citi Benefits Online at www.citibenefits.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 Forms and Claims on Citi Benefits Online at www.citibenefits.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 Optum Financial Payment Card	Visit the Optum Financial website through My Total Compensation and Benefits at www.totalcomponline.com Or Visit Forms and Claims on Citi Benefits Online at

Name of Plan	Name/Form Number and When to Use the Form	How to Obtain a Form
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.	www.citibenefits.commmc
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: Except for the Parking Cash Reimbursement Option (CRO), all other TRIP CRO claims must be filed within 12 months from the date of service. Parking Cash Reimbursement Option (CRO) claims must be filed by June 30 following the year in which the expense was incurred.	
Supplemental Medical Plans	The Aetna Simplified Claims Experience™ is available online on the My Aetna Supplemental app, or member portal at Myaetnasupplemental.com. You can also view your coverage and sign up for direct deposit. If you are also an Aetna medical member (enrolled in the In-Network Only Plan, Choice Plan, High Deductible Plans with HSA) you won't have to provide any medical documents to file your claim. If you're not enrolled in an Aetna plan, the process is the same, but you will be prompted to provide medical documents, like an itemized bill. Call Aetna Voluntary Member Services with any questions or for a paper claim form at 1 (800) 607-3366 (TTY: 711), Monday through Friday, 8 AM to 6 PM.	
MetLife Legal Plans	MetLife Legal Plans Out-of-Network Claim Form Note: You do not need to file a claim when you use an in-network attorney.	Contact MetLife Legal Plans at 1 (800) 821-6400 to request an out-of-network claim form. You will be reimbursed according to a set fee schedule.

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

- Medical, dental and vision claims must be filed within one year 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 (i.e., all substantiating documentation should be submitted) by June 30 following the year in which the expense was incurred.
- Supplemental medical plan claims must be filed within three years from the date of service.
- TRIP Parking Cash Reimbursement Option (CRO) claims must be filed by June 30 following the year in which the expense was incurred.



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
- Supplemental Medical Plans.

Invest in Yourself

Unlock the value of your benefits by learning about all that Citi has to offer. Take the time to invest in your health and the health of your family. Visit Find Benefits for Your Needs to learn more about the many tools and resources available to you.

Medical

The Citigroup Health Benefit 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 My Total Compensation and Benefits, lists the medical options available to you based on your home zip code (or your work zip code if you live in Canada).

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

- In-Network Only Plan, administered by Aetna and Anthem BlueCross BlueShield, provides coverage only when you receive care from a network provider (the Aetna Premier Care Plus Network (APCN+) or Anthem's National Blue High Performance Network (BlueHPN)*; or
- Choice Plan, administered by Aetna (Choice POS II Open Access) and Anthem BlueCross BlueShield (PPO Preferred Provider Organization plan); or
- High Deductible Plan with HSA, administered by Aetna (Choice POS II Open Access) and Anthem BlueCross BlueShield (PPO Preferred Provider Organization plan).

* Note: In certain parts of the country, one or both of the networks may not be available. If neither network is available in your area, the In-Network Only Plan won't be offered to you when you enroll. In certain states, contributions may differ across Aetna and Anthem due to stronger network discounts in those states.

HMOs:

1. Health Plan Hawaii Plus (HMSA);
2. Kaiser FHP of California — Northern; and
3. Kaiser FHP of California — Southern.

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Your Medical Options

Although each of the Citi medical plans offers comprehensive coverage, there are differences between the plans. The options include:

- In-Network Only Plan — Offers coverage only for services from a smaller network of doctors and hospitals that deliver high-quality care at lower costs. If you get care outside the smaller network, it won't be covered (except in emergencies). You pay for most health care with a copay. The deductible is lower than Citi's other medical plan options, and paycheck deductions fall in between the Choice Plan and the High Deductible Plan with HSA.
- Choice Plan — Offers the flexibility to choose any doctor or hospital when you need care. You'll pay less when you stay in-network. You pay higher paycheck deductions, but have a lower deductible than the High Deductible Plan with HSA. After meeting the deductible, you pay a percentage of costs through coinsurance.
- High Deductible Plan with HSA — Similar to the Choice Plan, however, you have access to a Health Savings Account (HSA) that Citi contributes to, giving you long-term savings and investment opportunities, if there is not an immediate need to use the funds to pay the deductible and other health care expenses. You pay lower paycheck deductions but have a higher deductible than the other medical plan options available. After meeting the deductible, you pay a percentage of costs through coinsurance.

Need Help Finding a Doctor or a Specialist for a Second Opinion?

Contact Health Advocate at 1 (866) 449-9933 or visit your plan provider's website (Aetna or Anthem BlueCross BlueShield) for more information. You can also contact Included Health for assistance with a second opinion second opinion. Call 1 (888) 306-7195 to speak with a Care Coordinator and set up your account.

Some high-level information is available in the table below. For HMO information, visit "2025 Insured HMOs" on page 103 or see the Health Plan Comparison Charts on Your Benefits Resources™ (YBR™). To access YBR™, visit My Total Compensation and Benefits at www.totalcomponline.com, available from the Citi intranet and the Internet.

Note: Precertification is required for certain procedures and services in network (and out of network with the Choice Plan and High Deductible Plan with HSA). Penalties may apply if precertification is not obtained. 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* section for a definition of MAA, which is sometimes referred to as "Recognized Charges." For out-of-network services, providers may charge you for medical expenses that exceed the MAA (referred to as "balance billing"), and you are responsible for those charges.

Overview of Your Medical Options

Here's an at-a-glance summary of the key differences between the options:

	In-Network Only Plan	Choice Plan	High Deductible Plan with HSA
What type of services are covered?	All plans cover the same health care services and offer free in-network preventive care		
Where can I receive care?	Only from doctors or hospitals in either the Aetna Premier Care Plus Network (APCN+) or Anthem's National Blue High Performance Network (BlueHPN)	From any doctor or hospital you want, but you'll pay less when you stay in-network	From any doctor or hospital you want, but you'll pay less when you stay in-network
How does the cost for coverage compare?	Paycheck deductions in the middle of Citi's other two plans	Highest paycheck deductions	Lowest paycheck deductions
What do I pay for doctor's office visits?	A flat copay ($25 for primary care/$45 for specialist)	Full cost of service up to the deductible, then coinsurance	Full cost of service up to the deductible, then coinsurance
What do I pay for emergency care?	Deductible, then a $200 copay (even out of network)	Deductible, then coinsurance	Deductible, then coinsurance
What do I pay for care at a hospital?	Deductible, then a flat copay ($200 for outpatient/$400 for inpatient)	Deductible, then coinsurance	Deductible, then coinsurance
How do the deductibles compare?	$250 individual/$500 family	$500 individual/$1,000 family*	$1,800 individual/$3,600 family*
How do the out-of-pocket maximums compare?	Out-of-pocket maximum in the middle of Citi's other plans ($4,000 individual/$8,000 family)	Lowest out-of-pocket maximum ($3,000 individual/$6,000 family)*	Highest out-of-pocket maximum ($5,000 individual $10,000 family ($6,850 per individual)*
Can I contribute to a tax-free account?	Yes, a Health Care Spending Account (HCSA)	Yes, a Health Care Spending Account (HCSA)	Yes, a Health Savings Account (HSA) with a contribution from Citi, plus a Limited Purpose Health Care Spending Account (LPSA)

* In-network deductibles and out-of-pocket maximums only; higher deductibles and out-of-pocket maximums apply for out-of-network care.

Remember: The In-Network Only Plan provides coverage only when you receive care from a network provider (with the exception of urgent and emergency care). With the Choice Plan or High Deductible Plan with HSA, if you use an out-of-network doctor, you'll pay more when you need care.

Medical Plan Administrators

The In-Network Only Plan, Choice Plan and High Deductible Plan with HSA are administered by Aetna and Anthem BlueCross BlueShield throughout the United States. The plan designs for each medical option are essentially the same no matter which vendor administers the Plan. The Plans are self-insured, meaning they are not subject to state laws and Citi pays the claims incurred.

The In-network Only Plan only covers services from doctors and hospitals who belong to the plan's network – either the Aetna Premier Care Plus (APCN+) Network or Anthem National Blue High Performance Network (BlueHPN). Both networks consist of doctors and hospitals that consistently deliver high-quality care at lower costs. These networks are smaller than those in Citi's other medical plans and are only available in certain parts of the country, so it's important to check to see if the networks are available in your area. (See "Finding In-Network Providers" on page 76.)

Using Your Medical Plan

This section provides important information about preventive care coverage, emergency room care, urgent care, mental health and substance use benefits, as well as other programs available to you through your medical plan. Understanding this information will help ensure you make the most of your medical plan coverage.

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 visits to obtain recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care;
- Certain U.S. 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 Drugs* 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 ; and
- Screening for gestational diabetes.

Additional preventive care services covered in full by Citi medical plans as part of the Affordable Care Act (also referred to as PPACA) include:

- Preventive services related to pregnancy for dependent children;
- Anesthesia performed in connection with a preventive colonoscopy;
- Genetic counseling and BRCA genetic testing for women who have had non-BRCA-related breast or ovarian cancer;
- Gender-based preventive services for transgender individuals;
- Human immune-deficiency virus (HIV) counseling and screening for all sexually active people;
- Interpersonal and domestic violence screening and counseling;
- Counseling on sexually transmitted infections for all sexually active people;

Access Doctors on Demand

If you're a member of a Citi Aetna or Anthem BlueCross Blue Shield medical plan, you have access to a national network of U.S. board-certified doctors, pediatricians, psychologists or therapists 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 or mental health issues via phone or online video consultation. Learn more about Aetna's Teladoc service at www.teladoc.com or about Anthem's LiveHealth Online service at www.livehealthonline.com.

- Tobacco-use cessation (for non-pregnant adults): counseling, behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy;
- Tobacco-use cessation (for pregnant women): counseling and behavioral interventions;
- Diabetes screening (at-risk adults): screening for abnormal blood glucose as part of cardiovascular risk assessment for overweight or obese adults ages 40-70 years; and intensive behavioral counseling about diet and exercise for patients with abnormal blood glucose; and
- High blood pressure screening (adults): hypertension screening for adults ages 18 and older.

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.uspreventiveservicestaskforce.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 ages 45-75, when 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 120-139 systolic/80-90 diastolic;
- *Lipid disorders* — covered for men ages 20-35 and women ages 20-45 if at high risk, and for men over 35 and 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 ages 65-75 who have ever smoked;
- *Breast cancer* — covered every one to two years starting at age 40;
- *Genetic testing for breast and ovarian cancer (BRCA)* — covered for women with family history BRCA1 or BRCA2;
- *Cervical cancer* — covered for sexually active women ages 21-65;
- *Osteoporosis* — covered for post-menopausal women ages 60-85;
- *Chlamydia* — covered for sexually active people who are under age 24 or pregnant;
- *Gonorrhea* — covered for sexually active people who are under age 24 or 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 ages 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; and
- *Obesity* — covered for adults and children age 6 and older, including intensive counseling and behavioral interventions.

Specific preventive care guidelines may apply depending on your Plan Administrator. For details, log on to the carrier's website (Aetna: www.aetna.com. Anthem BlueCross BlueShield: www.anthem.com) or call the number on the back of your ID card.

Screening and Counseling Services

Covered expenses include charges made by your physician, psychologist or therapist 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 that are covered to any extent under any other part of this plan;
- Services that 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; and
- 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 U.S. Food and 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 that 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.

Routine hearing and vision tests are covered in network at 100%, not subject to deductible.

Routine Cancer Screenings

In the In-Network Only Plan, Choice Plan and High Deductible Plan with HSA, cancer-screening tests are covered at 100% with no deductible when performed by in-network providers, regardless of age, family history, frequency and gender guidelines.

Cancer screening tests are:

- Pap smear;
- Mammography;
- Sigmoidoscopy;
- Colonoscopy;
- Total body skin exam (TBSE) for skin cancer;
- Prostate specific antigen (PSA) test; and
- Low-dose CT (LDCT) scan.

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;
- PSA tests;
- Sigmoidoscopies;
- Total body skin exam (TBSE);
- Double contrast barium enemas (DCBE); and
- Colonoscopies.

Not covered under this benefit are charges incurred for:

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

Important Note:

Annual routine cancer screenings, including total body skin exams (TBSE) to screen for skin cancer, are offered at no cost for all employees and dependents enrolled in a Citi medical plan when performed by an in-network doctor. This coverage is available regardless of age, family history, frequency and gender guidelines. Contact your physician, log on to the medical carrier's website (Aetna: www.aetna.com. Anthem BlueCross BlueShield: www.anthem.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 Plan does not cover non-emergency services provided in an emergency room.

Know Where to Go for Care?

Do you know when to go the emergency room, urgent care center or your doctor? Test your knowledge with the Right Place to Get Care quiz.

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).

MinuteClinic and HealthHUB Visits

We know that convenient access to medical care is important to you. MinuteClinic and HealthHUB centers (available in select CVS pharmacies) offer immediate treatment for minor conditions like ear infections, rashes, minor burns and cold or flu symptoms.

To make it easier on you and your covered family members to get this care when you need it, the In-network Only Plan and Choice Plan will cover many services provided by MinuteClinic or HealthHUB at no cost to you.* For High Deductible Plan with HSA members, you pay $0 after meeting the plan deductible.*

Of course, nothing can replace the value of having a trusted relationship with a primary care doctor who knows you and your health history. But MinuteClinic and HealthHUB offer convenient options when you need minor medical attention right away, saving you time and money. On cvs.com, you can search for MinuteClinic and HealthHUB locations near you.

*Any associated lab tests will be covered at standard cost.

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 the Aetna In-Network Only Plan, Choice Plan or High Deductible Plan with HSA, 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 all 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.

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;
- ABA — applied behavior analysis;
- Electroconvulsive therapy;
- Neuropsychological testing;
- Bariatric services;
- Cardiovascular services;
- Musculoskeletal services; and
- Gender affirmation surgery.

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

Mental Health/Substance Use

You must call Aetna for precertification before you obtain covered inpatient mental health and/or substance use treatment, including stays in a residential treatment facility or a partial hospitalization program, outpatient detoxification, Transcranial Magnetic Stimulation (TMS), or psychiatric home care services. You or your doctor must call Aetna within 14 days of a scheduled, non-emergency admission, or within 48 hours after an unscheduled or emergency admission.

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 116 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 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 noted above; 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 142.

Precertification Requirements for Anthem BlueCross BlueShield Plans

You are required to obtain precertification for in-network services (as well as out-of-network services under the Choice Plan and High Deductible Plan with HSA). Your network doctor does *not* obtain precertification on your behalf. You must contact the Plan to satisfy this requirement.

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:
  - Inclusive of all acute inpatient, skilled nursing facility, long-term acute rehab, and OB delivery stays beyond the federal mandate minimum length of stay (including newborn stays beyond the mother's stay);
  - Emergency admissions (requires plan notification no later than two business days after admission;
- Outpatient and surgical services:
  - Aduhelm - Aduhelm is a human monoclonal IgG1 anti-amyloid beta antibody. Used for the treatment of Alzheimer's disease.
  - Air ambulance (excludes 911 initiated emergency transport);
  - Bone-anchored and bone conduction hearing aids;
  - Cochlear implants and auditory brainstem implants;
  - Corneal collagen cross-linking;
  - Cryopreservation of oocytes or ovarian tissue;
  - Diaphragmatic/phrenic nerve stimulation pacing systems;
  - Deep brain, cortical, and cerebellar stimulation;

- Electric tumor treatment field (TTF) for treatment of glioblastoma;
- External upper limb stimulation for the treatment of tremors
- Genetic Testing for Inherited Diseases: Addresses testing for certain diseases with an established genetic basis. Used to confirm the diagnosis of a disorder when genetic testing may lead to changes in clinical management for those with uncertain clinical features;
- Genetic Testing for Lynch Syndrome, Familial Adenomatous Polyposis (FAP) Attenuated FAP and MYH-Associated Polyposis: Addresses genetic testing for hereditary colorectal cancer.
- Home Parenteral Nutrition: Addresses parenteral nutrition that is given in the home setting;
- Implanted Port Delivery Systems to Treat Ocular Disease;
- Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain;
- Implanted Artificial Iris Devices;
- Immunoprophylaxis for respiratory syncytial virus (RSV);
- Intraocular anterior segment aqueous drainage devices (without extraocular reservoir);
- Keratoprosthesis;
- Leadless Pacemaker;
- Microprocessor Controlled Knee-Ankle-Foot Orthosis;
- Minimally Invasive Treatment of the Posterior Nasal Nerve to Treat Rhinitis;
- MRI guided high intensity focused ultrasound ablation for non-oncologic indications;
- Neuromuscular electrical training for the treatment of obstructive sleep apnea or snoring
- Percutaneous neurolysis for chronic neck and back pain;
- Private duty nursing;
- Presbyopia and stigmatism – correcting intraocular lenses;
- Radiofrequency ablation to treat tumors outside the liver;
- Transanal Hemorrhoidal Dearterialization;
- Transcatheter ablation of arrhythmogenic foci in the pulmonary veins as a treatment of atrial fibrillation (Radiofrequency and Cryoablation);
- Transendoscopic therapy for gastroesophageal reflux disease and dysphagia;
- Treatments for urinary incontinence;
- Treatment of temporomandibular disorders;
- Vagus nerve stimulation;
- Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling;

- Diagnostic testing:
  - Chromosomal microarray analysis (CMA) for developmental delay, Autism Spectrum Disorder, intellectual disability (intellectual developmental disorder) and congenital anomalies;
  - Gene expression profiling for managing breast cancer treatment;
  - Genetic testing for breast and/or ovarian cancer syndrome;
  - Genetic testing for cancer susceptibility;
  - Preimplantation genetic diagnosis testing;
  - Testing for Biochemical Markers for Alzheimer's Disease;
  - Wireless capsule for the evaluation of suspected gastric and intestinal motility disorders;
  - Prostate saturation biopsy;

- Durable medical equipment (DME)/prosthetics:
  - Absolute quantitation of myocardial blood flow measurement;
  - Augmentative and alternative communication (AAC) devices/ speech generating devices (SGD);
  - Cellular therapy products for allogeneic stem cell transplantation;
  - Continuous interstitial glucose monitoring;
  - Electrical bone growth stimulation;
  - External (portable) continuous insulin infusion pump;
  - Functional electrical stimulation (FES); threshold electrical stimulation (TES);
  - Implantable infusion pumps;
  - Implantable shock absorber for treatment of knee osteoarthritis;
  - Lower limb prosthesis and microprocessor controlled lower limb prosthesis;
  - Oscillatory devices for airway clearance including high frequency chest compression and intrapulmonary percussive ventilation (IPV);
  - Pneumatic Compression Devices for Lymphedema;
  - Prosthetics: electronic or externally powered and select other prosthetics- (myoelectric-UE);
  - Robotic arm assistive devices;
  - Standing frame;
  - Ultrasonic diathermy devices;
  - Ultrasound bone growth stimulation;
  - Wheeled mobility devices: wheelchairs-powered, motorized, with or without power seating systems and power operated vehicles (POVs);
- Radiation therapy/radiology services:
  - Intensity modulated radiation therapy (IMRT);
  - Single photon emission computed tomography (SPECT) scans for noncardiovascular indications;
  - Proton beam therapy;
  - Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy (Azedra, Lutathera, Pluvicto, Zevalin);
  - Stereotactic radiosurgery (SRS) and stereotactic body radiotherapy (SBRT);
  - Transcatheter arterial chemoembolization (TACE) and transcatheter arterial embolization (TAE) for treating primary or metastatic liver tumors;
  - Transcatheter arterial chemoembolization (TACE) and transcatheter arterial embolization (TAE) for malignant lesions outside the liver- except CNS and spinal cord;
  - Wireless capsule endoscopy for gastrointestinal imaging and the patency capsule;
  - Xofigo (Radium Ra 223 Dichloride);
- Surgical services:
  - Ablative techniques as a treatment for Barrett's esophagus;
  - Autologous cellular immunotherapy for the treatment of prostate cancer;
  - Balloon and self-expanding absorptive sinus ostial dilation;
  - Bariatric surgery and other treatments for clinically severe obesity;
  - Bronchial thermoplasty for treatment of asthma;

- Cardio-vascular:
  - Cardiac Contractility Modulation Therapy
  - Cardiac resynchronization therapy (CRT) with or without an implantable cardioverter defibrillator (CRT/ICD) for the treatment of heart failure;
  - Carotid, vertebral and intracranial artery angioplasty with or without stent placement;
  - Cervical and Thoracic Discography;
  - Endovascular techniques (percutaneous or open exposure) for arterial revascularization of the lower extremities);
  - Implantable ambulatory event monitors and mobile cardiac telemetry;
  - Implantable or wearable cardioverter-defibrillator;
  - Intracardiac Ischemia Monitoring;
  - Mechanical circulatory assist devices (ventricular assist devices, percutaneous ventricular assist devices and artificial hearts);
  - Outpatient cardiac hemodynamic monitoring using a wireless sensor for heart failure management:
  - Partial left ventriculectomy;
  - Perirectal spacers for use during prostate radiotherapy;
  - Transcatheter closure of patent foramen ovale and left atrial appendage for stroke prevention;
  - Transcatheter heart valve procedures;
  - Transmyocardial/perventricular device closure of ventricular septal defects;
  - Treatment of varicose veins (lower extremities);
  - Venous angioplasty with or without stent placement/ venous stenting;
  - Wireless Cardiac Resynchronization Therapy for Left Ventricular Pacing;
- Cryosurgical ablation of solid tumors outside the liver;
- Electrophysiology-Guided Noninvasive Stereotactic Cardiac Radioablation
- Focal Laser Ablation for the Treatment of Prostate Cancer
- Functional endoscopic sinus surgery;
- Lower esophageal sphincter augmentation devices for the treatment of gastroesophageal reflux disease (GERD);
- Locally ablative techniques for treating primary and metastatic liver malignancies;
- Musculoskeletal surgeries:
  - Axial lumbar interbody fusion;
  - Implanted devices for spinal stenosis;
  - Implanted (epidural and subcutaneous) spinal cord stimulators (SCS);
  - Lysis of epidural adhesions;
  - Manipulation under anesthesia of the spine and joints other than the knee;
  - Meniscal allograft transplantation of the knee;
  - Percutaneous vertebroplasty, kyphoplasty and sacroplasty;
  - Sacroiliac joint fusion;
  - Surgical interventions for scoliosis and spinal deformity;
  - Total ankle replacement;
  - Treatment of osteochondral defects of the knee and ankle;

- Ovarian and internal iliac vein embolization as a treatment of pelvic congestion syndrome;
- Plastic/reconstructive surgeries/treatments:
  - Abdominoplasty,panniculectomy, diastasis recti repair;
  - Allogeneic, xenographic, synthetic and composite products for wound healing and soft tissue grafting hyperbaric oxygen therapy (systemic/topical);
  - Blepharoplasty;
  - Brachioplasty;
  - Breast procedures; including reconstructive surgery, Implants and other breast procedures;
  - Buttock/thigh lift;
  - Chin implant, mentoplasty, osteoplasty mandible;
  - Composite products for wound healing and soft tissue grafting;
  - Insertion/injection of prosthetic material collagen implants;
  - Hyperbaric oxygen therapy (systemic/topical);
  - Liposuction/lipectomy;
  - Mandibular/maxillary (orthognathic) surgery;
  - Mastectomy for gynecomastia;
  - Oral, pharyngeal and maxillofacial surgical treatment for obstructive sleep apnea or snoring;
  - Penile prosthesis implantation;
  - Procedures performed on the face, jaw or neck (including facial dermabrasion, scar revision);
  - Procedures performed on male or female genitalia;
  - Procedures performed on the trunk and groin;
  - Reduction mammaplasty;
  - Repair of pectus excavatum / carinatum;
  - Rhinoplasty;
  - Septoplasty;
  - Skin-related procedures;
  - Sacral nerve stimulation (SNS) and percutaneous tibial nerve stimulation (PTNS) for urinary and fecal incontinence and urinary retention;
  - Sacral nerve stimulation as a treatment of neurogenic bladder secondary to spinal cord injury;
  - Surgical and ablative treatments for chronic headaches;
  - Surgical treatment of obstructive sleep apnea and snoring
  - Transanal hemorrhoidal dearterialization (THD);
  - Viscocanalostomy and canaloplasty;
- Gender affirmation surgery;

- Human organ and bone marrow/stem cell transplants;
  - Inpatient admits for ALL solid organ and bone marrow/stem cell transplants (Including kidney only transplants);
  - Outpatient: All procedures considered to be transplant or transplant related including but not limited to:
    - Stem cell/bone marrow transplant (with or without myeloablative therapy);
    - Donor leukocyte infusion;
  - Axicabtagene ciloleucel (CAR) T-cell immunotherapy treatment;
  - Gene therapy treatment & replacement
  - Intrathecal treatment of spinal muscular atrophy (SMA);
- Out-of-network referrals:
  - Out-of-network services for consideration of payment at network benefit level (may be authorized, based on network availability and/or medical necessity.);
- Applied behavior analysis (ABA); and
- Infertility treatment

Mental Health/Substance Use

You must call Anthem for precertification before you obtain covered inpatient mental health and/or substance use treatment, including acute inpatient admissions, transcranial magnetic stimulation (TMS), intensive outpatient therapy (IOP), partial hospitalization (PHP), residential care, and behavioral health in-home programs. Contact the Plan to verify whether precertification is required for a specific treatment.

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 Plan" on page 147 or call 1 (855) 593-8123.

In-Network Only Plan

The In-Network Only Plan offers the same comprehensive coverage you expect from a Citi medical plan option, and it's administered by your choice of Aetna or Anthem BlueCross BlueShield.

The In-Network Only Plan provides coverage only when you receive care from a smaller network of doctors and hospitals who consistently deliver high-quality care at lower costs. These smaller networks — the Aetna Premier Care Plus Network (APCN+) and Anthem's National Blue High Performance Network (BlueHPN) — are subsets of the broader Aetna and Anthem networks. Note: In certain parts of the country, one or both of the networks may not be available. If neither network is available in your area, the In-Network Only Plan won't be offered to you when you enroll.

You pay a flat copay for most health care, so you'll know in advance your cost. There's a deductible to meet for some services, for example, when you need care at a hospital, but it's lower than in Citi's other plan options. The deductible doesn't apply to most care received outside a hospital, including doctor's office visits, urgent care, physical therapy and much more.

Here's an overview of the In-Network Only Plan's key features, which are the same whether you're enrolled through Aetna or Anthem.

In-Network Only Plan at a Glance

Note: For in-network covered expenses, the plan pays a percentage of discounted rates. Under the In-Network Only Plan, there are no payments/reimbursements for out-of-network services.

Type of Service	
Annual deductible	
Individual	$250
Maximum per family	$500
Annual medical out-of-pocket maximum (includes medical deductible and medical copays) Note: There is a separate annual out-of-pocket maximum for prescription drugs.	
Individual	$4,000
Maximum per family	$8,000
Lifetime maximum	None
Professional care (in office)	
PCP visits	$25 copay
Specialist visits	$45 copay
Allergy treatment	100%; not subject to deductible after applicable PCP or Specialist copay
Preventive care (subject to frequency limits)	
Well-adult visits	100%, not subject to deductible
Well-child visits	100%, not subject to deductible
Routine cancer screenings (see Routine Cancer Screenings on page 61)	100%, not subject to deductible
Adult and child routine immunizations	100%, not subject to deductible
Contraceptive devices	100%, not subject to deductible, for diaphragms and Mirena, an implantable device, and at least one in each category of the other applicable forms of contraception in the FDA Birth Control Guide that are not covered under the Citi Prescription Drug Program (see "Preventive Care" beginning on page 57). All other implantable devices will be covered at 100% after deductible.
Voluntary sterilization (including tubal ligation, sterilization implants and surgical sterilizations)	Tubal litigation: 100% covered, not subject to deductible Vasectomy and abortions: 100% after deductible and after $200 copay at an outpatient facility. 100% not subject to the deductible after professional care copay if done in an office setting.
Routine care (subject to frequency limits)	
Routine vision exams	100%, 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
Hospital (inpatient and outpatient services)	
Semiprivate room and board, doctor's charges, lab, X-ray, radiology and surgical care	100% after deductible and $400 copay per confinement for inpatient; 100% after deductible and $200 copay for outpatient
Anesthesia	100%, not subject to deductible
Non-routine outpatient	
Lab, X-ray and radiology	100%, not subject to deductible after $25 copay for independent lab or freestanding facility. If during office visit, PCP or specialist copay will apply (no separate copay). 100% after deductible after $200 copay for outpatient hospital

Type of Service	
Maternity care	
Physician office visit	• 100%, not subject to deductible after $25 copay • Prenatal and postpartum care services considered preventive are covered at 100%, see "How the In-Network Only Plan on page 72 for details
Hospital delivery	• 100% after deductible and $400 copay per confinement (confinement copay waived for newborn initial confinement) • Precertification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery
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 deductible and after $200 copay • Precertification is required for hospitalization and certain outpatient procedures
Emergency Transportation Services (no coverage when used as routine transportation to receive inpatient or outpatient services)	
Ambulance	• 100% after deductible and after $150 copay • Precertification required for air transport
Urgent care center/Walk-In clinic	
Urgent care facility	• 100%, not subject to deductible, after $45 copay
CVS MinuteClinic and HealthHub	100% for immediate treatment of minor health conditions, such as ear infections or rashes (associated lab tests and prescriptions will be covered at standard cost). See the *Prescription Drug* section for details about the cost of filling prescription medications.
Outpatient short-term rehabilitation	
*Physical or occupational therapy** PT/OT therapy visits are combined with a 60-visit per-year maximum. Additional visits require Medical Necessity review. Visit limit and medical necessity review is not applicable when there is a diagnosis of mental health, behavioral health or substance use, including Autism Spectrum Disorder.)	• 100%, not subject to deductible, after $25 copay
*Speech therapy** (90-visit per-year maximum. Additional visits require Medical Necessity review. (for Anthem BCBS). Visit limit and medical necessity review is not applicable when there is a diagnosis of mental health, behavioral health or substance use, including Autism Spectrum Disorder.)	• 100%, not subject to deductible, after $25 copay
*Chiropractic therapy** (medically necessary), up to 20 visits per year	• 100%, not subject to deductible, after $45 copay
Other services	
Durable medical equipment (includes orthotics/ prosthetics and appliances)	100%, not subject to deductible, after $25 copay
Private-duty nursing and home health care	100%, not subject to deductible, after $45 copay. Limited to 200 visits annually; precertification required
Hospice	Inpatient: 100% after deductible, after $400 copay per confinement; precertification required Outpatient: 100% not subject to deductible, after $45 copay
Skilled nursing facility	100% after deductible after $400 copay per confinement (limited to 120 days annually); precertification required

Type of Service	
Fertility treatment	• Covered up to a $24,000 per person lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. • Diagnosis and treatment of underlying medical condition: 100%, not subject to deductible, after $45 copay per visit . • Prescriptions covered through CVS Caremark up to a $7,500 lifetime pharmacy maximum per person.
SNOO Smart Sleeper (rental and accessories)	• 100% reimbursement for up to six months of rental and accessory fees when child is covered as a dependent within 31 days of birth. Includes initial SNOO rental with included accessories and reconditioning fee only, additional accessories are not covered under the medical plan
Prescription drugs (see the *Prescription Drugs* section) Mental health and substance use (see "Mental Health/" on page 76)	

* Visit limit is not applicable when there is a diagnosis of mental health, behavioral health or substance use, including Autism Spectrum Disorder.)

This table is 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 116 and "Exclusions and Limitations" on page 135.

Like all the other options under the Plan, the In-Network Only Plan option is self-insured; therefore, Citi pays the claims incurred. The In-Network Only Plan is not subject to state laws.

The Plan only cover services that are deemed medically necessary.

Precertification is required before any inpatient hospital stay and certain outpatient procedures.

How the In-Network Only Plan Works

In-Network Doctors and Hospitals

When you need health care, you'll choose a doctor or hospital from the network you selected when you enrolled in the plan — either the Aetna Premier Care Plus Network (APCN+) or Anthem's National Blue High Performance Network (BlueHPN). These networks are made up of a select group of doctors and hospitals that consistently deliver high-quality care at lower costs.

Copay

A copay is a flat fee you pay for medical care. When you go to the doctor to address a health concern, you'll pay either $25 for a primary care visit or $45 for a specialist visit. When you go to the hospital for treatment, you must first meet the medical deductible, then you pay either $200 for emergency room and outpatient care or $400 for inpatient care.

For prescriptions, you'll pay a copay for generic and preferred brand-name drugs after meeting the separate annual deductible for prescription drugs. This deductible is the same as the prescription drug deductible for the Choice Plan. (Non-preferred brand name drugs and some specialty drugs charge a coinsurance percentage, instead of a flat copay.)

Deductible

The deductible does not apply to office visits — all you pay is the copay. The deductible does apply if you need a surgical procedure or care at a hospital. You'll pay your hospital fees up to the plan's annual medical deductible ($250 individual/$500 family), plus a copay ($200 for emergency room and outpatient care or $400 for inpatient care). Note: Your prescription drug copays and coinsurance are subject to a separate annual deductible ($100 individual/$200 family).

Medical Out-of-Pocket Maximum

The medical out-of-pocket maximum is $4,000 individual/$8,000 family. This amount represents the most you will have to pay out of your own pocket in a calendar year for medical services. Once the out-of-pocket maximum has been satisfied, no additional medical copays will apply for the rest of the plan year. Note: Your prescription drug copays and coinsurance are subject to a separate out-of-pocket maximum ($1,500 individual/$3,000 family).

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 the In-Network Only Plan.

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 In-Network Only Plan network is available from the Claims Administrator. You may call or visit the Claims Administrator's website:

- Aetna: www.aetna.com. use the customized doc finder tool at www.aetnadocfind.com/in-networkonlyplan. Enter your home ZIP code in the 2025 Provider Search box, then click "Start Your Search." This automatically brings you to the APCN+ network directory. Enter your ZIP code again and continue as a guest to search for in-network doctors. For personal assistance, call 1 (800) 545-5862.
- Anthem BlueCross BlueShield: use the Find Care tool at www.anthem.com/find-care; to access a network provider. Select the "Guests" tile then choose "Medical" for the type of care. Choose the state you want to search in. Select Medical (Employer-Sponsored) for type of plan. Select National Blue High Performance Network (prefix E7F) for the plan/network. Click the "Continue" button and search for a doctor nearby or a special doctor by name. For personal assistance, you can also download the Engage Wellbeing app to search for doctors or call your Citi Health Concierge at 1 (855) 593-8123.

Specialists

If you need the services of a specialist, you may seek care from an in-network specialist directly without a referral. You will pay a flat copay of $45 per visit.

Preventive Care

Preventive care services are covered at 100% with no deductible to meet for the In-Network Only Plan. For additional information on what is considered to be preventive care, see "Your Medical Options" on page 55.

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.

- Prenatal and postpartum care:
  - Monthly physical exams up to 28 weeks gestation, biweekly physical exams to 36 weeks gestation, weekly physical exams from 36 weeks until delivery, post-partum physical exam (about 45 days after delivery)
  - Recording of weight, blood pressures, fetal heart tones, routine urinalysis
  - Breastfeeding support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
  - Folic acid supplements for women who may become pregnant
  - Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes
  - Gonorrhea screening for all women at higher risk
  - Hepatitis B screening for pregnant women at their first prenatal visit
  - Maternal depression screening for mothers at well-baby visits
  - Preeclampsia prevention and screening for pregnant women with high blood pressure
  - Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
  - Expanded tobacco intervention and counseling for pregnant tobacco users
  - Urinary tract or other infection screening

In addition, the In-Network Only Plan 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 covered regardless of age, family history, frequency and gender guidelines and include:

- Pap smear performed by an in-network provider annually;
- Mammogram;
- Sigmoidoscopy;
- Colonoscopy;
- Total body skin exam (TBSE) for skin cancer; and
- Prostate-specific antigen (PSA) screening annually with a digital rectal exam .
- Low-dose CT (LDCT) scan

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 of the Centers for Disease Control and Prevention; and
- Comprehensive Guidelines Supported by the Health Resources and Services Administration.

Routine Care

In-Network Only Plan 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 a network ophthalmologist or optometrist;

    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:
  - Covered at 100%, not subject to deductible; one exam per calendar year, performed by a network provider.

    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 100% for covered services after the deductible has been met, after a copay of $400 inpatient/$200 outpatient. Precertification of an inpatient admission is required. Precertification is also required for certain outpatient procedures and services.

Emergency Care

Services provided in a hospital emergency room are covered at 100% for covered services after the deductible has been met and after a $200 copay (even out of network).

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 precertification to use an urgent care center. Services provided by an urgent care center are generally covered at 100% for covered services after the deductible and the $45 copay has been met.

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 you need help finding an urgent care provider, you may call Member Services at the toll-free number on your ID card, or you may access Aetna's online provider directory at www.aetna.com, or Anthem BlueCross BlueShield's Find Care tool at www.anthem.com/find-care. 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.

Consider Using a CVS MinuteClinic or HealthHUB Center

When you use a CVS MinuteClinic and HealthHUB center (available in select CVS pharmacies), many services are covered at no cost to you. These facilities offer immediate treatment for minor conditions like ear infections, rashes, minor burns and cold or flu symptoms. On www.cvs.com, you can search for MinuteClinic and HealthHUB locations near you.

Charges Not Covered

An in-network provider contracts with the In-Network Only Plan 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 in-Network Only Plan or not approved by the In-Network Only Plan. In that case, the in-network provider may bill charges to you. However, these charges are not covered expenses under the In-Network Only Plan 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 142 or "Claims and Appeals for Anthem BlueCross BlueShield Medical Plan" on page 147.

Paying Your Bill at Your In-Network Doctor's Office

The plan will pay 100% for most covered services, after a copay. However, certain services require you to satisfy the annual deductible before coverage begins. In most cases, your doctor will bill you for the copay.

Finding In-Network Providers

A directory of the providers who participate in the In-Network Only Plan network is available from the Claims Administrator. You may call or visit the Claims Administrator's website:

- Aetna: www.aetna.com. Use the customized doc finder tool at www.aetnadocfind.com/in-networkonlyplan. Enter your home ZIP code in the 2025 Provider Search box, then click "Start Your Search." This automatically brings you to the APCN+ network directory. Enter your ZIP code again and continue as a guest to search for in-network doctors. For personal assistance, call 1 (800) 545-5862.
- Anthem BlueCross BlueShield: www.anthem.com; to access a network provider. You may also call Anthem at 1 (855) 593-8123. Use the Provider Directory tool at www.anthem.com/livewell. Select the blue button titled: **Network: National Blue High Performance Network (BlueHPN)**. Follow the prompts to conduct your search. You can also download the Engage Wellbeing app to search for doctors or call your Citi Health Concierge at 1 (855) 593-8123.

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.

Mental Health/Substance Use

The In-Network Only Plan provides confidential mental health and substance use 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 within 14 days before seeking scheduled inpatient treatment for mental health or substance use treatment (and within 48 hours after an emergency admission).

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 100% of the negotiated rate after a $400 copay per confinement.	• 100%, not subject to deductible after $25 copay

Coverage Levels

Mental health and substance use treatment benefits are subject to the same medical necessity requirements, coverage limitations and deductibles that are required under the In-Network Only Plan.

Mental health benefits include, but are not limited to:

- Assessment, diagnosis and treatment;
- Medication management; including Methadone maintenance for pain management and Methadone treatment for opioid addiction subject to medical policy guidelines;
- 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: Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office.

Inpatient Services

The In-Network Only Plan pays benefits at 100% of the negotiated rate contracted with the Claims Administrator (after a $400 copay per confinement) if you call the plan, you use an in-network provider, and the treatment is medically necessary and occurs 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, you must call the Claims Administrator for precertification within 14 days before a scheduled admission (or within 48 hours after an emergency 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 semiprivate 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 100% of covered expenses after paying a $25 copayment (no deductible).

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 four 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 use treatment does not require a referral. However, you are encouraged to call the Claims Administrator within 48 hours after an emergency admission. The Choice Plan's behavioral health providers are available 24/7 to accept calls.

Medically Necessary

. The Claims Administrator will help determine whether certain covered services and supplies are medically necessary (based on diagnosis and procedure codes and clinical information) 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* section for the definition of medical necessity.

For more information about what your plan covers, see "Covered Services and Supplies" on page 116. 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 In-Network Only Plan 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.

Choice Plan

With the Choice Plan, administered by Aetna (Choice POS II Open Access) and Anthem BlueCross BlueShield (PPO Preferred Provider Organization plan), you'll pay higher premiums, but have a lower deductible than the High Deductible Plan with HSA.

You must meet the annual deductible before the plan will share in the cost of benefits. Both in-network and out-of-network services will apply to meeting the deductible.

Here's an overview of the Choice Plan's key features, which are the same whether you're enrolled through Aetna or Anthem.

Choice Plan 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* section 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

Type of Service	In Network	Out of Network
Annual medical out-of-pocket maximum (includes medical deductible, medical coinsurance and medical copays; 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]	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 (see Routine Cancer Screenings on page61)	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
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, and at least one in each category of the other applicable forms of contraception in the FDA Birth Control Guide that are not covered under the Citi Prescription Drug Program (see “Preventive Care” beginning on page 57). 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)	Tubal litigation: 100% covered not subject to deductible. Vasectomies and abortions: 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 is 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

Type of Service	In Network	Out of Network
Maternity care		
Physician office visit	• 80% after deductible[2] • Prenatal and postpartum care services considered preventive are covered at 100%, not subject to deductible	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] • Prenotification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery
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 is required for hospitalization and certain outpatient procedures	• 80% of MAA after deductible[2] • Precertification is required for hospitalization and certain outpatient procedures
Emergency Transportation Services (no coverage when used as routine transportation to receive inpatient or outpatient services)		
Ambulance	• 80% after deductible[2] for transport to and from the nearest medical facility qualified to give the required treatment • Precertification required for air transport	• 80% of MAA after deductible[2] for transport to and from the nearest medical facility qualified to give the required treatment • Precertification required for air transport
Urgent care center/Walk-In clinic		
Urgent care facility	80% after deductible[2]	80% of MAA after deductible[2]
CVS MinuteClinic and HealthHub	100% for immediate treatment of minor health conditions, such as ear infections or rashes (associated lab tests and prescriptions will be covered at standard cost). See the *Prescription Drug* section for details about the cost of filling prescription medications.	n/a
Outpatient short-term rehabilitation		
Physical or occupational therapy[3] PT/OT therapy visits are combined with a 60-visit per-year maximum. Additional visits are reviewed for medical necessity. This limit applies to in-network and out-of-network services combined. Visit limit and medical necessity review is not applicable when there is a diagnosis of mental health, behavioral health or substance use, including Autism Spectrum Disorder.)	• 80% after deductible[2] • 70% after deductible[2] for visits approved for medical necessity over plan limits	• 60% of MAA after deductible[2] • 50% of MAA after deductible[2] for visits approved for medical necessity over plan limits
Speech therapy[3] 90-visit per-year maximum. Additional visits may be approved. This limit applies to in-network and out-of-network services combined. Visit limit and medical necessity review is not applicable when there is a diagnosis of mental health, behavioral health or substance use, including Autism Spectrum Disorder.)	• 80% after deductible[2] • 70% after deductible[2] for visits approved for medical necessity over plan limits	• 60% of MAA after deductible[2] • 50% after deductible[2] for visits approved for medical necessity over plan limits
Chiropractic therapy[3] (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]

Type of Service	In Network	Out of Network
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
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
Fertility treatment	• Covered up to a $24,000 per person lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. • 80% after deductible[2] up to the lifetime maximum; precertification required • Prescriptions covered through CVS Caremark up to a $7,500 lifetime pharmacy maximum per person	• Covered up to a $24,000 per person lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. • 60% after deductible[2] up to the lifetime maximum; precertification required • Prescriptions covered through CVS Caremark up to a $7,500 lifetime pharmacy maximum per person
SNOO Smart Sleeper (rental and accessories)	100% reimbursement for up to six months of rental and accessory fees when child is covered as a dependent within 31 days of birth. Includes initial SNOO rental with included accessories and reconditioning fee only; additional accessories are not covered under the medical plan	
Prescription drugs (see the *Prescription Drugs* section)		
Mental health and substance use (see "Mental Health/" on page 76)		

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 by cash or check, or with before-tax dollars if you have available funds in a Health Care Spending Account (HCSA).

3 Visit limit is not applicable when there is a diagnosis of mental health, behavioral health or substance use, including Autism Spectrum Disorder.

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 116 and "Exclusions and Limitations" on page 135.

The Choice Plan is self-insured; therefore, Citi pays the claims incurred. The Choice Plan 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 depend 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 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. *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.

How the Choice Plan Works

With the Choice Plan, you have the flexibility to use in-network or out-of-network providers. However, if you use an out-of-network provider for medical services these expenses generally are reimbursed at a lower level than in-network expenses, after you have met the out-of-network deductible.

Deductible

For most covered services, you must satisfy a deductible before coverage begins. The deductible does not apply to most preventive care services.

- In-Network: 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.
- Out-of-Network: 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 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. After the deductible is satisfied, the Choice Plan normally pays 60% of the 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.

Family Deductible

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 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 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% in-network 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 or $6,000 individual/$12,000 family out-of-network. This amount represents the most you will have to pay out of your own pocket in a calendar year. This amount does not include penalties, charges above the MAA, prescription drug expenses or services not covered under Choice Plan. 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 in-network services (or 100% of MAA for out-of-network services) for the remainder of the calendar year. In-network copays 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 copays 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 in-network/$6,000 out-of-network) to the family out-of-pocket maximum ($6,000 in-network/$12,000 out-of-network).

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 Choice 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 of $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 Choice Plan 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 POS II Open Access Plan, or call 1 (800) 545-5862.
- Anthem BlueCross BlueShield: www.anthem.com/livewell; to access a network 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.

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 you receive services other than an allergy injection, coinsurance will apply.

Preventive Care

Preventive care services are covered at 100% in-network with no deductible to meet for the Choice Plan.

Each participant in the Choice Plan 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. For additional information on what is considered to be preventive care, see "Your Medical Options" on page 55.

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.
- Prenatal and postpartum care:
  - Monthly physical exams up to 28 weeks gestation, biweekly physical exams to 36 weeks gestation, weekly physical exams from 36 weeks until delivery, post-partum physical exam (about 45 days after delivery)
  - Recording of weight, blood pressures, fetal heart tones, routine urinalysis

- Breastfeeding support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Maternal depression screening for mothers at well-baby visits
- Preeclampsia prevention and screening for pregnant women with high blood pressure
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Expanded tobacco intervention and counseling for pregnant tobacco users
- Urinary tract or other infection screening

In addition, Choice Plan will cover both annual 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 covered regardless of family history, frequency, age or gender guidelines and include:

- Pap smear performed by an in-network provider annually;
- Mammogram;
- Sigmoidoscopy;
- Colonoscopy;
- Total body skin exam (TBSE) for skin cancer;
- Prostate-specific antigen (PSA) screening annually with a digital rectal exam; and
- Low-dose CT (LDCT)scan.

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 of the Centers for Disease Control and Prevention; and
- Comprehensive Guidelines Supported by the Health Resources and Services Administration.

Routine Care

Choice Plan 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 care.

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

- In-Network: 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.
- Out-of-Network: 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 semiprivate 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

Services provided in a hospital emergency room from a network provider are covered at 80% for covered services after the deductible has been met.

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, mental health and substance use, 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 precertification 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 ID 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.

Consider Using a CVS MinuteClinic or HealthHUB Center

When you use a CVS MinuteClinic and HealthHUB center (available in select CVS pharmacies), many services are covered at no cost to you. These facilities offer immediate treatment for minor conditions like ear infections, rashes, minor burns and cold or flu symptoms. On www.cvs.com, you can search for MinuteClinic and HealthHUB locations near you.

Out-of-Network 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, 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.

Charges Not Covered

An in-network provider contracts with the Choice Plan 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 Choice Plan or not approved by the Choice Plan. In that case, the in-network provider may bill charges to you. However, these charges are not covered expenses under the Choice Plan 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 142 or “Claims and Appeals for Anthem BlueCross BlueShield Medical Plan” on page 147.

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

The Choice Plan is administered by Aetna and Anthem BlueCross BlueShield. When you enroll in the Choice Plan, 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 POS II Open Access Plan, or call 1 (800) 545-5862.
- Anthem BlueCross BlueShield: www.anthem.com/livewell; to access a network.

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.

Mental Health/Substance Use In and Out of Network

The Choice Plan provides confidential mental health and substance use 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 within 14 days before seeking scheduled inpatient treatment for mental health or substance use treatment (and within 48 hours after an emergency admission).

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.	After the deductible, eligible expenses are 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 are covered at 60% of MAA.	After the deductible, eligible expenses are covered at 60% of MAA.

Coverage Levels

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

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

Inpatient Services

The Choice Plan pays benefits at the in-network level (80% of the negotiated rate contracted with the Claims Administrator) if you call the plan, you use an in-network provider, and the treatment is medically necessary and occurs 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 occurs 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, you must call the Claims Administrator for precertification within 14 days before a scheduled admission (or within 48 hours after emergency 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 semiprivate 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 four 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 use treatment does not require a referral. However, you are encouraged to call the Claims Administrator within 48 hours after an emergency admission. The Choice Plan's behavioral health providers are available 24/7 to accept calls.

Medically Necessary

. The Claims Administrator will determine whether certain covered services and supplies are medically necessary (based on diagnosis and procedure codes and clinical information) 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* section for the definition of medical necessity.

For more information about what your plan covers, see "Covered Services and Supplies" on page 116. 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 Choice Plan 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.

High Deductible Plan with HSA

The High Deductible Plan with HSA, administered by Aetna and Anthem BlueCross BlueShield, covers the same services as the Choice Plan. However, there are certain major differences between the plans.

- The High Deductible Plan with HSA provides flexibility and choice around how to spend your health care dollars. The High Deductible Plan with HSA is generally available at a lower premium cost, yet it 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 High Deductible Plan with HSA gives you access to different accounts than other plans do.
- The High Deductible Plan with HSA 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.
- High Deductible Plan with HSA 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 funds contributed to an HSA by Citi on your behalf.
- If you had a HCSA prior to a qualified change in status, then you are permitted to retain the HCSA, even if you elect a High Deductible Plan with HSA. 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 High Deductible Plan with HSA, 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 High Deductible Plan with HSA until you meet the deductible.

The High Deductible Plan with HSA is self-insured; therefore, Citi pays the claims. The plan is not subject to state laws.

Note: If you are 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.

High Deductible Plan with HSA 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* section 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 services 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 copays)		
Single	• $5,000 • Includes prescription drug expenses	• $7,500 • Includes prescription drug expenses
Family[1]	• $10,000 ($6,850 per individual) • Includes prescription drug expenses	• $15,000 ($15,000 per individual) • Includes prescription drug expenses
Lifetime maximum	None	None

Type of Service	In-network	Out-of-network
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]	60% of MAA after deductible[2]
Preventive care (subject to frequency limits)		
• Well-adult visits and routine immunizations • Well-child visits and routine immunizations • Routine cancer screenings (see Routine Cancer Screenings on page 61)	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, and at least one in each category of the other applicable forms of contraception in the FDA Birth Control Guide that are not covered under the Citi Prescription Drug Program (see "Preventive Care" beginning on page 57). 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	Tubal litigation: 100%, not subject to deductible. Vasectomies and abortions: 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; limited to one exam per calendar year	100% of MAA, not subject to deductible; limited to one exam per calendar year
Routine hearing exam	100%, not subject to deductible; limited to one exam per calendar year	100% of MAA, not subject to deductible; limited to 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 required for certain outpatient procedures	60% of MAA after deductible;[2] precertification required for certain outpatient procedures
Maternity care		
Physician office visit	• 80% after deductible[2] • Prenatal and postpartum care services considered preventive are covered at 100%, not subject to deductible	60% of MAA after deductible[2]
Hospital delivery	80% after deductible[2]	60% of MAA after deductible[2]

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)	80% after deductible;[2] precertification required if admitted	80% after deductible;[2] precertification required if admitted
Urgent Care/Walk-In Clinics		
Urgent care facility	80% after deductible[2]	80% of MAA after deductible[2]
CVS MinuteClinic and HealthHUB	100% after deductible, for immediate treatment of minor health conditions, such as ear infections or rashes (associated lab tests and prescriptions will be covered at standard cost). See the *Prescription Drug* section for details about the cost of filling prescription medications.	n/a
Emergency Transportation Services (no coverage when used as routine transportation to receive inpatient or outpatient services)		
Ambulance	• 80% after deductible[2] • Precertification required for air transport	• 80% of MAA after deductible; precertification required for inter-facility transfers • Precertification required for air transport
Outpatient short-term rehabilitation		
Physical/occupational therapy (combined)[3] PT/OT therapy visits are combined with a 60 visit per year maximum (in-network and out-of-network combined). Additional visits are reviewed for medical necessity. Visit limit and medical necessity review is not applicable when there is a diagnosis of mental health, behavioral health or substance use, including Autism Spectrum Disorder.)	• 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[3] (90 visits a year in-network and out-of-network combined maximum. Additional visits may be approved. Visit limit and medical necessity review is not applicable when there is a diagnosis of mental health, behavioral health or substance use, including Autism Spectrum Disorder.)	• 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
Chiropractic therapy[3] (medically necessary), up to 20 visits per year for in-network and out-of-network services combined	• 80% after deductible[2]	• 60% after deductible[2]

Type of Service	In-network	Out-of-network
Other services		
Durable medical equipment (includes orthotics/ prosthetics and appliances)	• 80% after deductible[2]	• 60% after deductible[2]
Fertility treatment	• Covered up to a $24,000 per person 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 CVS Caremark up to a $7,500 lifetime pharmacy maximum per person	• Covered up to a $24,000 per person 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 CVS Caremark up to a $7,500 lifetime pharmacy maximum per person
SNOO Smart Sleeper (rental and accessories)	100% reimbursement after deductible for up to six months of rental and accessory fees when child is covered as a dependent within 31 days of birth. Includes initial SNOO rental with included accessories and reconditioning fee only, additional accessories are not covered under the medical plan	
Prescription drugs (see the *Prescription Drugs* section)		
Mental health and substance use (see "Mental Health/" on page 76)		

1 The family deductible can be satisfied as a family or by an individual within the family. Each of your covered family members has an individual out-of-pocket maximum of only $6,850 for in-network coverage. After reaching that amount, your plan will cover 100% of that individual's in-network health care expenses for the rest of the year. Once the $10,000 family in-network out-of-pocket maximum is met, your plan will cover 100% of the family's in-network health care expenses for the rest of the year.

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 by cash or check, or with before-tax dollars if you have available funds in an HSA.

3 Visit limit is not applicable when there is a diagnosis of mental health, behavioral health or substance use, including Autism Spectrum Disorder

High Deductible Plan with HSA 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 the maximum allowed amount (MAA) after the deductible has been met. Note: Only your deductible, coinsurance and any copays — 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, low dose CT (LDCT) scan, total body skin exam (TSBE) skin cancer screening, and PSA test. Note: When using in-network doctors, annual cancer-screening tests are covered at 100% with no deductible regardless of family history, frequency, age or gender guidelines.
- 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 CVS Caremark. 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 CVS Caremark Home Delivery program for the plan's copay or coinsurance, except as described in the bullet immediately following.
- You can purchase certain preventive care medications for a copay or coinsurance *before* the deductible is met. Copays/coinsurance count toward your out-of-pocket maximum. For a list of preventive medications, visit the CVS Caremark website. If you are a participant in a medical plan with prescription drug coverage through CVS Caremark, visit www.caremark.com.
- The plan has no lifetime maximum benefit other than for fertility coverage and travel and lodging expenses.

How the Plan Works

This section contains more-detailed information about High Deductible Plan with HSA'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 POS II Open Access Plan, or call 1 (800) 545-5862.
- Anthem BlueCross BlueShield: www.anthem.com/livewell; select the state in which you live, 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) coverage 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 family member 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 family member 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). Each of your covered family members has an individual out-of-pocket maximum of only $6,850 for in-network coverage. After reaching that amount, your plan will cover 100% of that individual's in-network health care expenses for the rest of the year. The amount includes the $1,800/individual and $3,600/family (out-of-network $2,800/$5,600) deductible, coinsurance and any medical copays. 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 copays — 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. Each of your covered family members has an individual out-of-pocket maximum of only $6,850 for in-network coverage. After reaching that amount, your plan will cover 100% of that individual's in-network health care expenses for the rest of the year. Once the $10,000 family in-network out-of-pocket maximum is met, your plan will cover 100% of the family's in-network health care expenses for the rest of the year. 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.
- Prenatal and postpartum care:
  - Monthly physical exams up to 28 weeks gestation, biweekly physical exams to 36 weeks gestation, weekly physical exams from 36 weeks until delivery, post-partum physical exam (about 45 days after delivery)
  - Recording of weight, blood pressures, fetal heart tones, routine urinalysis
  - Breastfeeding support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
  - Folic acid supplements for women who may become pregnant
  - Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes
  - Gonorrhea screening for all women at higher risk
  - Hepatitis B screening for pregnant women at their first prenatal visit
  - Maternal depression screening for mothers at well-baby visits
  - Preeclampsia prevention and screening for pregnant women with high blood pressure
  - Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
  - Expanded tobacco intervention and counseling for pregnant tobacco users
  - Urinary tract or other infection screening

In addition, the plan will cover cancer-screening tests at 100% with no deductible when performed by network providers, regardless of age, family history, frequency or gender guidelines.

Cancer screenings tests are:

- Pap smear;
- Mammography;
- Sigmoidoscopy;
- Colonoscopy;
- Total body skin exam (TBSE) for skin cancer;
- Prostate-specific antigen (PSA) test; and
- Low-dose CT (LDCT) scan.

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 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 57.

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, mental health and substance use, 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 ID 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.

Consider Using a CVS MinuteClinic or HealthHUB Center

When you use a CVS MinuteClinic and HealthHUB center (available in select CVS pharmacies) many services are covered at no cost to you after you meet the deductible. These facilities offer immediate treatment for minor conditions like ear infections, rashes, minor burns and cold or flu symptoms. On www.cvs.com, you can search for MinuteClinic and HealthHUB locations near you.

Mental Health/Substance Use

The Aetna/Anthem BlueCross BlueShield High Deductible Plan with HSA provides confidential mental health and substance use 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 within 14 days before seeking scheduled inpatient treatment for mental health or substance use treatment (and within 48 hours after an emergency admission).

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.	After the deductible, eligible expenses are covered at 80% of negotiated rate.
If you call the plan but do not use its network provider/facility	After the deductible, eligible expenses are covered at 60% of MAA.	After the deductible, eligible expenses are covered at 60% of MAA.

Coverage Levels

Mental health and substance use treatment benefits are subject to the same medical necessity requirements, coverage limitations and deductibles that are required under the High Deductible Plan with HSA.

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 possible 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, you must call the Claims Administrator for precertification within 14 days before a scheduled admission (or within 48 hours after emergency 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 semiprivate 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 four 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 use 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 determine whether certain covered services and supplies are medically necessary (based on diagnosis and procedure codes and clinical information) 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* section for the definition of medical necessity.

For more information about what your plan covers, see “Covered Services and Supplies” on page 116. 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 Plan with HSA.

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

- Pay for expenses incurred before you meet your deductible;
- Pay for qualified medical expenses that are not otherwise reimbursable by the High Deductible Plan with HSA; 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 High Deductible Plan with HSA;
- Have no other health coverage except what is permitted under “other health coverage”;
- Not be enrolled in Medicare Parts A and B or Medicaid; and
- Not be claimed as a dependent on someone else’s tax return.

Regardless of your insurance you may visit Citi's on-site medical clinics for preventive care (health screenings and flu shots) and episodic care (if you are ill, have an emergency or accident at work or need non-prescription medications). You may also receive allergy injections if you have a prescription from your doctor and supply the allergy medications. Blood tests for monitoring health conditions with a prescription from your doctor can be done and will be billed to your insurance. Citi’s on-site medical clinics are not a replacement for your own primary care doctor. If you established an HSA, you may not use Citi's on-site medical clinics for care that is considered impermissible. Examples of impermissible medical coverage include, but are not limited to: routine annual physical exams and ongoing treatment of chronic medical conditions.

Citi will contribute to your HSA if you:

- Enroll in the High Deductible Plan with HSA for 2025;
- Open a Citi HSA through Optum Financial; 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 p.m. ET on 12/31/24	$125	$250
Q2	4 p.m. ET on 3/31/25	$125	$250
Q3	4 p.m. ET on 6/30/25	$125	$250
Q4	4 p.m. ET on 9/30/25	$125	$250

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

The maximums that you can contribute to an HSA for 2025 are:

- $4,300[1] for an eligible individual with Employee Only coverage, and
- $8,550[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 Optum Financial.

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

Under federal law, individuals who are 55 or older by December 31, 2025, can make a catch-up contribution of an additional $1,000 for 2025 and each year going forward.

If you do not enroll in the High Deductible Plan with HSA, 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 High Deductible Plan with HSA.
- 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 is 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 benefits plan sponsored by Citi and it is not subject to ERISA.

The HSA and the LPSA

If you enroll in the High Deductible Plan with HSA and make tax-free contributions to an HSA, you cannot participate in an HCSA. *HCSA enrollment is considered "impermissible medical care coverage" and disqualifies your contributions to an HSA.* According to IRS regulations, if you enroll in the High Deductible Plan with HSA, 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 High Deductible Plan with HSA 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" subsection in the 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 certain HMOs, listed below, to provide health benefits to eligible employees. Although HMOs generally deliver benefits in the same way, the coverage that each HMO provides differs.

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 "2025 Insured HMOs" on page 103. There is a separate HMO Certificate of Insurance for each fully insured HMO.

- The *Eligibility and Participation* section and the *Administrative Information* section 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 "2025 Insured HMOs" on page 103 or on your ID card.

For a list of the HMOs offered by Citi and the Certificate of Insurance for each HMO, see "2025 Insured HMOs" on page 103. 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 "2025 Insured HMOs" on page 103. 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. After you meet 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.

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 Health Plan HawaiiPlus (HMSA).

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 "2025 Insured HMOs" on page 103 for HMO contact information.

PCPs

In general, when you are 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 provider directories of the HMOs, which are listed under "2025 Insured HMOs" on page 103. 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 precertification from your HMO. Your PCP may help 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 (prostate-specific antigen) screenings;
- Routine vision exams; and
- Routine hearing exams.

Hospital Care

Generally, hospital care — both inpatient and outpatient — requires a copay 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 coordinate the approval.

See the HMO Certificate of Insurance listed under “2025 Insured HMOs” on page 103 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. 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. No referral is needed for OB/GYN visits under the Kaiser plans.

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 covered 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 “2025 Insured HMOs” on page 103 for more information about maternity coverage.

Call the Citi Benefits Center through ConnectOne at 1 (800) 881-3938 (see the *For More Information* section for detailed instructions, including TDD and international assistance) within 31 days of the child’s birth to add your newborn child to your coverage.

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 (including mental health or substance use conditions) 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 copay for each emergency room visit. If you are admitted to the hospital, the copay is generally waived. Non-emergency services provided in an emergency room are not covered.

See the HMO Certificate of Insurance listed under “2025 Insured HMOs” on page 103 for more information, including your HMO’s definition of a true medical emergency.

Benefit Limits

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

2025 Insured HMOs

The following fully insured HMOs are offered by Citi for 2025 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 HMO Summaries of Benefits Coverage (SBCs), please visit citibenefits.com/Forms-and-Documents. For more information on plan coverage details, contact your HMO.

HMO	Contact Information
Health Plan Hawaii Plus (HMSA)	• 1 (808) 948-6372 • 1 (808) 948-5060 (Annual Enrollment information) • hmsa.com
Kaiser FHP of California — Northern	• 1 (800) 464-4000 • select.kp.org/citi • california.kpvr.org/
Kaiser FHP of California — Southern	• 1 (800) 464-4000 • select.kp.org/citi • california.kpvr.org/

[1] The list of network doctors was updated in 2025. Members should check that their doctor continues to be part of the network for 2025 as the plan does not provide out-of-network coverage (except in the case of emergencies).

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. If your health data indicates that you have a particular chronic condition, you may be contacted by a professional from your medical plan to participate in a specific program to address your chronic health conditions. The information that follows provides an overview of the available programs. Please contact your carrier for more details.

Aetna

Care Management is available to you and your dependents under the Aetna program. Aetna's Care Management program is focused on supporting all aspects of your care needs. You can speak with a nurse to support a whole range of issues such as diabetes, heart disease, cancer, low back pain and digestive conditions. Care Management can help you to:

- Manage your condition;
- Lower your risks for new conditions;
- Work better with your doctor;
- Take your medicine safely; and
- Connect you with other resources available from both Citi and Aetna.

If you enroll in the Care Management program upon invitation, you will work directly with an Aetna nurse, who acts as a personal Advocate to you and your family. Depending on your situation, you may receive a call, text or letter from Aetna inviting you to participate.

Anthem BlueCross BlueShield

The Anthem BlueCross BlueShield Condition Management Program helps you maintain your health, improve your health outcomes and control health care expenses associated with chronic conditions such as:

- Asthma (pediatric and adult);
- Diabetes (pediatric and adult);
- Heart failure;
- Coronary artery disease; and
- Chronic obstructive pulmonary disease.

If you are enrolled in a Citi medical plan and you or a family member has diabetes, you can participate in. See “Other Health Management Programs” on page 107 for more information.

Total Health Complete

Whether you’re trying to meet health goals, get ready for surgery or compare costs, Anthem is here to help. As part of your benefits, you have access to a personal Primary Nurse who’s ready to give you the support you need – all at no extra cost to you.

As an experienced nurse, your very own Primary Nurse can help you:

- Manage pain or chronic conditions, like asthma or diabetes
- Navigate hospital stays or major medical decisions
- Work through a difficult life situation—such as depression or a death in the family
- Stay healthy through wellness resources
- Find community agencies, local support groups and online resources for your health issues.
- Anthem has a team ready to help—from nurses to social workers, dietitians, respiratory therapists, pharmacists, exercise physiologists, health coaches, and more

It’s all included in your plan, at no cost to you. To speak with your Primary Nurse, just call Anthem at 1 (866) 670 5671 and select prompt 2. Anthem may also reach out to you if they spot a program that they think could help you.

Citi Health Concierge at Anthem

The Citi Health Concierge at Anthem 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.

Centers of Excellence (COEs)

Centers of Excellence (COE) 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. Due to the recognition of the importance of having certain specialized procedures performed only at top-rated facilities with a history of achieving faster recovery times and better-than-expected outcomes, the Citigroup Choice Plan and High Deductible Plan with HSA include the following requirements:

- Bariatric procedures will only be covered when performed at a COE by an in-network physician / surgeon.
- Orthopedic and transplant procedures will be covered at the out-of-network level when received outside of a COE.

Note that if you are enrolled in the In-Network Only Plan, coverage is provided through network providers only. You are not required to receive bariatric, orthopedic and transplant procedures at a COE.

If you enroll in a medical plan through Aetna or Anthem BlueCross BlueShield, you'll have access to Centers of Excellence for certain conditions, referred to as "Aetna Institutes™" by Aetna and as "Blue Distinction Centers" by Anthem BlueCross BlueShield as described below.

The plan will assist the patient and family with travel and lodging arrangements for the recipient and a companion as described under "Covered Services and Supplies" beginning on page 116.

Aetna Institutes™

The Aetna Institutes are a network of high-performing hospitals, clinics and health care facilities that offer specialized care. These institutes focus on bariatric, cardiac and orthopedic/spine surgeries, as well as on transplant support and fertility services. Our members look for the Aetna Institutes name so they can receive high-quality care at a reasonable cost.

The types of Aetna Institutes are:

- Institutes of Excellence™
- Institutes of Quality®

Aetna Institutes of Excellence

Aetna Institutes of Excellence help patients who are facing a transplant or going through treatment for fertility. To be selected, a health care facility must maintain accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and meet quality criteria for:

- Number of procedures
- Success rates
- Cost-effective care
- How often patients return to the hospital, and
- Rates of complications.

IOE Transplant Support

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 that 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.

Institutes of Quality

Aetna Institutes of Quality provide bariatric, cardiac and orthopedic procedures. We select hospitals that meet certain standards of quality and cost efficiency. We measure many factors, such as:

- Patient satisfaction
- Level of care, and
- How often people return to the hospital after surgery.

Important Notes:

- If a member does not have services in an Aetna Institute of Quality™ facility for knee, hip or spine surgery, it will be covered at the out-of-network benefit level.
- Bariatric services require an Aetna Institute of Quality facility and in network provider/surgeon for any coverage or benefits. If services are received at a non- Aetna Institute of Quality facility for bariatric surgery, there is no coverage, If services are performed by an out-of-network physician at an Aetna Institute of Quality facility, there is no coverage for the physician charges.

Anthem Blue Distinction Centers

Anthem BlueCross BlueShield, 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 (inpatient and outpatient);
- Transplants (bone marrow/stem cell, heart, lung, liver, pancreas);
- Knee and hip replacement;
- Spine surgery (discectomy, spinal fusion, spinal decompression);
- Cardiac care (percutaneous coronary interventions, coronary artery bypass grafts); and
- Complex and rare cancers.

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.

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. The information that follows provides an overview of the available programs. Please contact your carrier for more details.

Citi Health Concierge

If you are enrolled in the In-Network Only Plan, the Choice Plan or the High Deductible Plan with HSA, your Citi Health Concierge can provide personalized support and guide you to the right resources when you need them, so you get the most out of all of Citi’s benefits — even if your question isn’t specific to your medical coverage. When in doubt, start with your personal Citi Health Concierge as your first call.

Among the services Citi Health Concierge offers, it can help with:

- Estimating medical costs, finding a doctor or getting a new medical ID card;
- Support if you’re diagnosed with a new medical condition;
- Backup childcare or elder care referrals; and
- If you are overwhelmed and need help finding resources.
- You can contact your Citi Health Concierge by calling the phone number on your medical ID card.

Transform Diabetes Care® Program

If you or a covered dependent are enrolled in a Citi medical plan, have diabetes and meet the standard requirements, CVS Health may contact you to discuss your diabetes management and the Transform Diabetes Care® Program. The program offers three key components:

- A personalized blood glucose meter to meet your specific needs;
- A smart analytics platform that provides predictive and personalized insights; and
- Virtual coaching from Certified Diabetes Educators.

This approach encourages more frequent blood glucose checks, provides just-in-time outreach from Certified Diabetes Educators and automates the often-cumbersome task of ordering supplies and manually tracking blood glucose readings. Most importantly, participants receive personalized, real-time information that can enable more confident self-management and improved glycemic control.

Medical Specialty Drugs Administered by a Medical Provider

Aetna and Anthem will provide the following medical specialty medication programs to plan members:

Mandatory Site of Care Redirection Program

If you receive certain specialty drugs at an outpatient hospital facility, you may receive a letter from Aetna or Anthem about utilizing a lower level of care which meets your needs. This would include receiving your infusion in the office setting, an infusion center, or in the comfort of your home through a home infusion provider. If this affects you, Aetna or Anthem will work with you to transition your care to one of these settings, or call your Citi Health Concierge at the number on your medical ID card to learn more.

Precertification

Precertification is required for certain Medically Administered Specialty Drugs to help make sure proper use and guidelines for these drugs are followed. Your provider will submit clinical information which will be reviewed for decision. Aetna or Anthem will give the results of the decision to both you and your provider by letter.

For a list of Medically Administered Specialty Drugs that need precertification, please contact Aetna or Anthem at the number on your medical ID card. The precertification list is reviewed and updated from time to time. Including a Specialty Drug on the list does not guarantee coverage under your Plan. Your provider may check with Aetna or Anthem to verify Specialty Drug coverage, to find out which drugs are covered and if precertification is required.

If you are receiving an infused medication, certain medications may require use of the lowest cost site of care.

Site of Care Programs

Aetna's Site of Care program and Anthem's Right Drug Right Channel program target self-administered specialty drugs that can be best managed through the pharmacy benefit program rather than through the medical plan. If you are currently receiving a specialty drug which is on the drug list for this program through your medical benefit, you will need to get the drug through your pharmacy benefit.

If the drug you take is given as an injection, you will need to give the drug(s) to yourself and it will now be provided through your pharmacy benefit program. Your doctor or nurse can teach you or a caregiver how to give the injection. You can also ask your doctor to call the Provider Services number on your medical ID card and find out if a nurse can train you at home.

PrudentMed

If you are enrolled in the Aetna Choice Plan or Aetna In-Network Only medical plan option and taking an eligible medication, the PrudentMed Solution will help you to enroll in a manufacturer copay assistance program. Medications on the PrudentMed Program Drug List are included in the program and will be subject to a 30% coinsurance. However, if you are participating in the PrudentMed Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, you will have a $0 out-of-pocket responsibility for your prescriptions covered under the PrudentMed Solution.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications – in particular, specialty medications. The PrudentMed Solution will assist you in obtaining copay assistance from drug manufacturers to reduce your cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

If you currently take one or more specialty medications included in the PrudentMed Program Drug List, you will receive a welcome letter from PrudentRx that provides information about the PrudentMed Solution as it pertains to your medication. All eligible members must call PrudentRx at 1 (855) 476-4118 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call to register, PrudentRx will make outreach to you to assist with questions and enrollment. If you choose to opt out of the PrudentMed Solution, you must call 1 (855) 476-4118. Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentMed Solution will be responsible for paying a 30% coinsurance on specialty medications that are eligible for the PrudentMed Solution.

If you or a covered family member will start a new medication covered under the PrudentMed Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentMed Solution. PrudentRx can be reached at 1 (855) 476-4118 to address any questions regarding the PrudentMed Solution.

The PrudentMed Program Drug List may be updated periodically.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentMed Solution will not count toward your plan deductible or out-of-pocket maximum (if any), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act (ACA), will not count toward your deductible or your ACA out-of-pocket maximum (if any), unless otherwise required by law. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

If you have questions, PrudentRx can be reached at 1 (855) 476-41188.

Sword Health

If you or a covered 13+ years old dependent are enrolled in an Aetna or Anthem Citi medical plan, you have the option to receive free virtual physical therapy for the treatment of muscle and joint problems through Sword Health.

With Sword Health:

- You are matched with a licensed professional physical therapist to receive an evaluation and personalized treatment plan
- A live virtual consultation and video instruction will show you how to use wearable sensors and a monitoring device, provided at no cost to you, that will allow you to receive real-time feedback to correct your form as you do your prescribed exercises.
- Your physical therapist will review your progress and make adjustments to your program as needed
- You can use the Sword app to watch educational videos, chat with your physical therapist, learn about your condition and apply behavioral therapy strategies to help train your brain as you work on your body.

Physical therapy through Sword Health can help reduce pain and improve strength and mobility as you recover from surgery, work to avoid surgery, or try to reduce the need for medication.

For more information, visit join.swordhealth.com/livewell.

Aetna

Teladoc — Doctors on Demand

Teladoc provides access to a national network of U.S. board-certified doctors, pediatricians, psychologists or therapists 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, psychologist or therapist relationship, but enhances it as a convenient, affordable alternative for medical care.

Generally, you pay a copay (e.g., $56 for physician visits; $90 for therapist visits; $215 for initial psychologist visit and $100 for follow-up psychologist visits) copay subject to the deductible per Teladoc phone or video consultation with a physician, psychologist or therapist. After the deductible has been met, you will pay 20% of the consult, or $10, per consult. Charges for phone or video consultations with a physician, psychologist, or therapist 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 with 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; and
- 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 username and password on the secure member website. Then go to the Health Records tab and click on "Personal Health Record."

Aetna Cancer Support Center

The Aetna Cancer Support Center is available to Aetna members at no cost and provides a range of services including personalized support from a dedicated advocate and assistance with genetic testing and counseling to guide your care plan. To learn more, or to connect with a personal navigator (Care Manager) call the phone number on the back of your medical ID card (1 (800) 545-5862) to reach the Aetna Concierge Team.

Aetna Enhanced Maternity Program

Aetna's enhanced maternity management program is available to Aetna members and 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; and
- 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; and
- Extra support, if needed.

The Aetna Enhanced Maternity Program 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 the secure member website 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.

Aetna's Autism Advocate Program

Employees and their dependents have access to a designated Autism Advocate who is specifically trained in Autism Spectrum Disorder (ASD). The Autism Advocate is a dedicated single point of contact to help families affected by an autism diagnosis by:

- Addressing questions about autism benefits;
- Finding providers;
- Overseeing Utilization Management (authorization) for applied behavior analysis (ABA);
- Resolving claims issues;
- Assuring that treatment is effective;
- Connecting parents to all available resources; and
- Coordinating with integrated autism care providers and supports.

Autism Clinical Requirements

- There must be a diagnosis of Autism Spectrum Disorder;
- The maladaptive target behavior must be severe (risk to personal safety, or the safety of others in the child's environment, or very significantly/completely interferes with ability to function);
- Parent/caregiver(s) must be involved in training of behavioral techniques;
- There is a time-limited, individualized treatment plan with objective measures that describes behavioral interventions;
- There is involvement of community resources (such as the school district); and
- Services must be provided by individuals licensed by the state or certified by the Behavior Analyst Certifying Board.

Anthem BlueCross BlueShield

Engage Wellbeing

Engage provides a one-stop shop for a seamless healthcare experience to managing your health plan from your phone, computer, or other mobile device.

Engage lets you access tools that will keep you connected to important health information 24/7. Think of Engage as your personalized health assistant. Visit engage-wellbeing.com and register in minutes to:

- Get peace of mind. Clearly see what's covered by your plan, how much services will cost, where you've spent your health care dollars, and access your digital insurance card anytime, anywhere
- Find doctors you'll love. Search ratings and reviews from real people, and find high-quality doctors or specialists in your network and near you
- Make the most of your perks. Save time and money by discovering additional benefits and programs

Register for Engage at no cost at https://engage.castlighthealth.com/v2/registration/e/citigroup or just search for Engage Wellbeing in the App Store®

LiveHealth Online

LiveHealth Online provides access to a national network of U.S. board-certified doctors, pediatricians, psychologists or therapists 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, psychologist or therapist relationship, but enhances it as a convenient, affordable alternative for medical care.

For 2025, you pay $59 per LiveHealth Online phone or video consultation with a physician until the deductible is met. After that, you pay $11.80 per consultation. Online visits with a therapist are $80, with a psychologist are $95 and with a psychiatrist are $175 for the initial evaluation and $75 for follow up visits, all applying to your medical plan deductible and coinsurance. Once you meet the annual out-of-pocket maximum, consultations are covered in full for the remainder of the year. If you are enrolled in an HSA or HCSA/LPSA, the fee is considered a qualified health care expense and can be reimbursed through your spending account. Charges for phone or video consultations with a physician, psychologist or therapist 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.

Building Healthy Families

Building Healthy Families helps expectant mothers with routine to high-risk pregnancies focus on early prenatal interventions, risk assessments and education, leading to overall healthier outcomes for mothers and newborns. You will have 24/7 access to Building Healthy Families through web or mobile, as well as digital chat and telephone support from family-building coaches and Anthem nurses to help you connect to useful resources and navigate every stage of your unique journey. The program includes:

- 24/7 phone access to a nurse coach who can talk with you about your pregnancy and answer your questions
- Useful tools to help you, your doctor and your Building Healthy Families nurse coach track your pregnancy and spot possible risks

Also, the digital program can help support your family from preconception through the stages of pregnancy, childbirth, and early childhood (to age 5 and beyond). It is available 24/7 through anthem.com, our Engage mobile app, or our Sydney℠ Health mobile app and features an extensive content library covering topics to support families. In addition, the app features many tools including fertility, diaper change, and feeding trackers, due date calculators, and blood pressure monitoring. Visit anthem.com or the Sydney Health app to enroll today.

Also, with Breastfeeding Support on LiveHealth Online, you can have secure and private video chats with a certified lactation consultant, counselor or registered dietitian at no cost. These professionals will be able to provide personalized support to help you with breastfeeding techniques, including consultations about milk production, baby hunger cues, foods to avoid, postpartum nutrition and more. Sign up for free at www.livehealthonline.com or on the mobile app. You do not have to be enrolled in the Building Healthy Families program to utilize this service.

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.

WINFertility

Anthem offers a fertility support program that is administered by WINFertility. WINFertility is an industry leader in fertility management services whose foundation is built on value and delivering the highest quality fertility care. WIN will complete prior authorization of each treatment cycle available under your benefits. Through the program, you will have 24/7 access to WIN's Nurse care Manager who can answer your questions while considering your level of risk and the success rates of different treatment options, as well as listen to your concerns while you are trying to get pregnant. You can use the program to learn:

- About fertility causes, testing and types of treatment;
- About the types of drugs used for fertility treatment;
- About the side effects, storage and proper usage of your fertility drugs;
- How to select a provider;
- How to find a high-risk maternity group and health plan programs to join; and
- How to access Anthem's National Network of Reproductive Endocrinologists.

WINFertility assists Anthem members with managing their prescription drugs for fertility services.

WINFertility also provides 24/7 access to Nurse Care Managers who can answer your questions, help you find providers and listen to your concerns while you are trying to get pregnant.

For more information or if you have any questions call 1 (833) 204-2713 or go to https://managed.winfertility.com/citi/.

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.

AIM Imaging Cost and Quality Program

Anthem BlueCross BlueShield has partnered with AIM Specialty Health to offer access to important information about imaging services you might need.

If you need an MRI or a CT scan, it's important to know that costs can vary quite a bit depending on where you go to receive the service. Sometimes the differences are significant — anywhere from $300 to $3,000 — but a higher price does not guarantee higher quality. Your benefits require you to pay a portion of the cost (through deductible and coinsurance), so where you go can make a very big difference to your wallet. AIM does the research and makes it available to help you find the right location for your MRI or CT scan. Here's how the program works:

- Your doctor refers you to a radiology provider for an MRI or CT scan.
- AIM works with your doctor to help make sure that you are receiving the right test — using evidence-based guidelines.
- AIM also reviews the referral to see if there are other providers in your area that are high quality but have a lower price than the referred one.
- If AIM finds another provider that meets the quality and price criteria, AIM will give you a call to let you know.
- You can choose which radiology provider you wish to perform the service. AIM will even help you schedule an appointment with the new provider.

Cancer Care Engagement

If you are enrolled in an Anthem medical plan, you have access to the Cancer Care Engagement program. The focus is on you, so you can focus on your health. Under this program, you receive personalized support during your treatment journey including:

- Expert guidance. A virtual second opinion program helps ensure you receive the right care. You'll also have regular check-ins with cancer experts throughout your journey.
- Premier treatment. Receive treatment from hospitals specializing in the care you need, including cutting-edge treatments available for your specific condition.
- Peace of mind. If you travel for care, Cancer Care Engagement will take care of booking, confirming, and covering your arrangements.

To learn more about the Cancer Care Engagement program, contact your Citi Health Concierge at Anthem at the number on the back of your ID card.

Sleep Study Program

The Plan includes benefits for a Sleep Management Program, administered by AIM Specialty Health, which is a program that helps your doctor make better-informed decisions about your treatment for sleep-related issues. The Sleep Management Program includes outpatient and home sleep testing and therapy. If you require sleep testing, depending on your medical condition, you may be asked to complete the sleep study in your home. Home sleep studies provide the added benefit of reflecting your normal sleep pattern while sleeping in the comfort of your own bed versus going to an outpatient facility for the test.

As part of this program, you are required to get precertification for:

- Home sleep tests (HST);
- In-lab sleep studies (polysomnography or PSG, a recording of behavior during sleep);
- Titration studies (to determine the exact pressure needed for treatment); and
- Treatment orders for equipment, including positive airway pressure devices (APAP, CPAP, BPAP, ASV), oral devices and related supplies.

If you need ongoing treatment, AIM will review your care quarterly to assure that medical criteria are met for coverage. Your equipment supplier or your doctor will be required to provide periodic updates to ensure clinical appropriateness. Ongoing claim approval will depend partly on how you comply with the treatment your doctor has ordered.

Please talk to your doctor about getting approval for any sleep testing and therapy equipment and supplies.

Autism Spectrum Disorder (ASD) Program

The ASD Program is a specialized, dedicated team of clinicians within Anthem who have been trained on the unique challenges and needs of families with a member who has a diagnosis of ASD. Anthem provides specialized case management services for members with Autism Spectrum Disorder and their families. The program also includes precertification and medical necessity reviews for applied behavior analysis, a treatment modality targeting the symptoms of Autism Spectrum Disorder.

For families touched by ASD, Anthem's Autism Spectrum Disorder Program provides support for the entire family, giving assistance wherever possible and making it easier for families to understand and utilize care — resulting in access to better outcomes and more effective use of benefits. The ASD Program has three main components:

Education

- Educates and engages the family on available community resources, helping to create a system of care around the member; and
- Increases knowledge of the disorder, resources and appropriate usage of benefits.

Guidance

- Applied behavior analysis management, including clinical reviews by experienced licensed clinicians. Precertification delivers value, ensuring that the member receives the right care, from the right provider, at the right intensity. ABA therapy is covered, subject to deductible and coinsurance, in accordance with Anthem's clinical policy.
- Increased follow-up care encouraged by appointment setting, reminders, attendance confirmation, proactive discharge planning and referrals; and
- Assures that parents and siblings have the best support to manage their own needs.

Coordination

- Enhanced member experience and coordination of care;
- Assistance in exploration of medical services that may help the member, including referrals to medical case management; and
- Licensed behavior analysts and program managers provide support and act as a resource to the interdisciplinary team, helping them navigate and address the unique challenges facing families with an autistic child.

Primary Nurse

Primary Nurse serves as a personal health guide for individuals and their families. Each personal nurse provides education, counseling, tools and support to help you navigate the health care system and make wise decisions. Primary Nurse is available if you are experiencing health issues or need assistance managing lifestyle issues. Primary Nurse primarily uses the following:

- Coaching for education and self-care via web-based self-help tools and the program's 24/7 NurseLine;
- Collaborative goal planning and intervention strategies;
- Facilitation, coordination and referral to necessary services;
- Incorporating clinical resources such as pharmacists, social workers and dietitians; and
- Mailed and telephonic education, including healthy living support through the Healthwise Knowledgebase®.

The program also offers you and any covered family members one-on-one support by phone from a health coach with strategies to help with:

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

The coach works with you and your family to create an individualized program care plan that features personalized goals to ensure you are following your provider's plan of care.

24/7 NurseLine

You may have emergencies or questions for nurses around the clock. 24/7 NurseLine provides you with accurate health information at any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number, you can make more-informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues. Specifically, the 24/7 NurseLine features:

- A skilled clinical team, including an RN-licensed nurse (BSN preferred), that helps you assess symptoms and understand medical conditions, ensures you receive the right care in the right setting, and refers you to programs and tools appropriate to your condition;
- Bilingual RNs, language line and hearing-impaired services;
- Access to the Audio Health Library, containing hundreds of audiotapes on a wide variety of health topics;
- Proactive callbacks within 24 to 48 hours if you are referred to 911 emergency services or poison control, and for pediatric members with needs identified as either emergent or urgent; and
- Referrals to relevant community resources.

Inclusive Care

Part of living a healthy life is finding a doctor you trust. To make this easier for members who are lesbian, gay, bisexual, transgender, and queer (LGBTQ+), Inclusive Care helps you find doctors who will treat you with dignity and respect and who are experienced in providing compassionate, high-quality LGBTQ+ healthcare. Call your Citi Health Concierge at Anthem at the member services number on the back of your identification card for information.

The program is available to members looking for:

- Access to the plan's large network of medical and behavioral health professionals, including primary and specialty care from a provider with LGBTQ+ experience.
- Expert, whole-health care regardless of gender identity.
- Gender-affirmation services as permitted by applicable law, based upon your benefit coverage.
- Support for coming out at work.
- Information on gender-affirming surgery and services, benefits, and options.
- Ways to support a family member or friend who is LGBTQ+.

Covered Services and Supplies

This list of covered services and supplies applies to all In-Network Only Plan, Choice Plan and High Deductible Plan with HSA 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, a sickness or a pregnancy. Reimbursement for all covered services and supplies listed in this section is subject to the 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, copays 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 postoperative 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);
- Postoperative dental pain; and
- Temporomandibular disorders (TMD).

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

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 for those at risk; for those at risk, two doses at least six months apart;
- Hepatitis B: Immunize if age 46 or under; if over age 45, only for 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 for those at risk); if at 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 45 years
- Zostavax vaccine for shingles: Adults age 50 or older.

Ambulatory Surgical Center

A center's services must be given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

Anesthetics

Anesthetics are 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.

Autism Assistance Benefits

If you enroll in an Anthem or Aetna medical plan, family members who have been diagnosed with Autism Spectrum Disorder have access to autism assistance benefits, including applied behavior analysis (ABA) therapy.

Members diagnosed with Autism Spectrum Disorder (ASD) have coverage available for the diagnosis and treatment of ASD, when ordered by a physician, licensed psychologist or licensed clinical social worker as part of a treatment plan.

Baby Care

The following services and supplies may be 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.

Note: If your covered dependent child gives birth, only the services for your dependent child are covered. Your newborn grandchild is not eligible for coverage.

Birth Center

Room and board and other services, supplies and anesthetics.

Cancer Detection

Diagnostic screenings not subject to precertification or notification include:

- Mammograms;
- Pap smears;
- Gynecological exams;
- Fecal occult blood tests;
- Digital rectal exams;
- PSA tests;
- Sigmoidoscopies;
- Total body skin exam (TBSE); and
- Low-dose CT (LDCT)scan (for Anthem plans only, Aetna plans require precertification).

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.

Aetna and Anthem BlueCross BlueShield plans 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.

Gender Affirmation Services

Gender affirmation treatment benefits are provided as permitted by applicable law and as are determined to be medically necessary or appropriate by the applicable Claims Administrator. Please see below for those services that are generally covered and those services that are not covered.

Many of the services noted below require pre-service authorization. Contact the Plan's Member Services for details.

It is strongly recommended that you call the applicable Claims Administrator before receiving any related services to ensure that the services you seek are covered under the Plan.

Generally, covered expenses include the following as permitted by applicable law and as determined to be medically necessary or appropriate by the applicable Claims Administrator:

- Outpatient office visits
- Hormone therapy (and any subsequent associated risks) is covered under the pharmacy benefit (refer to the *Prescription Drugs* section for coverage information and any pre-service authorization instructions)
- Puberty suppression
- Voice modification and communication therapy
- Genital surgery and surgery to change secondary sex characteristics (including but not limited to thyroid chondroplasty, bilateral mastectomy, and augmentation mammoplasty). Inpatient hospital services or treatment require pre-service authorization
- Reconstructive and complementary procedures (including but not limited to tracheal shave, male chest reconstruction, pectoral implants, gluteal augmentation, hair removal and hair transplants). The Claims Administrator will review appropriateness of treatment. Inpatient hospital services or treatment require pre-service authorization.
- All preventive care is covered regardless of sex assigned at birth.

Note that all covered expenses are subject to plan pre-authorization limits.

Not covered

- Services performed solely for beautification or to improve appearance;
- Charges for services or supplies that are not determined to be medically necessary or appropriate by the applicable Claims Administrator.
- Donor sperm and eggs.

Note: The Plan will not cover costs related to reversal procedures or services. However, complications of procedures derived from reversal surgeries or treatments that are medically necessary will be covered.

Gene Therapy Services

Anthem BlueCross BlueShield and Aetna: The Plan includes benefits for gene therapy services, when Anthem or Aetna approves the benefits in advance through precertification. To be eligible for coverage, services must be medically necessary and performed by an approved provider at an approved treatment center. Even if a provider is an in-network provider for other services it may not be an approved provider for certain gene therapy services. Please call Anthem or Aetna Member Services to find out which providers are approved providers. (When calling Member Services, ask for the transplant case manager for further details.)

Your Plan does not include benefits for services determined to be experimental/investigational or services provided by a non-approved provider or at a non-approved facility.

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 an 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.

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.

Anthem BlueCross BlueShield: You are eligible for hospice care if your doctor and hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are covered services when given by a hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the member's death. Bereavement services are available to surviving members of the immediate family for one year after the member's death. Immediate family means your spouse/partner, children, stepchildren, parents, brothers and sisters.

Hospital Services

Aetna: Hospital services include:

Covered services include inpatient and outpatient hospital care. This includes:

- Semi-private room and board (your plan will cover the extra expense of a private room when appropriate because of your medical condition)
- Services and supplies provided by the outpatient department of a hospital, including the facility charge
- Services of physicians employed by the hospital
- Administration of blood and blood products

The following are not covered services:

- All services and supplies provided in:
  - Rest homes
  - Any place considered a person's main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

Anthem BlueCross BlueShield: 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 be 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, 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 (or 96 hours as applicable). Authorizations are required for longer stays.

Fertility Treatment and Cryopreservation

Precertification is recommended for treatment of fertility. However, no penalties apply if the treatment is received without precertification.

In order to be eligible for fertility benefits you must be a covered employee, spouse/partner or eligible dependent ("covered person") under a Citi medical plan

- Basic fertility expenses: These expenses do not count toward the medical lifetime fertility maximum. Covered expenses include:
  - Charges made by a physician to diagnose and to surgically treat the underlying medical cause of fertility;
  - Intrauterine insemination; and
  - Artificial insemination.
- Advanced reproductive technology (ART) benefits: ART is defined as:
  - Ovulation induction
  - In vitro fertilization (IVF) cycles, including freeze-all cycle (fertilization and culture of embryo)
  - Reciprocal IVF cycles
  - Intrauterine embryo lavage
  - Embryo transfer
  - Elective single embryo transfer
  - Gamete intrafallopian tube transfer (GIFT)
  - Zygote intrafallopian tube transfer (ZIFT)
  - Low tubal ovum transfer
  - Assisted hatching
  - Pre-implantation genetic diagnosis (PGD) and screening (PGS), when it is medically necessary (subject to medical criteria)
  - Evaluation by a reproductive endocrinologist or fertility specialist, drug therapy, and intracytoplasmic sperm injection (ICSI)
  - Cryopreserved embryo transfers
  - Oocyte (Egg) thaw cycles
  - ART services for procedures that are covered expenses including charges associated with storage and procurement of partner's sperm for ART and Testis Biopsy, when the partner is also covered under the Plan
  - Sperm sourcing includes specialized sperm retrieval techniques (including vasal sperm aspiration, microsurgical epididymal sperm aspiration (MESA), percutaneous epididymal sperm aspiration (PESA), electroejaculation, testicular sperm aspiration (TESA), microsurgical testicular sperm extraction (TESE), seminal vesicle sperm aspiration and sperm recovery from bladder or urine for retrograde ejaculation are considered medically necessary to overcome anejaculation or azoospermia

- Cryopreservation:
  - Medically Necessary: Cryopreservation of sperm, oocytes or embryos is considered medically necessary for members undergoing fertility due to chemotherapy, pelvic radiotherapy or other gonadotoxic therapies, with no storage time limitation when approved and covered under the plan. Gonadotoxic treatments include chemotherapy, radiation, conditions, and surgical resection (for treatment of disease or gender affirmation treatment).
  - For IVF: All cryopreservation services are provided for members undergoing IVF.
  - Elective: Cryopreservation of oocytes when being done electively and not for medical reasons is covered, but the storage limitation will be for the 1st year and the cost of this service will apply to the fertility lifetime maximum.
- Exclusions:
  - Fertility services, except as described under Covered Services.
  - The plan does not cover charges for the storage of cryopreserved embryos or oocytes after the first year, or storage of sperm unless medically necessary.
  - Covered services do not include the costs associated with surrogate mothers and the costs of donating donor eggs or services rendered to a non-covered member. Payment for charges associated with the care of an eligible covered person under this plan who is participating in a donor IVF program.
  - Third-Party Donors: The purchase of donor sperm and any charges for the storage of sperm; the purchase and storage of donor eggs and any charges associated with care of the donor required for donor egg retrievals or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier.
  - Reversal of sterilization surgery.

Medical expenses for fertility treatment are covered up to a covered person's lifetime maximum of $24,000. Only expenses for elective cryopreservation and advanced services (e.g., IVF, GIFT, ZIFT) accumulate toward the lifetime maximum.

Expenses for diagnosis and treatment of the underlying medical condition do not count toward the lifetime maximum.

Prescription drug expenses associated with fertility treatment and elective cryopreservation are covered up to a lifetime maximum of $7,500 per covered person under the Plan, as outlined in the *Prescription Drugs* section.

HMOs

Each HMO offers different fertility coverage and limits, if they offer any such coverage at all. Check with your HMO for details of fertility coverage.

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

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 use treatment.

Marriage and Family Therapy

Effective June 1, 2025, services of a licensed counselor for marriage and family therapy.

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:

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- 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;
- 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; and
  - Aetna: Blood, blood products, processing, storage and administration. Blood and blood products such as platelets or plasma are reimbursable. Blood product processing fees (typing, serology and cross-matching and blood storage) are also reimbursable. However, transportation charges are included in the reimbursement for the product itself and are not separately reimbursable. Note: Routine harvesting and storage from stem cells from newborn cord blood is not covered. However, Aetna covers stem cells for hematopoietic cell transplant when deemed medically necessary according to the following criteria: Aetna considers compatibility testing of prospective donors who are close family members (first-degree relatives [i.e., parents, siblings and children] or second-degree relatives [i.e., grandparents, grandchildren, uncles, aunts, nephews, nieces, half-siblings]) and harvesting and short-term storage of peripheral stem cells or bone marrow from the identified donor medically necessary when an allogeneic bone marrow or peripheral stem cell transplant is authorized by Aetna.
  - Aetna considers umbilical cord blood stem cells an acceptable alternative to conventional bone marrow or peripheral stem cells for allogeneic transplant.
  - Aetna considers medically necessary the short-term storage of umbilical cord blood for a member with a malignancy undergoing treatment when there is a match. Note: The harvesting, freezing and/or storing of umbilical cord blood of non-diseased persons for possible future use is not considered treatment of disease or injury. Such use is not related to the person's current medical care.
  - Anthem BlueCross BlueShield: Blood, blood products, processing, storage and administration. Blood and blood products such as platelets or plasma are reimbursable. Blood product processing fees (typing, serology, cross-matching and blood storage) are also reimbursable. However, transportation charges are included in the reimbursement for the product itself and are not separately reimbursable. Blood and blood product administration services are reimbursable only on an outpatient basis when billed hourly or at a flat rate with total eligible charges capped at the average approved semiprivate room rate.

  The use of umbilical cord blood progenitor cell transplantation is considered medically necessary for selected individuals when all of the following criteria are met:

  - One or two donor cord unit(s) are used for a single recipient;
  - The total nucleated cell (TNC) count is equal to or greater than 2.3 x 107 per kg; and
  - The umbilical cord blood stem cell unit(s) is used for an allogeneic stem cell transplant for an approved indication and the appropriate stem cell transplant criteria are met.

  Collection and storage of cord blood is considered medically necessary only when an allogeneic transplant is imminent for an identified recipient and the above criteria are met. Storage will only be authorized at centers approved by one of the following accreditation bodies:

  - Foundation for Accreditation of Cellular Therapy (FACT);
  - National Cancer Institute (NCI);
  - AABB (formerly known as American Association of Blood Banks); and
  - California Department of Public Health.

Investigational and Not Medically Necessary: The use of umbilical cord blood progenitor cell transplantation is considered investigational and not medically necessary when it does not meet the criteria listed above.

Prophylactic collection and storage of umbilical cord blood is considered investigational and not medically necessary when proposed for an unspecified future use for an autologous stem cell transplant in the original donor or for an unspecified future use as an allogeneic stem cell transplant in a related or unrelated donor.

Medical Transportation Services

Covered expenses for ground ambulance include charges for transportation:

- To the first hospital where treatment is given in a medical emergency;
- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition;
- From hospital to home or to another facility when medically necessary according to health plan clinical guidelines;
- From home to hospital for covered inpatient or outpatient treatment when medically necessary according to health plan clinical guidelines; and
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Air Transportation

- Air ambulance requiring a transport to a hospital or from one hospital to the nearest hospital because:
  - A covered member is injured/stricken by illness more than 200 miles from their home, and
  - Need for care is determined by the current ordering provider to be longer than seven days, and
  - Need for care meets the utilization review criteria completed by the Aetna or Anthem clinical team, and
  - A commercial flight is deemed as not medically appropriate.
  - In-network ambulances should be utilized in all circumstances, network permitting.
- Air ambulance is not covered for transport that is:
  - Directly to the covered member's home residence,
- For short-term illness or injury (less than seven days of ongoing inpatient medical care needed),
- For illness or injury not requiring ongoing covered inpatient medical care/rehabilitation stay,
- For custodial services or any care that does not meet medical requirements for coverage,
- For location less than 200 miles from home region, or
- The current facility determines the covered member is not stable to travel.

In extremely rare occasions, exceptions may be made based on the Medical Director discretion.

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 119.

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;
- 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:
- 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;
  - 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.:

- Oral surgery;
- Full or partial dentures;
- Fixed bridgework;
- Prompt repair to sound and natural teeth; and
- Crowns.

Organ/Tissue Transplants

Keep in mind that qualified transplant procedures will be covered at the out-of-network level when performed at a facility that is not deemed a Center of Excellence (COE) or Blue Distinction Center (BDC) through BlueCross BlueShield. Contact your plan for more information about locating a COE (or BDC).

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.

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 cells 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 and Anthem BlueCross BlueShield 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 (Choice Plan and High Deductible Plan with HSA), 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. With the In-Network Only Plan, any approved IOE or a participating Aetna facility.

The National Medical Excellence (NME) Program® will coordinate all solid organ, bone marrow and CAR-T and T-cell therapy services, and other specialized care you need.

Many pre and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the NME Program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the covered service is not directly related to your transplant.

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 (Choice Plan and High Deductible Health Plan with HSA), coverage is based on the facility used for the transplant. If a Blue Distinction Center (BDC or BDC+) is used, the service will be covered at 80% with access to the travel and lodging benefit. Blue Distinction Centers 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 BDC or BDC+ facility. With the In-Network Only Plan, any network provider will be covered.

Precertification is required for these services. Services performed at BDC or BDC+ 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 under the Choice Plan and High Deductible Health Plan with HSA. With the In-Network Only Plan, transplants are covered at 100% after deductible with a $400 copay per confinement for services in an approved network facility.

Medical Care and Treatment

Covered expenses for services provided in connection with the transplant procedure include:

- Pre-transplant 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 cells 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., semiprivate room and board in an acute hospital setting) and a postoperative global period.

When available, the plan will assist the patient and family with travel and lodging arrangements when a qualified procedure, listed in this section, is medically necessary and performed at a designated Center of Excellence facility. See “Travel and Lodging" on page 134.

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.

Orthopedic Surgery

Keep in mind that qualified orthopedic procedures will be covered at the out-of-network level when performed at a facility that is not deemed a Center of Excellence (COE) or a Blue Distinction Center (BDC or BDC+) through BlueCross BlueShield. Contact Member Services at your health carrier for more information about locating a COE (or BDC).

Qualified Procedures

If a qualified procedure, listed in this section, is medically necessary and performed at a designated Center of Excellence facility, the "medical care and treatment" and "transportation and lodging" provisions described in this section apply.

- Total knee replacement;
- Total hip replacement; and
- Spine surgery (discectomy, spinal fusion, spinal decompression).

When available, the plan will assist the patient and family with travel and lodging arrangements when a qualified procedure, listed in this section, is medically necessary and performed at a designated Center of Excellence facility. See "Travel and Lodging" on page 134.

For Anthem BlueCross BlueShield, coverage is based on the facility used for the transplant. If a Blue Distinction Center (BDC or BDC+) is used, the procedure will be covered at 80%. Blue Distinction Centers meet stringent clinical criteria, established in collaboration with expert physician panels and national medical societies 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 BDC or BDC+ facility.

Precertification is required for these services. Services performed at BDC or BDC+ facilities are covered at 80% benefit; all other facilities are covered at 60%. If care at a BDC or BDC+ facility requires you to travel 75 miles or more from your home, you'll have access to a travel and lodging benefit, with a maximum of $10,000 per surgery or treatment. There is no travel and lodging benefit for services rendered outside of a Blue Distinction Center.

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 under-converge or over-converge. 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 131.

Outpatient Physical Therapy

See "Rehabilitation Therapy" on page 131.

Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than six hours per day, five days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

Prescribed Drugs

Prescribed drugs and medicines for inpatient services.

Preventive Care

Covered expenses include:

- Routine physical exam (including a well-woman exam), subject to frequency limits;
- 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. (Choice Plan only). 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.

For more specific information regarding what is considered to be Preventive Care, see "Preventive Care" on page 57.

Private-Duty Nursing Care (combined with Home Health Care)

Private-duty nursing care is given on an outpatient basis by an RN, LPN or licensed vocational nurse (LVN). This service must be approved by your Claims Administrator.

- Aetna Choice Plan and Anthem BlueCross BlueShield Choice Plan: 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.

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 (including Down syndrome and medically necessary care associated with pervasive developmental disorders, which can include autism spectrum disorder).

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 services, wherever the services are being provided, for example, at home, at a therapist's office or in a free-standing therapy facility.
- Choice Plan and High Deductible Plan with HSA: Spinal manipulation therapy is 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 except when there is a diagnosis of mental health, behavioral health or substance use, including Autism Spectrum Disorder.

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 (Choice Plan only).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

Residential Treatment Center/Facility

For Aetna a Residential Treatment Center/Facility is defined as follows:

- A facility that provides mental health disorder services or substance related disorder services and meets the following requirements:
  - Is licensed and operated in accordance with applicable state and federal law
  - Provides treatment under the direction of an appropriately licensed physician for the level of care provided
  - Maintains a written treatment plan prepared by a licensed behavioral health provider (RN or master's level) requiring full-time residence and participation
  - Has a licensed behavioral health provider, (RN or master's level) on-site 24 hours per day 7 days per week, and is:
    - Credentialed by Aetna, or
    - Accredited by The Joint Commission (TJC); The Committee on Accreditation of Rehabilitation Facilities (CARF); The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP); or The Council on Accreditation (COA)

For Anthem: An inpatient facility that provides multidisciplinary treatment for mental health and substance use disorder conditions. The facility must be licensed as a Residential Treatment Center in the state in which it is located, must satisfy Anthem's accreditation requirements, and be approved by Anthem.

The term Residential Treatment Center/Facility does not include a provider, or that part of a provider, used mainly for nursing care, rest care, convalescent care, care of the aged, custodial care or educational care.

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.

For Aetna, Nursing Facility Services is defined as a facility that provides skilled nursing care and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law;
- Provides treatment under the direction of an appropriately licensed physician for the level of care provided;
- Maintains a written treatment plan prepared by a licensed provider (RN or master's level) requiring full-time residence and participation; and
- Has a licensed provider (RN or master's level) on-site 24 hours per day 7 days per week, and is:
  - Credentialed by Aetna, or
  - Certified by Medicare, or
  - Accredited by The Joint Commission (TJC) or The Committee on Accreditation of Rehabilitation Facilities (CARF).

Skilled nursing facilities also include rehabilitation hospitals, and portions of a rehabilitation hospital and a hospital designated for skilled or rehabilitation services.

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- Custodial care services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of mental health disorders or substance related disorders. Facilities that primarily provide treatment or services for mental health or substance use disorders are governed by the Plans' provisions for residential treatment facilities or centers.

For Anthem: An Inpatient Facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a Skilled Nursing Facility in the state in which it is located, satisfy Anthem's accreditation requirements, and be approved by Anthem.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care, or domiciliary care, or a place for rest, educational, or similar services.

It does not include institutions that primarily provide for the care and treatment of mental health disorders or substance related disorders. Facilities that primarily provide treatment or services for mental health or substance use disorders are governed by the Plans' provisions for residential treatment facilities or centers.

Snoo Smart Sleeper

Reimbursement for up to six months of a SNOO smart bassinet rental and accessories (including a Small & Medium sized SNOO Sack and 1 fitted sheet) when the child has been added as a dependent within 31 days of birth. A SNOO bassinet helps babies fall and stay asleep with gentle rocking and soothing. For those covered under the High Deductible Plan with HSA, you must first meet the annual deductible before the plan reimburses you for a SNOO smart bassinet rental and accessories.

Note: Citi employees are eligible for a discount on rentals and accessories.

Speech Therapy

See "Rehabilitation Therapy" on page 131.

Spinal Manipulations

Services of a physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion of the spine. Routine maintenance and adjustments are not a covered service under this plan.

Surgery

Services for surgical procedures.

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 copays 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 rate or MAA.
- Second procedure: The plan will allow 50% of the negotiated rate or MAA.
- Third and additional procedures: The plan will allow 50% of the negotiated rate or MAA for each additional procedure.
- Bilateral and separate operative areas: The plan will allow 100% of the negotiated rate or MAA for the primary procedure, 50% of the negotiated rate or MAA for the secondary procedure, and 50% of the negotiated rate 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.

Termination of Pregnancy

- Voluntary (i.e., abortion);
- Involuntary (i.e., miscarriage); and
- Travel and Lodging Expenses related to voluntary termination of pregnancy (i.e., abortion). The plan will assist the patient and family with travel and lodging arrangements. Services must be received at an in-network facility. See "Travel and Lodging" below.

  Note: In light of the U.S. Supreme Court's recent ruling in Dobbs v. Jackson Women's Health, any related claim submitted for payment shall be subject to additional review to determine if payment is legally permitted under applicable state law. If upon subsequent review, a paid claim is determined to be impermissible under applicable law, the Plan shall be reimbursed upon demand.

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.

Gender Affirming Care

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 as permitted by applicable law and as are determined to be medically necessary or appropriate by the applicable Claims Administrator.

Travel and Lodging

- For covered medical services, the Plan will pay travel and lodging (T&L) expenses if such services cannot be obtained from a qualified provider within a 75-mile radius of the covered individual's residence, subject to certain conditions.
- For eligible T&L expenses, there is a $10,000 lifetime reimbursement limit per covered individual, per covered service. "Per covered service" relates to each event; for instance, the $10,000 lifetime limit will apply for a single hip replacement as opposed to a lifetime limit for all hip replacements.

- Covered travel includes transportation for the patient and one companion by car at the current federal rate of reimbursement, plane (economy/coach only), train, taxi, bus, or car rental (excluding mileage). There can be no element of recreation or vacation in the travel away from home to receive medical care.
- Lodging away from home includes coverage for the patient and one companion up to the IRS limit of $50 per day, per person ($100 per day for patient and companion). Lodging must be primarily for and essential to receiving the covered medical service and may not be considered "lavish or extravagant" per IRS rules. Meals, groceries, and personal care items are not covered.
- For covered services that require precertification/prior authorization (e.g., bariatric surgery), any related T&L expenses do not require precertification/prior authorization.
- To be eligible for coverage, T&L expenses must be for medical services that are covered under the Plan, legal in the state in which they are performed, and received from a qualified provider, including a doctor or other licensed health care professionals.
- To have eligible T&L expenses apply to your deductible, and receive reimbursement if applicable, you must complete and submit a claim form and required documentation/receipts within two years of the date of service.
- Please be aware that our travel benefits cover travel and lodging for any medical procedure that meets applicable conditions and is subject to applicable limits, effective as of January 1, 2022. If you are eligible for reimbursement for covered expenses incurred on or after January 1, 2022, please remember to submit a claim any time within one year after the expense was incurred.

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;
  - 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;
- 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;
  - 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 to health outcomes for these conditions.
- Biofeedback, except as specifically approved by the Claims Administrator;
- Blood, blood plasma and blood derivatives other than those described under "Covered Services and Supplies" on page 116.
  - Aetna: Blood, blood products, and related services which are supplied to your provider free of charge.
- 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 it is 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 116;
- 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 or Anthem BlueCross BlueShield);

- 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 consisting of the following:
  - 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 himself or herself or another caregiver can be or is being trained to care for the patient;
- 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 116 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, bodybuilding, 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 (except medically necessary care associated with pervasive developmental disorders, including but not limited to services associated with autism spectrum disorder), 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, and caffeine or nicotine use) problems and learning disabilities are not covered by the plan; see "Covered Services and Supplies" on page 116 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 makes 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; and
  - That the Claims Administrator has determined, based on scientific evidence, demonstrate effectiveness or show promise of being effective for the disease. See the *Glossary* section for the definition of experimental, investigational or unproven services;
- Eyeglasses and contact lenses (Anthem BlueCross BlueShield 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;
- Gender affirmation services performed solely for beautification or to improve appearance; charges for services or supplies that are not permitted by applicable law and are not determined to be medically necessary or appropriate by the applicable Claims Administrator; donor sperm and eggs
- 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 or metabolic diseases, psychological disorders (such as stress or depression), burns, or acute traumatic scalp injury associated with hair loss must be evaluated and precertified 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, appliances 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 116;
- 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 Special Offers Program. Log in to Anthem’s website at www.anthem.com and click on “Discounts” for information about the Anthem Special Offers Program;
- Household equipment including, but not limited to, the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypoallergenic pillows, mattresses or waterbeds, equipment or supplies to aid sleeping or sitting, and the removal from your home, workplace or other environment of carpeting, hypoallergenic 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);
- Fertility services, except as described under Covered Services.
- The plan does not cover charges for the storage of cryopreserved embryos or oocytes after the first year, or storage of sperm unless medically necessary.
- Covered services do not include the costs associated with surrogate mothers and the costs of donating donor eggs or services rendered to a non-covered member. Payment for charges associated with the care of an eligible covered person under this plan who is participating in a donor IVF program.
- Third-Party Donors: The purchase of donor sperm and any charges for the storage of sperm; the purchase and storage of donor eggs and any charges associated with care of the donor required for donor egg retrievals or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier.
- Reversal of sterilization surgery.
- Inpatient private-duty or special nursing care. Outpatient private-duty nursing services must be precertified by the Claims Administrator;

- Membership costs for health clubs, personal trainers, massages, weight loss clinics and similar programs;
- Naturopathy (Note that the plan includes coverage for naturopaths licensed by the state for services that are covered under the Plan);
- Nutritional counseling and nutritionists except as described under “Covered Services and Supplies” on page 116;
- 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;
- 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 municipal, 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;

- Aetna: Transplant services:
  - Services and supplies furnished to a donor when the recipient is not a covered person
  - Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
  - Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness
- Anthem: 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; and
  - Urine auto-injections;
- 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;
- Therapy or rehabilitation including, but not limited to:
  - Primal therapy;
  - Chelation therapy (except to treat heavy metal poisoning);
  - Rolfing;
  - In-home wrap around treatment:
  - Wilderness therapy, including health resorts, recreational programs, outdoor skills programs, relaxation or lifestyle programs, and any other programming deemed to be experimental or investigational.
  - Boot camp therapy:
  - 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;
- Aetna: Treatment of spinal disorder:
  - Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body;
  - Other physical treatment of any condition caused by or related to neuromusculoskeletal disorders of the spine, including manipulation of the spine;
  - 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 or other physical treatment of any condition caused by or that has to do with biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically covered in the plan;
- 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 the In-Network Only Plan, the Choice Plan and the High Deductible Plan with HSA, as noted.

Mental Health and Substance Use Benefits

All visits for both inpatient and outpatient mental health and substance use 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 and Anthem BlueCross BlueShield provide confidential mental health and substance use 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 use 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 twelve months 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. Claims are processed and applied toward deductibles when appropriate in the order in which they are received from providers. Note: This can differ from the order of the date of services.

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. *For More Information* section for detailed instructions, including TDD and international assistance.

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 and Appeals for Aetna Medical Plans" 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 period 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 (Preservice 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 preservice claim. You will be notified of the decision not later than 15 days after receipt of the preservice 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 preservice 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 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 preservice claims that name a specific claimant, medical condition, and service or supply for which approval is requested, and that are submitted to an Aetna representative responsible for handling benefit matters, but that otherwise fail to follow the plan's procedures for filing preservice claims, you will be notified of the failure within five 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 precertification 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 of, reduction of, 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 basis, 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 preservice 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 preservice 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 preservice 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 that 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 five business days following the date of receipt of the request, Aetna must provide a preliminary review determining that 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), 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: 1 (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-day 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 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 them 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 time frame 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 time frame 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 Plan

The Plan wants your experience to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your Identification Card. The Claims Administrator will try to resolve your complaint informally by talking to your provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file an appeal, which is defined as follows:

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 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.

The Claims Administrator will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on Federal laws. You may call the phone number on the back of your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-urgent Continued Stay/Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make a decision, the Claims Administrator will tell the requesting provider of the specific information needed to finish the review. If the Claims Administrator does not get the specific information needed by the required timeframe, the Claims Administrator will make a decision based upon the information it has.

The Claims Administrator will notify you and your provider of its decision as required by Federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

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., preservice, concurrent, post-service, urgent, etc.).

For preservice 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, 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 preservice 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 under "Appeals" on page 148.

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 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 preservice 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 12 months after the date of receipt of the final adverse decision or if earlier, within 2 years from the date on which the participant was aware or should have been aware of the claim at issue. 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 benefits plan is sponsored by your employer and is 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.

Important Health Plan Notices

The following notices provide important information about your rights as a Health plan participant.

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, they must ensure that financial requirements (such as copays and 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.

Prescription Drugs

CVS Caremark manages the Citigroup Prescription Drug Program (Program) for participants in the In-Network Only Plan, Choice Plan (formerly known as the "ChoicePlan 500") and High Deductible Plan with HSA (formerly known as the "High Deductible Health Plan"). The Citigroup Prescription Drug Program is a component of the Citigroup Health Benefits Plan.

Prescription drug benefits for HMOs are provided through the HMOs and are not included here. Contact your HMO for information about its prescription drug benefits.

CVS Caremark 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 with a prescription in compliance with the Affordable Care Act . Keep in mind that your Health Care Spending Account can be used to reimburse the cost of non-covered over-the-counter products. If you have any questions about whether a medication is covered, call CVS Caremark Customer Care at 1 (844) 214-6601.

CVS Caremark offers three ways to purchase prescription drugs:

1. Through a comprehensive national network of nearly 65,000 retail pharmacies nationwide (a variety of chain and independent pharmacies, such as CVS retail stores, including those within a Target retail store), where you can obtain prescription drugs for your immediate short-term needs, such as an antibiotic to treat an infection;
2. Through the CVS Caremark Mail Service or Maintenance Choice® program, where you may save money by having your maintenance and preventive drugs (up to a 90-day supply, plus refills if appropriate) either delivered by mail or picked up at a CVS pharmacy store; and
3. Through the CVS Caremark Specialty Pharmacy, you must use the CVS Specialty Pharmacy.

You will pay a deductible, as shown in "Prescription Drug Benefits at a Glance" on page 154, for drugs purchased at a retail pharmacy, through Mail Service or Maintenance Choice, or through the CVS Specialty Pharmacy before the Program will pay benefits. *You will never pay more than the cost of the drug.*

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Prescription Drug Benefits at a Glance

	Prescription Drug Benefits		
	In-Network Only Plan	Choice Plan	High Deductible Plan with HSA[1]
Annual Deductible Choice Plan: In-network and out-of-network expenses combined count toward meeting your annual deductible.			
Individual	$100 per person (prescription drug deductible)		$1,800 in-network/$2,800 out-of-network; includes medical expenses
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)
Annual Out-of-Pocket Maximum In-Network Only Plan: Annual prescription drug out-of-pocket maximum includes prescription deductible, copays and prescription coinsurance. This is separate from the annual medical out-of-pocket maximum. Choice Plan: Annual prescription drug out-of-pocket maximum includes prescription deductible, prescription coinsurance and prescription copays. In-network and out-of-network expenses are combined. This is separate from the annual medical out-of-pocket maximum. Eligible prescription 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 ($1,500) to the family out-of-pocket maximum ($3,000). High Deductible Plan with HSA: 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 non-CVS pharmacy.			
Individual	$1,500 per person (prescription drug out-of-pocket maximum)		$5,000 in-network/$7,500 out-of-network Includes both medical and prescription drug expenses
Maximum per family	$3,000 family maximum (prescription drug out-of-pocket maximum)		$10,000 ($6,850 per individual) in-network/ $$15,000 ($15,000 per individual) out-of-network Includes both medical and prescription drug expenses
Copay/Coinsurance — In-Network Retail Pharmacy Copay/coinsurance for up to a 31-day supply at an in-network retail pharmacy (including Target pharmacies), after you meet your deductible. You may have the same maintenance prescription filled up to three times at a non-CVS pharmacy; on the fourth fill, you will pay 100% of the cost of the medication. However, maintenance medication will be available through a CVS pharmacy or through Mail Service for your 90-day copay.[2]			
Generic drug[2]	$10		
Preferred brand-name drug[3]	$30		
Non-preferred brand-name drug	50% of the cost of the drug, with a minimum payment of $50, to a maximum of $150. If the cost of the drug is less than $50, you will pay the cost of the prescription drug.		
Certain preventive care drugs as required under ACA	Generics and Single Source Brands: 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		

	Prescription Drug Benefits		
	In-Network Only Plan	Choice Plan	High Deductible Plan with HSA[1]
Copay/Coinsurance — Mail Service Program or Maintenance Choice Program Copay/coinsurance for a 90-day supply through the CVS Caremark Mail Service program or Maintenance Choice program (through a CVS pharmacy) after you meet your deductible.			
Generic drug[2]	$20		
Preferred brand-name drug[3]	$75		
Non-preferred brand-name drug	50% of the cost of the drug, with a minimum payment of $125, to a maximum of $375		
Certain preventive care drugs as required by ACA	Generics and Single Source Brands: 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		
Copay/Coinsurance — Specialty Medication Copay/coinsurance for a 31-day supply of specialty medication dispensed through the CVS Specialty Pharmacy after you meet your deductible.[4] See the PrudentRx Copay Program on page 159 for information about how this program may affect your cost share for eligible specialty medications.			
Generic drug[2, 4]	$20		
Preferred brand-name drug[3, 4]	25% of the cost of the drug, with a minimum payment of $50, to a maximum of $150		
Non-preferred brand-name drug4	50% of the cost of the drug, with a minimum payment of $100, to a maximum of $250		
Out-of-Network Benefits			
Benefits at an out-of-network pharmacy	Reimbursed at the contracted rate after you have met the annual deductible and paid the applicable copay		
Lifetime maximum benefit for fertility drugs	Fertility drugs are limited to $7,500 per lifetime per covered person		

1 In the High Deductible Plan with HSA, you must meet your combined medical/prescription drug deductible before the Program will pay benefits, except for certain preventive drugs. To determine whether your medication is considered preventive, visit www.caremark.com. Your cost for these preventive drugs is the applicable copay or coinsurance, which will count toward your out-of-pocket maximum.

2 The use of generic equivalents whenever possible (through both the retail and CVS Caremark Mail Service programs) is more cost-effective. Ask your medical professional about this distinction. If you or your doctor requests 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 copay for the generic drug Pharmacy and/or CVS Caremark Mail Service Dispense as Written (DAW) penalty amounts do not count toward your pharmacy or medical plan's annual deductible or out-of-pocket maximum.

3 Citi does not determine preferred brand-name drugs. Rather, CVS Caremark 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 CVS Caremark Customer Care at 1 (844) 214-6601 or visit www.caremark.com for a copy of its Preferred Formulary (updated at least quarterly).

4 You are required to fill a specialty prescription through CVS Specialty Pharmacy. However, specialty prescriptions can be dropped off or picked up at a CVS retail pharmacy (yet they typically take more time to fill than non-specialty prescriptions). In the event of an emergency, please contact CVS Specialty Pharmacy Services to fill the prescription. You will be charged only the applicable retail/specialty copay.

Note: For the In-Network Only Plan and Choice Plan, pharmacy and/or CVS Caremark Mail Service copays 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. See "PrudentRx Copay Program" on page 159 for In-Network Only Plan and Choice Plan details.

Meeting Your Deductible

When you buy a prescription drug, you must meet the applicable deductible (individual or family) before the Program will pay benefits. Keep in mind, however, that you will only be required to pay the negotiated price at network pharmacies regardless of whether you have met your deductible.

For answers to your questions about the applicable deductibles, call CVS Caremark Customer Care at 1 (844) 214-6601.

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 In-Network Only Plan and Choice Plan. 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 medication through a non-CVS pharmacy.

There is a combined medical and prescription drug out-of-pocket maximum under the High Deductible Plan with HSA of $5,000 individual and $10,000 ($6,850 per individual) family in-network ($7,500 individual and $15,000 family out-of-network). This amount includes your medical/prescription drug deductible, coinsurance and copays. This represents the most you will have to pay out of your own pocket in a plan year.

Note: For in-network services under the High Deductible Plan with HSA, the family out-of-pocket maximum is $10,000, but each of your covered family members has an individual out-of-pocket maximum of only $6,850. After reaching that amount, your plan will cover 100% of that individual's in-network health care expenses for the rest of the year. Once the $10,000 family in-network out-of-pocket maximum is met, your plan will cover 100% of the entire family's in-network health care expenses for the rest of the year.

For answers to your questions about the out-of-pocket maximum, call CVS Caremark Customer Care at 1 (844) 214-6601.

Caremark Cost Savings Program

Through the Caremark Cost Saver program, you will receive automatic access to discounted prices on generic prescription drugs through GoodRx. When you submit a prescription to be filled, your Caremark benefits and any available GoodRx discounts will be applied to ensure you pay the lowest available price. The amount you pay will automatically be applied to your plan's prescription deductible and out-of-pocket maximum. This program applies to generic medications only and will be part of the prescription drug coverage included with the In-network Only Plan, Choice Plan, and High Deductible Plan with HSA. Note: The Caremark Cost Saver program is not available in Florida.

Retail Network Pharmacies with CVS Caremark

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 (including those within a Target) that participate in the CVS Caremark network and obtain up to a 31-day supply for your copay (once you meet your deductible).

For some drugs to be covered, your doctor may need to provide additional documentation. Prescriptions may be screened for specific requirements and must be related to the diagnosis for which they are prescribed.

To find out whether a pharmacy participates in the CVS Caremark network:

- Ask your pharmacist;
- Visit www.caremark.com to access the pharmacy locator;
- Download the CVS Caremark free mobile app from your device's app store (search for "CVS Caremark"); or
- Call CVS Caremark Customer Care at 1 (844) 214-6601.

A network pharmacy will accept your prescription and prescription drug ID card and, once you have met your deductible, will charge you the appropriate copay/coinsurance for a covered drug. Your copay/coinsurance will be based on whether your prescription is for a generic drug, a preferred brand-name drug on the CVS Caremark 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 165 for more information.

Using Your Prescription Drug ID Card

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

Upon your enrollment, CVS Caremark will receive your eligibility information. If you do not have an ID card, please ask your pharmacist to contact CVS Caremark so they can attempt to process the prescription through your pharmacy insurance. You can print out a temporary ID card online at www.caremark.com You can also download the CVS Caremark mobile app to access your virtual ID card.

If you do not use your ID card at network pharmacies, you must pay the entire cost of the prescription drug and then submit a claim form to be reimbursed. You will be reimbursed according to the CVS Caremark contracted rate for the covered prescription drug after you have met the annual deductible and paid the applicable copay. Submissions for reimbursement can be processed by utilizing the Caremark web portal (Caremark.com), the Caremark mobile app (available for Android and Apple), or through a claim form. To obtain a claim form, visit "Forms and Documents" on citibenefits.com.

Send all completed claim forms to:

CVS Caremark Pharmacy
P.O. Box 52136
Phoenix, Arizona 85072-2136

CVS Caremark Mail Service

Through CVS Caremark Mail Service, you can purchase up to a 90-day supply of medication at one time and have it shipped directly to your home. You will make one home-delivery copay for each prescription drug or refill after you first meet your deductible and save money.

The Convenience of Mail Service

Receive up to a 90-day supply of maintenance medications delivered to your home and save money by enrolling in your prescription drug plan's mail Service program. To enroll in CVS Caremark Mail Service, visit www.caremark.com, or call 1 (844) 214-6601.

When you use CVS Caremark Mail Service:

- Your medications are dispensed by one of the CVS Caremark Mail Service pharmacies and delivered to your home.
- Medications are shipped by standard delivery (7 – 10 business days, including shipping time) at no cost to you. You can also request express shipping for an additional cost. (Next day or second day express shipping options are available.). Please note that processing requires 1-2 business days for refills: 4 – 5 business days for new prescriptions in addition to express shipping time.
- You can order and track your refills online at www.caremark.com or via the CVS Caremark mobile app. You can also call CVS Caremark at 1 (844) 214-6601 to order your refill by telephone.
- Registered pharmacists are available 24/7 for consultations.

If you are a first time Mail Service user, you can get started by using the Fast Start program. You can dial 1 (844) 214-6601 and speak to a CVS Caremark representative who will gather important information and contact your physician to obtain a 90-day prescription on your behalf.

Please note that CVS Caremark does not accept manufacturer coupons for prescriptions filled through the Mail Service pharmacy.

CVS Caremark Maintenance Choice® Program

Maintenance Choice is a program available to you that provides added convenience in filling your maintenance drugs. You may obtain a 90-day prescription at a CVS pharmacy or Costco Pharmacy. Keep in mind that the prescription must be written to dispense in a 90-day supply, plus any appropriate refills.

When you purchase prescriptions through the CVS Caremark Maintenance Choice® Program, you pay the appropriate deductible and/or coinsurance and receive up to a 90-day supply of your medication.

Choose one of four ways to start filling your 90-day prescriptions through CVS Caremark:

1. At a CVS or Costco location -- Take your prescription to a CVS pharmacy or Costco Pharmacy
2. By phone -- Call CVS Caremark Customer Care at 1 (844) 214-6601
3. By mail -- Fill out and return a Mail Service order form. You can download one from the CVS Caremark website, www.caremark.com, or request one from CVS Caremark Customer Care
4. Online: Visit www.caremark.com and log in. You may then request a new Mail Service prescription from your doctor using "Request a Prescription with Fast Start."

If you are currently receiving prescription medications through a program other than the CVS Caremark Maintenance Choice® Program or the CVS Mail Service Pharmacy, ask your doctor to write a new prescription (for up to a 90-day supply plus refills). After your third fill of a 30-day supply of a maintenance medication, you will be subject to the full cost of your prescription drug if you do not fill through the CVS Mail Service Pharmacy or the CVS Maintenance Choice® Program.

CVS Specialty Medication with CVS Caremark

The CVS Caremark 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. You are required to fill the prescription through CVS Specialty Pharmacy. However, specialty prescriptions can be dropped off or picked up at a CVS retail pharmacy (they typically take more time to fill than non-specialty prescriptions). In the event of an emergency, please contact CVS Specialty Pharmacy Services to fill the prescription. Prescriptions sent to CVS Caremark Mail Service that should be filled by the Specialty Pharmacy will be forwarded. Specialty medications purchased through the CVS Specialty Pharmacy are limited to a 31-day supply or less. It's important to know that prescriptions for specialty medications take longer to fill than traditional medications due to added steps and approvals.

The CVS Specialty Pharmacy offers the following:

- Once you are using the program, the CVS Specialty Pharmacy 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, or to a CVS pharmacy of your choice, within 48 hours of ordering.
- You are not charged for needles, syringes, bandages or any supplies needed for your injection program.
- A team of representatives is available to take your calls, and you can consult 24/7 with a pharmacist or nurse experienced in injectable medications.
- The CVS Specialty Pharmacy will send monthly refill reminders to you.

To learn more about CVS Caremark's Specialty Pharmacy services, including the cost of your prescription drugs, call 1 (844) 214-6601.

CVS Caremark AccordantCare Health Services

The AccordantCare program is designed to help members find the answers and support they need to manage their health care needs and maximize their overall health status. This program is a voluntary, no-cost service that offers covered employees and dependents with one of eight complex and chronic conditions who fill their specialty medications through CVS Specialty with the opportunity to work with CVS Caremark AccordantCare Health Management Nurses.

AccordantCare registered nurse care managers serve as liaisons and advocates, facilitating relationships between members, physicians, specialists, insurance companies and employers to ensure high-quality care delivery within realistic cost-containment strategies. AccordantCare nurses can help identify gaps in care, improve patient experience and outcomes, reduce costs, and avoid disease complications and hospitalizations. Care managers continually evaluate and coordinate treatment progress to make sure that members receive the most appropriate care for their individual needs. Covered conditions are:

- Crohn's disease;
- Cystic fibrosis;
- Gaucher disease;
- Hemophilia;
- Hereditary angioedema (HAE)
- Multiple sclerosis;
- Rheumatoid arthritis;
- Systemic lupus erythematosus; and
- Ulcerative colitis.

Specialty Medication Copayment Assistance

PrudentRx Copay Program

You and your family will be eligible to participate in the PrudentRx Copay Program for certain specialty medications from drug manufacturers. PrudentRx reduces your cost share for eligible medications thereby reducing your out-of-pocket expenses. The PrudentRx Copay Program assists members by helping them enroll in manufacturer's copay assistance programs.

If you are not enrolled in the PrudentRx program, medications in the specialty tier will be subject to a 30% coinsurance on specialty medications that are eligible for the Prudent Rx program, and the amount may not count towards the deductible or out-of-pocket maximum. However, enrolled members who get a copay card for their specialty medication (if applicable) will have a $0 out-of-pocket coinsurance for their prescriptions covered under the PrudentRx Copay Program. Note, you must first satisfy the annual deductible under the High Deductible Health Plan with HSA.

If you currently take one or more medications included in the PrudentRx Program Drug List (available at https://www.prudentrx.com/SpecialtyDrugList/; this list is subject to change), you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication, including how to enroll. If you take one or more eligible specialty medications, you must speak with a representative from PrudentRx to register for the specialty medication copay assistance program.

If you or a covered family member are not currently taking but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx directly or they will contact you the day after your applicable prescription is filled through CVS Specialty Pharmacy, so you can take full advantage of the PrudentRx program. PrudentRx can be reached at 1 (800) 578-4403 to address any questions regarding the PrudentRx Copay Program. The CVS Specialty pharmacy may also transfer you to PrudentRx when filling your prescription.

The amount that a participant is required to pay for certain specialty medications that are not subject to special treatment under the Affordable Care Act (not determined to be "essential health benefits" related to prescription drugs) will not count towards the Plan's out-of-pocket maximum, regardless of the payment source (the participant or the manufacturer copayment assistance program).

For questions about the PrudentRx Copay Program, please call 1 (800) 578-4403.

CVS Health Pharmacy Advisor Support Program

This program helps individuals with chronic conditions improve their medication adherence and close gaps in care. You may consult a CVS pharmacist at a time that's convenient for you for quick, confidential advice, information about medications and their effects on your body and guidance to help you stay on track with your medications.

Dispense as Written (DAW) Solutions

The Dispense as Written Solutions program is 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 or your doctor chooses the brand-name drug when a generic exists, you must pay the difference in cost between the brand-name drug and the generic drug (the "penalty") in addition to your copay. This charge will be applied regardless of whether the doctor or you require the brand-name drug to be dispensed.

Note that pharmacy and/or CVS Caremark Mail Service Dispense as Written (DAW) penalty amounts do not count toward your pharmacy or medical plan's annual deductible or out-of-pocket maximum.

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 whether your prescription qualifies for step therapy or is subject to limitations, call CVS Caremark at 1 (844) 214-6601. Participation in this program is optional.

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 whether 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 Mail Service.
2. The pharmacist enters the prescription information into the CVS Caremark information system.
3. The claim is submitted for processing — the CVS Caremark system automatically looks back at the member's claim history to see if the member had a prescription filled in that time period (typically 130 days) for the alternative drug.
4. If a claim for an alternative, lower cost 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 or 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 regarding whether the request has been approved or denied.

Call CVS Caremark at 1 (844) 214-6601 or www.caremark.com to obtain information about whether your medication requires step therapy and/or about the applicable copay for the generic, preferred brand or non-preferred category of drug.

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 CVS Caremark 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 CVS Caremark

For you to purchase certain medications or to receive more than an allowable quantity of some medications, your pharmacist must receive prior authorization from CVS Caremark 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 whether your medication requires prior authorization or is subject to a quantity limit, call CVS Caremark at 1 (844) 214-6601 or visit the CVS Caremark website at www.caremark.com. Your pharmacist can also determine whether 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 (844) 214-6601. After your physician provides the required information, CVS Caremark will review your case, which typically takes one to two business days. Once the review is completed, CVS Caremark 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 CVS Caremark

Under certain circumstances, you and your physician may request that CVS Caremark perform a medical review of your medications. For additional information and instructions on how your physician can request a review, call CVS Caremark at 1 (844) 214-6601.

Transform Diabetes Care® Program

If you or a covered dependent are enrolled in a Citi medical plan, have diabetes and meet the standard requirements, CVS Health may contact you to discuss your diabetes management and the Transform Diabetes Care® Program. The program offers three key components:

- A personalized blood glucose meter to meet your specific needs;
- A smart analytics platform that provides predictive and personalized insights; and
- Virtual coaching from Certified Diabetes Educators.

This approach encourages more frequent blood glucose checks, provides just-in-time outreach from Certified Diabetes Educators and automates the often-cumbersome task of ordering supplies and manually tracking blood glucose readings. Most importantly, participants receive personalized, real-time information that can enable more confident self-management and improved glycemic control.

Opioid Management Program

The Opioid Management Program limits the quantity of opioids and requires step therapy and is designed to (i) help improve management of opioid use; and (ii) reduce potential misuse/abuse. It is aligned with the Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention (CDC). The Program uses the CDC criteria of Morphine Milligram Equivalent (MME) to limit the quantity of opioid products. Prior authorization requests can be made if your doctor believes the dose should exceed the MME within the CDC recommendation. The Opioid Management Program is not intended to be applicable to cancer treatment or palliative end-of-life care.

High Deductible Plan with HSA Information

The High Deductible Plan with HSA covers the cost of certain preventive drugs without having to meet a deductible. You will pay the applicable copay or coinsurance, which will count toward your combined medical/prescription drug out-of-pocket maximum.

For a list of these preventive medications, call CVS Caremark at 1 (844) 214-6601. You can also visit www.caremark.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 (for members covered under the Citi medical and prescription drug plan only; no coverage is provided for a donor who is not covered under the Plan);
- Certain drugs used for hormone therapy such as testosterone, progesterone, and GnRH agonists (for FTtM) and estrogen, antiandrogens, and GnRH agonist (for MtF);
- Legend vitamins;
- Amphetamines used for ADHD, through age 18;
- Drugs to treat impotency, for males (quantity limits apply);
- Retin-A/Avita (cream only), through age 34; and
- Retin-A (gel), through age 34.

Some drugs require prior authorization, such as (this list is not all-inclusive):

- Legend anti-obesity preparations;
- Disposable insulin pumps and continuous blood glucose monitors
- 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, as indicated below, 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 and generic drugs are subject to the applicable copay or deductible.

	Criteria
Aspirin (for preeclampsia)	• Generic OTC with prescription • 81 mg • Females age 12 to 59
Bowel preps	• Generic and Single source brands prescription drugs • Adults (age 45 to 75)

Health Care Reform In compliance with the Affordable Care Act, certain prescribed drugs, as indicated below, 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 and generic drugs are subject to the applicable copay or deductible.	
	Criteria
Contraceptive methods for women	• Generic and single source brands barrier methods (diaphragm and cervical cap) • Generic and single source brands hormonal contraceptives • Generic and single source brands emergency contraceptives • Prescribed OTC generic contraceptives
Fluoride (oral formulations)	• Brand and generic single ingredient prescription drugs • Children 5 years of age and younger
Folic acid	• Generic OTC (with prescription) and generic prescription drugs • Women through age 55
Smoking cessation	• OTC (with prescription) and prescription drugs • Adults age 18 and over
Tamoxifen and Raloxifene for breast cancer prevention	• Generic prescription drugs • Women ages 35 and over for primary prevention only (physician or member must request no copay)
Preexposure Prophylaxis	• Generic Truvada (Emtricitabine/tenofovir disoproxil fumarate 200mg-300mg with prescription) • Preventative use only • Quantity limit (1 tab/day)
Statins	• Generic low-to-moderate-dose statins for members ages 40 to 75

Other Limits

Coverage limits apply to some categories of drugs. These categories include but are not limited to:

- Fertility medications (subject to a lifetime maximum benefit limit of $7,500 per covered person);
- 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 2025 CVS Caremark Preferred Drug List Exclusions at Citi Benefits Online. You 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 coverage for a specific drug, please call CVS Caremark Customer Care at 1 (844) 214-6601.

General exclusions include:

- 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 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, non-disposable insulin pumps and supplies (covered under medical benefit);
- 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®);
- Deuxis and Vimovo;
- Injectable 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 CVS Caremark

The amount of time CVS Caremark 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]
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.

CVS Caremark First-Level Appeal

If you disagree with a claim determination after following the steps outlined in "CVS Caremark Urgent Claim Appeals" on page 167, 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 preservice 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.

CVS Caremark 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 is 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.

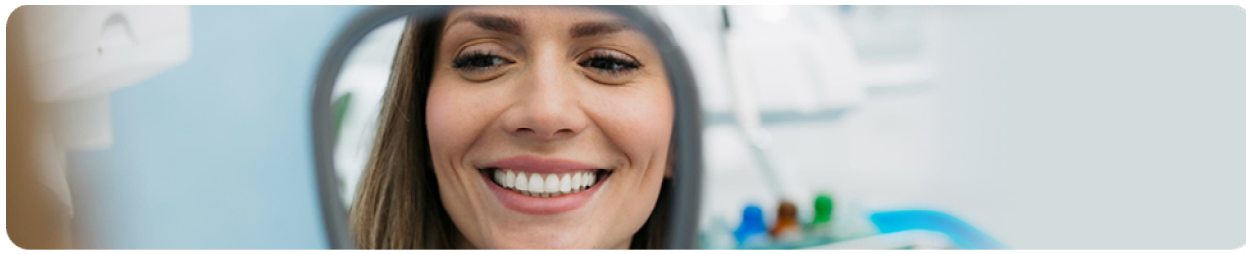
A Final External Review Decision is a determination by an ERO at the conclusion of an External Review.

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:

CVS Caremark Appeal Program
P.O. Box 52136
Phoenix, Arizona 85072-2136

Telephone: 1 (800) 294-5979
Fax: 1 (888) 836-0730



Dental

The Citigroup Dental Benefit Plan (the "Dental Plan" or the "Plan") offers two options to provide dental care for you and your eligible dependents (including your spouse/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.

Need Help Finding a Dentist?

Contact Health Advocate at 1 (866) 449-9933 or visit your plan provider's website Cigna or MetLife through My Total Compensation and Benefits.

For more information on the dental coverage available, see the MetLife PDP fact sheet and the Cigna Dental HMO fact sheet available on **www.citibenefits.com** under "Forms and Documents."

Quick Tips

Dental Plan Differences

The MetLife PDP costs you more per paycheck than the Cigna Dental HMO. However, the MetLife PDP gives you the flexibility to see any dentist you choose. When you visit an in-network dentist, you will pay a discounted fee. While the Cigna Dental HMO costs less than the MetLife PDP, 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 "MetLife Preferred Dentist Program (MetLife PDP)" on page 172 and "Cigna Dental HMO" beginning on page 177 for more information and plan details.

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 HCSA or LPSA 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 Accounts* section.

If you choose medical coverage under the High Deductible Plan with HSA, you can establish a Health Savings Account (HSA) and make contributions to a LPSA, which can both be used for eligible dental expenses.

For details, see "Health Savings Accounts (HSAs)" in the Citigroup *Medical* section.

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Dental Options at a Glance

The Plan provisions (deductibles, coinsurance and annual and lifetime maximums) will be the same whether or not your dentist is a PDP provider as shown in the table below. However, using preferred dentists can reduce your out-of-pocket costs.

	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	Copay when you use your network dentist. See “Patient Charge Schedule” on page 179 for more information.
Major restorative services such as crowns, inlays/onlays, bridges and dentures	50% after deductible	Copay when you use your network dentist. See “Patient Charge Schedule” on page 179 for more information.
Orthodontia	50% after deductible	Copay when you use your network dentist. See “Patient Charge Schedule” on page 179 for more information.
Lifetime orthodontia limit for children and adults	$3,000 per person	Coverage limited to 24 months of treatment
Temporomandibular joint (TMJ) treatment excluding surgery	50% after deductible if not the result of an accident (covered under orthodontia)	100% paid for oral evaluation; copay for other related services when you use your network dentist
Implants	Subject to “dental necessity”	Copay 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 the 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) Cigna 24 (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 online at www.citibenefits.com under “Forms and Documents.”

MetLife Preferred Dentist Program (MetLife 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;
- 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 My Total Compensation and Benefits at www.totalcomponline.com; or
- Call 1 (888) 830-7380 for a provider directory.

When You Schedule 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.

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). The annual maximum benefit does not apply to preventive and diagnostic services. However, the annual maximum benefit does apply to basic and major services. In addition, 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 the maximum allowed amount (MAA) charges. The MetLife PDP determines the 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 "completion date" is considered the date the charge is incurred. The claim will be paid in a lump sum (excluding orthodontia). For example, the completion date is considered for:

- Root canal therapy as the date the pulp chamber was closed;
- A crown as the date the tooth was completed for the crown;
- Partial and complete dentures as the date of completion; and
- Fixed bridgework as the date the abutment teeth were completed 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 = $166.66 × 50% benefit = $83.33;
- Therefore, the monthly payment will be $83.33.

A monthly payment of $83.33 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 is 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 $2,500.

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 or a maximum of three cleanings per calendar year for employees enrolled in a Healthy Pregnancy Program through Anthem or Aetna, Citi's Diabetes Management Program or Citi's Disease Management Program. Note: members eligible to receive a third cleaning are required to submit a Preventative Plus Form completed by their provider with the claim to receive reimbursement. This form is available online at www.citibenefits.com or by calling MetLife at 1 (888) 830-7380.
- Fluoride treatments to age 15: maximum of two applications per calendar year;
- Space maintainers to age 19;
- Full mouth series and panoramic X-rays: once every 60 months;
- Bitewing X-rays: up to one set per calendar year for adults and two sets per calendar year for children;
- Sealants: on the 1st and 2nd permanent molars only, to age 19; one application per tooth every 60 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 per quad;
- Repair prosthetics: no limit;
- Recementing (crowns, inlays, onlays, bridgework or dentures): no limit;
- Addition of teeth to existing partial or full denture, or addition of teeth to existing fixed bridgework; bridgework must be at least five years old and unserviceable); limited to once every five years;
- Denture relining and rebasing: once every 36 months if 6 months after initial installation of the denture;
- Adjustments to removable dentures made within the first six months of installation;
- 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;

- 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; bridgework must be at least five years old and unserviceable): limited to once every five years; and
- Dental implants (subject to medical necessity and consultant review): medical necessity, as determined by the Claims Administrator, is based on the number and distribution of all missing, unreplaced teeth in the arch, as well as the overall periodontal condition of the remaining normal teeth.

Orthodontia Services

- Orthodontic X-rays;
- Evaluation;
- Treatment plan and record;
- Services or supplies to prevent, diagnose or correct a misalignment of the teeth, bite, jaws or jaw-joint relationship;
- Removable and/or fixed appliance(s) insertion for interceptive 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. Benefits are payable if this is completed while covered since payment is based on completion date;
  - 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;
- 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.

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 183.

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. (Note: Coverage may vary slightly by state depending on where you are located. Members located in AK, DC, IN, LA, MN, NV, OK, OR, SC, UT, and WA should refer to the Cigna plan documents for a list of exceptions and limitations available in the "Forms and Documents" section at citibenefits.com).

As a Cigna Dental HMO Plan member, you may be eligible for various discounts, benefits and other considerations to promote your general health and well-being. Upon enrollment, members will receive a welcome kit, ID card and copy of Cigna plan documents. Visit the Cigna website at www.myCigna.com for more information.

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 179 for more information. You can obtain a schedule of charges when you enroll in the Cigna Dental HMO by calling Cigna Dental at 1 (800) Cigna24 (1 (800) 244-6224) or by visiting www.myCigna.com/dental. It is also available at www.citibenefits.com.

Please note: In the event this document conflicts with Cigna's plan documents, including applicable insurance certificates, service agreements, policies and patient charge schedules, Cigna's plan documents and administration will prevail.

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 www.Cigna.com.

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. Coverage may vary slightly by state depending on where you are located. (Members located in AK, DC, IN, LA, MN, NV, OK, OR, SC, UT, and WA should refer to the Cigna plan documents for a list of exceptions and limitations available in the "Forms and Documents" section at citibenefits.com).

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 copay; 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 13 to be treated by a network pediatric dentist. Exceptions for coverage at the network pediatric dentist for children age 13 and 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 you do not choose a network dentist, you will be placed in a "hold for assignment" status and notified to contact Cigna Dental. Please note that if you live in California, Illinois, Maryland or Texas, you will be automatically assigned a network dentist if you do not elect one during enrollment.

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 approved 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 approves payment. Treatment by a network specialist must begin within 90 days from the date of Cigna Dental's approval. If you are unable to obtain treatment within the 90-day period, call Customer Service 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 13. Services performed by a pediatric dentist after the child reaches age 13 are not covered.

You should verify with the network specialist that your treatment plan has been approved for payment by Cigna Dental before treatment begins. If you receive specialty care and payment is not approved 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, visit www.myCigna.com or call Customer Service at 1 (800) Cigna24 (1 (800) 244-6224). Transfers will be effective the first day of the month following the day 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 generally not covered, and patients will be charged the dentist's usual fee for those procedures. Please see your Patient Charge Schedule (according to your state of residence) for a complete list of exclusions and exceptions. 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 by calling Cigna Dental at 1 (800) Cigna24 (1 (800) 244-6224) or by visiting www.myCigna.com (if you are already a member). It is also available under the Forms and Documents section of Citibenefts.com.

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 results 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 to 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
PO 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.

Customer Service

If you have any questions or concerns about the Cigna Dental HMO, call a Customer Service 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 Customer Service 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 approval 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 13th 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 13th birthday.
- Oral surgery: The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons. 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 Customer Service 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) Cigna24 (1 (800) 244-6224) for more information.

Conversion to an Individual Policy

You may have the right to convert your Cigna Dental HMO coverage to an individual policy after you terminate employment with Citi. For more information, contact Cigna at 1 (800) Cigna-24 to obtain information about how to apply for a conversion policy.

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 or 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 179);
- 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 a no-fault auto or insured motorist policy; 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 184.

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 nonpayment 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 nonpayment of premiums.

Disclosure Statement

Cigna Dental refers to the following operating subsidiaries of Cigna Corporation: Connecticut General Life Insurance Company and Cigna Dental Health, Inc., and its operating subsidiaries. The Cigna Dental Care Plan is provided by Cigna Dental Health Plan of Arizona, Inc.; Cigna Dental Health of California, Inc.; Cigna Dental Health of Colorado, Inc.; Cigna Dental Health of Delaware, Inc.; Cigna Dental Health of Florida, Inc., a prepaid limited health services organization licensed under Chapter 636, Florida Statutes; Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska); Cigna Dental Health of Kentucky, Inc.; Cigna Dental Health of Maryland, Inc.; Cigna Dental Health of Missouri, Inc.; Cigna Dental Health of New Jersey, Inc.; Cigna Dental Health of North Carolina, Inc.; Cigna Dental Health of Ohio, Inc.; Cigna Dental Health of Pennsylvania, Inc.; Cigna Dental Health of Texas, Inc.; 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]
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; 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 Preferred Dental Plan. The Claims Administrator's decisions are conclusive and binding. The Claims Administrator's decision is based only on whether 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 the Employee Retirement Income Security Act of 1974, as amended (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 Customer Service 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 Customer Service 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 appeal 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 in-network and out-of-network benefits. For example, you can obtain an annual eye exam from an in-network provider while purchasing frames and lenses out of network. However, before taking a prescription from one vendor to be filled at another vendor, you should confirm that the prescription will be honored 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 at **www.citibenefits.com** under "Forms and Documents."

Save Money with Spending Accounts

Take advantage of the *Health Care Spending Account or Limited Purpose Health Care Spending Account* to pay for eligible medical, dental and vision expenses with before-tax dollars. For more information, visit the spending account website through My Total Compensation and Benefits. From the main page, click on "TRIP and Spending Accounts."

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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 calendar year
Frames and lenses	• One pair of frames and lenses per calendar year • Standard plastic lenses (single vision, bifocal, trifocal and lenticular) covered at 100% once every calendar year • Standard progressive lenses covered at 100% • Premium progressive lenses covered at 100% after copay: – Tier 1: $20 copay, – Tier 2: $30 copay, – Tier 3: $45 copay. – Tier 4: $120 copay • Lens enhancements covered at 100% including: UV treatment, tint (solid and gradient), standard plastic scratch coating, standard polycarbonate, standard anti-reflective coating, photogrey glass, oversize lenses, intermediate vision lenses, blended bifocals, and polarized • Lens enhancements covered at 100% after a $30 copay: Hi-index lenses, photocromatic / transitions plastic • Frame allowance: The Plan pays $150 towards any frame available at the provider location once every calendar year; additional 20% off any 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 calendar year in lieu of eyeglasses • The Plan pays $130 towards elective conventional or disposable contact lenses; receive an additional 15% discount off any balance over $130 allowance for conventional contact lenses • Fit and follow up: Pay no more than $40 for standard contact lens fitting and receive a 10% discount off the retail price for premium contact lenses • 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 calendar year
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 • Premium anti-reflective coating: up to $46
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 an out-of-network provider 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 select "Find a Provider." 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 190 for more information on submitting a claim.

Online Providers

The Vision Plan includes in-network, on-line providers for your convenience. Register at www.contactsdirect.com, www.glasses.com, www.ray-ban.com, www.targetoptical.com or www.lenscrafters.com and shop for your favorite glasses or contacts. Your benefits will be applied during check out and your purchase shipped directly to the location you choose. Visit www.aetnavision.com and look for the "special offers" page to find discounts on shipping and other promo codes before shopping.

In-Network Benefits

In-network benefits include:

- Routine eye exam: one eye exam, including dilation, when professionally indicated; each calendar year covered at 100%;
- Frame and spectacle lenses: one pair of eyeglasses each calendar year; frame allowance of $150 per calendar year; members pay 20% 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 Plan 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 calendar year 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; standard polycarbonate lenses; oversized lenses; ultraviolet coating; blended bifocal segment lenses; PGX (sun-sensitive) glass lenses; scratch-resistant coating; intermediate-vision lenses; and polarized lenses.

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

Mail-Order Contact Lenses

You can purchase replacement or additional pairs of contact lenses by calling the 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 Vision Plan will provide reimbursements of up to the following amounts:

- Routine eye exam: one eye exam, including dilation, when professionally indicated: reimbursable up to $50;
- Frame and spectacle lenses: one pair of eyeglasses each calendar year: reimbursable up to $100;
- Lenses: reimbursable up to $50 for single vision, up to $60 for bifocal, up to $90 for trifocal and up to $125 for lenticular;
- Progressive lenses: reimbursable up to $90;
- Anti-reflective coating: reimbursable up to $32 for standard, reimbursable up to $46 for premium Tier 1, Tier 2, and Tier 3;
- Contact lenses: reimbursable up to $130 if elective and up to $225 if medically necessary.

The following products are reimbursable as indicated: ultraviolet coating, up to $11; tinting of plastic lenses, up to $11; scratch-resistant coating, up to $11; standard polycarbonate lenses, up to $28; standard anti-reflective coating, up to $32; blended bifocal segment lenses, up to $25; photochromic/Transitions plastic lenses, up to $32; PGX (sun-sensitive) glass lenses, up to $35; polarized lenses, up to $56; and intermediate vision testing, up to $125.

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.citibenefits.com or Aetna at 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 claim, call the Vision Plan at 1 (877) 787-5354.

Laser Vision Correction

You will receive a discount of 15% off retail or 5% off promotional prices for laser vision correction services. In addition, featured LasikPlus providers offer special member prices from $695 to $1,895 per eye plus a free LASIK exam. The LASIK discount is only available from U.S. Laser Network by calling 1 (800) 422-6600.

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 Ave.
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 190 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.

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 an 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 circumstances, or a statement that such explanation will be provided free of charge upon request.

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 the 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. If your deadline to file an external review of your denied claim falls within the defined COVID-19 Outbreak Period and you have exceeded the deadlines outlined in your plan documents or denial notification, you may have additional time to submit your request.

For more information, contact your vision plan Claims Administrator to obtain additional information about the external review process and any related additional time to file your claim.

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

The Live Well at Citi Program is intended to help you improve your health and reduce health care costs.

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The Live Well at Citi Program

The Live Well at Citi Program is designed to help you and your family to improve your health. The program provides tools and resources to help you manage your health care and help you achieve your health goals.

As an incentive to participate in the program, you can also earn valuable Live Well Rewards, either in the form of reductions to your medical premiums or gift cards, or both — depending on whether you are enrolled in a Citi medical plan (details below).

Get Excited About Living Well!

Do you want to lose weight? Manage stress? Just feel better? Whether you're looking to improve or maintain your good health, the Live Well at Citi Program has something for you. Learn more at Citibenefits.com.

Earn Live Well Rewards all year long by completing healthy activities. The benefits of the Live Well at Citi Program vary by location; however, here are the components of the Live Well at Citi Program open to all U.S. employees:

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.	Health Advocate can be accessed 24/7 at 1 (866) 449-9933. Staff is available for assistance after hours and on weekends.
Live Well Health Assessment	An interactive health questionnaire, offered through Personify Health (formerly Virgin Pulse) that takes about 15 minutes to complete. It is designed to help you identify ways to improve your health	You can access Personify Health (formerly Virgin Pulse) via My Total Compensation and Benefits, online at https://landing.personifyhealth.com/LiveWell, or through the Personify Health app, which you can download to your Apple or Android smartphone. If you are a first time user, you must register with Personify Health to get started on the platform.
Live Well Healthy Activities	A variety of programs that address stress, nutrition, physical activity, weight management and back pain. You can speak with an expert Personify Health (formerly Virgin Pulse) 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.	You can access Personify Health (formerly Virgin Pulse) via My Total Compensation and Benefits, online at https://landing.personifyhealth.com/LiveWell, or through the Personify Health app, which you can download to your Apple or Android smartphone. If you are a first time user, you must register with Personify Health to get started on the platform.
Live Well Chronic Condition Management Programs	Programs for members enrolled in an Aetna or Anthem BlueCross BlueShield medical plan and who have a chronic health condition, such as heart disease or diabetes.	If you or a covered dependent meets program condition criteria, a nurse from your medical plan may invite you to participate.
Citi Medical Clinics	(See "Citi On-Site Medical Clinics" on page 204)	

Your Information Is Protected

The information you enter into your Health Assessment and the data in your personalized report are protected in accordance with the privacy and security rules under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). Personify Health adheres to HIPAA privacy and security guidelines that are designed to ensure that no one at Citi has access to your personalized data or results.

Health Advocate

Health Advocate is a free program available to you *and* your family — your spouse/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 the 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 is a phone-based resource that helps you compare costs of medical services and procedures.

Many people do not realize that the cost of a medical procedure can vary by over 100%, even within the same geographic area. With consumers picking up more of the cost of their health care, they need clear, actionable, preservice information to help project their out-of-pocket costs.

Health Advocate's HCE+ pricing transparency tool compares the costs of hundreds of common health care 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 health care dollars and reduce health care costs.

Easy Access

Available free to all Citi employees (regardless of whether you are enrolled in a medical plan), the HCE+ tool can be accessed by calling a Personal Health Advocate at 1 (866) 449-9933, who will 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 benefits eligible employees. You do not need to be enrolled in a medical plan offered by Citi to participate. Spouses/partners may also complete the Live Well Health Assessment, but only if they are enrolled in a medical plan offered by Citi.

Once you register with Personify Health (formerly Virgin Pulse), you can take the Health Assessment right from your phone or access the Health Assessment by visiting Your Benefits Resources™ (YBR™), available through My Total Compensation and Benefits. 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 Activities

The Live Well at Citi Program offers a number of resources to help you develop and maintain healthy habits. Live Well Healthy Activities, offered through Personify Health (formerly Virgin Pulse), include supportive online programs and tools that can help you achieve your wellness goals.

Personify Health provides access to great programs like:

- Phone coaching
- My Care Checklist
- Health Assessment
- Journeys® Digital Coaching
- Healthy Habit and Activity Tracking – you can sync a device or app for automatic tracking
- Tobacco cessation.

You'll also get programs, challenges and features that give you the choice, support and flexibility you need to reach your wellness goals like:

- Incentive Opportunities: Access the many new activities offered by Personify Health to earn rewards daily, weekly, and even monthly for things you do every day, like walking, working out, tracking calories and even sleeping!
- Daily Cards: Complete your cards every day and get quick tips that are personalized to your specific goals.
- Challenges: Participate in Personal Healthy Habit Challenges, Personal Step Challenges and Team Challenges. Set up challenges for yourself or gather a small group of team members or friends, and start your own group challenge whenever you want!
- Rewards Options: Redeem your wellness rewards through an expanded list of gift card options or donate your earned dollars to charities.

Use the Personify Health best-in-class app to customize your wellness activities to meet your individual interests and health goals. Sync your phone or tracking device and receive daily alerts and tips to help you complete your activities and earn incentives when and wherever it works for you.

Visit the Live Well at Citi page for more details on how to register, download the app and earn rewards through healthy activities.

Live Well Tobacco Cessation Program

The Live Well Tobacco Cessation Program is available to active, benefits eligible employees. You do not need to be enrolled in a medical plan offered by Citi to participate. Spouses/partners may also participate in the Live Well Tobacco Cessation Program, but only if they are enrolled in a medical plan offered by Citi. .

If you choose the Health Coaching option, your coach will work with you to identify the challenges you face when quitting and set goals to overcome them. You and your spouse/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 being 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 do not need to wait to be invited. To get started, log on to the Personify Health (formerly Virgin Pulse) platform or call Personify Health at 1 (855) 814-5595.

You can also complete a Journeys®, digital coaching focused on quitting tobacco use. (See below.)

Tobacco Attestation

If you and your spouse/partner are enrolled in Citi medical coverage during Annual Enrollment in 2024, you will have the opportunity to complete the Tobacco Attestation on Your Benefits Resources™. If during that time you indicate that you use tobacco products (including vapor products and all forms of smokeless tobacco products) or if you fail to complete the Tobacco Attestation before your enrollment deadline, you and your covered spouse/partner will each pay a $600 annual penalty on your health care coverage in 2025.

If you participate in the Live Well Tobacco Cessation Program in 2025 and you're paying the tobacco penalty, these payments will stop once you complete the Live Well Tobacco Cessation Program through Personify Health (within one to two pay cycles of program completion). If you complete the program before December 31, 2025, you will also receive a refund of the tobacco penalty payments that were assessed for 2025, before you completed the Tobacco Cessation Program.

Note: If you are age 18 or over and are enrolled in the Citi medical coverage, you may be eligible to receive generic over-the-counter and generic prescription drugs, or Chantix smoking cessation products at no cost to you.

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 2025.

Journeys® Digital Coaching

Digital coaching tools are online wellness programs, tailored to your interests that can help you make progress on health topics of your choosing by taking small steps toward your goals. The digital coaching tools can be accessed over the web or via your mobile device.

Want to exercise more? Better manage a health issue? You can use our digital coaching tool, Journeys, to make simple changes to your health, one small step at a time. You will earn Pulse Points when you complete a journey step and finish a whole journey.

Connect a Fitness Tracker

Sign up for a Personify Health (formerly Virgin Pulse) account online at https://landing.personifyhealth.com/LiveWell or download the Personify Health app to your Apple or Android smartphone. Connect your phone or a fitness tracker to get credit for your steps, active minutes and sleep. You can sync many devices and apps (Apple Watch, Fitbit, Apple Health, Google Health, etc.)

Health Coaching

Personify Health (formerly Virgin Pulse) 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.

Included Health: Expert Guidance. Expert Care.

You don't have to be enrolled in Citi medical coverage to use this free service. Included Health provides expert medical opinions and support for you and your family members, ensuring a personalized, all-in-one healthcare experience. Whether you need help finding top physicians in your area, understanding a new diagnosis or treatment, or seeking guidance on whether surgery is right for you, Included Health is here to assist you with such decisions.

Working with top doctors and specialists nationwide, Included Health identifies the highest-quality physicians tailored to your specific needs. You can find a high quality, in-network provider anytime, day or night, through the Included Health app.

Use Included Health whenever you or a family member needs assistance, especially if you're seeking a second opinion on a new or long-term health issue or treatment plan. To get started, visit https://includedhealth.com/livewell or download the Included Health app and follow the registration instructions. You can also reach out by phone at 1-888-306-7195. You will earn Pulse Points (one guidance reward per program year) for engaging in an Expert Medical Opinion and a reward for registering with Included Health.

You don't have to be enrolled in Citi medical coverage to use this free service. Included Health provides you and your family members with expert medical opinions and support to help ensure you always receive the best care possible. Whether you need help finding the best physician in your area, information about a new diagnosis or treatment or support deciding if surgery is right for you, Included Health will assist you with such decisions. Included Health works with top doctors and specialists across the country and identifies the highest quality physicians for your unique needs. You can find a high quality, in-network provider anytime, day or night, through the Included Health app.

Use Included Health any time, but especially if you need a second opinion on a new or long-term health issue or treatment plan. Sign up by visiting https://includedhealth.com/livewell. Just follow the instructions for registering. You will earn Pulse Points (one guidance reward per program year) for engaging in an Expert Medical Opinion and a reward for registering with Included Health

My Care Checklist

Keeping up with preventive care means fewer sick days, feeling your best and stopping costly conditions before they start. My Care Checklist is an easy way to keep track of your personal information and healthcare history and remind you when you are due for well visits, routine screenings and vaccinations.

Transform Diabetes Care

If you and your family are enrolled in a Citi medical plan and you or a family member has diabetes, you may be invited to participate in CVS's Transform Diabetes Care program. The program offers highly individualized support to help three key components:

- Blood glucose control through a connected blood glucose meter. A trained professional will follow-up with you if you have an out-of-range reading. Your results and a health summary report can be shared with your health care providers. ;
- Medication management including one-on-one counseling with a CVS pharmacist, notifications to your health care provider about gaps in your therapy and how to resolve the problem and medication management support tools; and
- Condition management including coaching with Certified Diabetes Educator, MinuteClinic diabetes preventive monitoring visits with results logged into your electronic health record, personalized educational tips and motivational messages integrated into your blood glucose meter and actionable health messaging delivered on your prescription bag label.

This approach encourages more frequent blood glucose checks, provides just-in-time outreach from Certified Diabetes Educators and automates the often-cumbersome task of ordering supplies and manually tracking blood glucose readings. Most importantly, participants receive personalized, real-time information that can enable more confident self-management and improved glycemic control.

Fertility Support

WINFertility offers industry leading fertility management services to help Anthem members receive the highest quality care and personal support along their fertility journey. If you're enrolled in an Anthem medical plan, you or your Anthem-enrolled spouse/partner can register with WINFertility to earn Pulse Points (one reward per program year).

Download the Anthem Engage App

The Anthem Engage app can help you take charge of your health and well-being. For example, you can check what is covered under your medical plan and how much services will cost to help you make more confident health care decisions. If you are enrolled in Citi's Anthem medical plan and registering your online account for the first time, be sure to register on the Engage app to earn Pulse Points.

Chronic Condition Management Programs

The Live Well Chronic Condition Management Program can help you manage a chronic condition, such as heart disease or diabetes. If you are invited to participate, you will work with a nurse from your medical plan and also earn Pulse Points up to once per program year (must be enrolled in Citi's Anthem or Aetna plan).

Maternity Care Management

Having support during your pregnancy can help provide a healthy start for both you and your baby. If you're enrolled in an Aetna or Anthem medical plan, complete a risk survey (Aetna) or an initial risk assessment (Anthem) and earn Pulse Points.

Take Advantage of Telehealth

Telehealth allows you to speak by phone or video with a board-certified doctor 24/7 for a diagnosis on minor, short-term issues, such as a fever or the flu. If you are enrolled in an Aetna or Anthem medical plan, visit the Teladoc website (Aetna) or LiveHealthOnline website (Anthem) to register for telehealth today. You'll earn Pulse Points when you register and when you complete a telehealth session (one session reward per program year).

Live Well Chronic Condition Management Programs

The Aetna and Anthem BlueCross BlueShield medical plans offered by Citi include access to Live Well Chronic Condition Management Programs for certain members. If you or a covered dependent meets 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);
- Pregnancy care;
- 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 Live Well Chronic Condition Management Programs that may be available to you.

Live Well Rewards

For the 2025 plan year, you can earn Live Well Rewards for activities such as exercising and participating in a health screening. You can even earn Rewards if you are not enrolled in a Citi medical plan, and your spouse/partner can earn them too. The Live Well at Citi Program can help you feel better and even spend less on health care in the long run.

	Healthy Activity	Your Reward	Who Can Participate
Take action to save on your health plan premiums in 2025			
Live Well Health Assessment	Take the Live Well Health Assessment between October 1 and November 15, 2024	Earn a $100 discount off your annual health plan premiums OR Employees can earn $100 in Live Well Rewards (redeemable for a gift card) if not enrolled in a Citi medical, dental or vision plan	Benefits eligible Citi employees; spouses/partners* who are enrolled in a Citi medical plan
Tobacco Attestation	Complete the Tobacco Attestation on Your Benefits Resources™ (YBR™), available through My Total Compensation and Benefits at www.totalcomponline.com, or complete the Live Well Tobacco Cessation Program in 2025 You'll see the attestation during your enrollment flow when you enroll in your benefits.	Avoid the $600 penalty per person (if enrolled in Citi medical coverage) if you are tobacco-free	Only Citi employees and spouses/partners who are enrolled in Citi medical coverage are subject to the tobacco penalty
Complete Healthy Activities in 2025 to earn gift card Rewards throughout the year			
Live Well Healthy Activities	Every step toward a healthier you counts! Earn Rewards if you: • Participate in Global Fitness Challenge • Track your sleep • Get a health screening • Register for Included Health and get a second opinion • Complete an online Journey or digital/phone coaching program • Complete a Financial Journey • Participate in Thrive Physical Therapy • And more!	You'll accumulate Personify Health (formerly Virgin Pulse) Points to unlock four levels of rewards—worth $70 each quarter—up to $280 a year! Plus, look for opportunities to earn and improve your health when you participate in the Global Community Day Reimagined and more! In total, you'll be able to earn over $500 in Live Well Rewards in 2025. Spouses/partners enrolled in a Citi medical plan can earn	• All Citi employees and spouses/partners who are enrolled in a Citi medical plan. • For Included Health, all Citi employees, and spouses/partners; enrolment in a Citi medical plan is not required.

	Healthy Activity	Your Reward	Who Can Participate
Take action to save on your health plan premiums in 2025			
More Opportunities to Earn Rewards	• Register for telehealth and complete one session • Take advantage of LiveWell Chronic Condition Management Programs • Take a survey on the Personify Health (formerly Virgin Pulse) website • And more!	more than $400 in Live Well Rewards, too!	• Citi employees and spouses/domestic partners enrolled in a Citi medical plan administered by Aetna or Anthem BlueCross BlueShield. • For LiveWell Chronic Condition Management Programs, selected employees and spouses/partners enrolled in a Citi medical plan administered by Aetna or Anthem BlueCross BlueShield.

* "Spouse/partner" includes legal spouse (regardless of gender, gender identity or expression), domestic partner and civil union partner.

After you take the Health Assessment, start completing Healthy Activities to earn Rewards.

All Citi employees, regardless of whether they are enrolled in a Citi medical plan and spouses/partners who are enrolled in a Citi medical plan can participate in healthy activities to accumulate Live Well Rewards points.

By completing healthy activities each quarter, you'll accumulate Personify Health Points to unlock four levels of rewards—worth $70 each quarter—up to $280 a year! Plus, look out for instant opportunities to earn and improve your health when you participate in Global Community Day Reimagined, complete a health screening and more! Look for "How to Earn" under the Home tab on web or click Rewards and 'Learn how to Earn More Points' on mobile for a complete list.

Each quarter, you can earn:

	Level 1	Level 2	Level 3	Level 4	
Points	1,000 points	5,000 points	12,000 points	20,000 points	Total Reward for the quarter ("Q"):
Live Well Reward	$10	$15	$20	$25	$70

Maximum Live Well Rewards earned by unlocking levels per year can be $280 ($70 X 4 quarters) plus any instant awards available throughout the year.

Example:

- If you reach Level 3 (12,000 points) in Q1, you will earn $45 in rewards (Level 1 = $10 + Level 2 = $15 + Level 3 = $20).
- At the end of Q1, your points will reset and you will begin Q2 with 0 points.
- If you reach Level 4 (20,000 points) in Q2 you will earn $70 in rewards (Level 1 = $10 + Level 2 = $15 + Level 3 = $20 + Level 4 = $25) on top of the $45 you earned in Q1.

Remember you can earn up to $70 in rewards each quarter – that's a maximum of $280 in rewards each year for unlocking levels.

For more details about each incentive visit https://www.citibenefits.com/Well-Being/Live-Well-at-Citi-Program#Overview.

Important Things to Note

- If you're enrolled in a Citi medical, dental or vision plan, you'll receive health plan premium discounts for completing your Live Well Health Assessment. If you are not enrolled in a Citi medical plan, you can earn $100 in gift cards by completing the Live Well Health Assessment.
- You can also earn gift card Rewards throughout the year for completing activities and earning points. Choose from a wide selection of gift cards to many popular retailers as well as the option to donate your Live Well Rewards to a number of different charities. Gift cards are considered taxable income. To compensate for the tax, Citi will "gross up" or issue payments approximating any tax you'll pay.
- You are eligible for the Health Assessment Reward if you were transferred from a Citi International Business or newly hired before October 1, 2024. 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/partner in Citi Benefits for the first time in 2025, your spouse/partner can earn a Live Well Reward of $100 by completing the Health Assessment by November 15, 2024.)
- If you use tobacco products, you will stop paying the penalty once you complete the Live Well Tobacco Cessation Program through Personify Health, either with a tobacco-cessation health coach or online through one of the tobacco-cessation-focused 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. To have your 2025 tobacco penalty payments stopped and receive your $600 refund, you must complete the Tobacco Cessation Program either by working with a health coach or by completing a tobacco-cessation-focused Journey by December 31, 2025.
- If you leave Citi, your Live Well Rewards will be forfeited unless redeemed prior to leaving.

To learn more about Live Well Rewards, log on to the Personify Health (formerly Virgin Pulse) platform or call 1 (855) 814-5595.

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 (Personify Health (formerly Virgin Pulse)) 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 or shared by other people. 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 in the following locations: Jacksonville and Tampa, FL; Florence, KY; O'Fallon, MO; Jersey City; New York (388 Greenwich St.) and Irving and San Antonio, TX.

The clinics offer the following services:

Primary Care at your on-site medical clinic

Keep in mind, you can choose to use your on-site medical clinic as your primary care physician (PCP). Primary Care services include:

- Annual physical exams and routine vaccinations
- Women's health and annual well visits
- Chronic condition management (e.g. high blood pressure, diabetes)
- Biometric screenings
- Personal travel assessments

Fee Schedule

Preventive visits, nurse visits, and many other visit types will continue to be available at no charge. Citi Aetna and Anthem Choice Plan (PPO) and In-network Only Plan (EPO) members will continue to have no fee for any services.

There are rules surrounding the tax benefits of Health Savings Accounts (HSAs). If you are in a Citi High Deductible Health Plan (HDHP) you will be charged a $35 fee for visits related to illness when you see a provider (MD, DO, NP or PA) until your deductible has been met.

This fee will also apply to non-Citi health plan members (e.g. you are on a spouse's plan) where you will be able to submit claims separately.

As always, your clinic remains convenient, personalized and time saving with easy access to a healthcare provider, your patient portal, online scheduling and telehealth. With Primary Care services your on-site clinic can also serve as your centralized medical home.

Visit type

- Well and Preventive Visits including annual physicals, well women, chronic condition management
  - Citi HDHP Free
  - Citi PPO or EPO Plan Free
  - Non-Citi Health Plan Free
- Routine Vaccinations
  - Citi HDHP Free
  - Citi PPO or EPO Plan Free
  - Non-Citi Health Plan Free
- Travel Medicine
  - Citi HDHP Free
  - Citi PPO or EPO Plan Free
  - Non-Citi Health Plan Free
- Sick Visits with an MD/ DO, NP, or PA
  - Citi HDHP $35 (until deductible is met)
  - Citi PPO or EPO Plan Free
  - Non-Citi Health Plan $35
- Physical Therapy (Tampa only)
  - Citi HDHP $10 (until deductible is met)
  - Citi PPO or EPO Plan Free
  - Non-Citi Health Plan $10

Be Well Program

Citigroup has partnered with TELUS Health to offer you a number of programs designed to help you navigate life, work, and family care issues, including:

- Short-term counseling services through TELUS Health
- Geriatric care services
- Resource and referral services

Short-Term Counseling Services

Short-term counseling, provided through TELUS Health, is a confidential service designed to help you and your household 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 more.

When you or your household members call for counseling support, 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. This benefit provides up to five face-to-face, virtual, or telephonic counseling sessions per issue per year with a licensed counselor at no cost to you. If you require additional counseling, Be Well 24/7 will make every effort to refer you to a counselor in your medical plan. Additional counseling would be covered under the terms of the medical plan in which you enrolled, if applicable. Contact your specific plan to confirm coverage details.

All counseling 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 counseling service is a core benefit available to all benefits-eligible employees and their household family members. You don't need to be enrolled in any Citi plan or make contributions to take advantage of the program.

Employees and their household family members can also connect with the Be Well program as follows:

- Download the TELUS Health One app for convenient support for your mental, physical, social and financial well-being at anytime. You can use online chat to contact a counselor, easily search for resources and tools on a wide range of topics, review the latest information on the app's news feed, or work out from home with free LIFT Virtual Session Fitness classes. To download the app on Android or iOS:
  - Search for TELUS Health One, then
  - Open the app, click on 'Log in' and enter your log-in credentials:
    - Username: bewell
    - Password: livewell
- Visit the TELUS Health website at one.telushealth.com (universal username: bewell; case-sensitive password: livewell) for online access to the Be Well program. You can use the live chat feature and access hundreds of articles, e-books, audio recordings, assessments, toolkits and more.

You can access the same features of the Be Well program on both the mobile app and website.

Geriatric Care Services

When an older relative's physical or mental health changes or his or her 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.

Geriatric Care Services can provide the following:

- Consultation with an experienced professional who can answer common caregiving questions;
- Four hours of consultation time with a Geriatric Care Manager;
- 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.

Resource and Referral Services

Resource and referral services are designed to save you time by providing valuable research and advice on a number of common everyday challenges facing Citi employees. Whether you are researching options for child care, or dealing with the concerns of your elderly parent, this service can help. These services are completely confidential.

The Be Well team will provide practical solutions, customized referrals and resources on a wide variety of topics, including parenting/child care, adoption, and caring for older adults.

Resource and referral services are a core benefit available to all benefits-eligible employees and their household family members. You do not have to enroll or make any contributions to use this benefit. Citi provides this service through a contract with TELUS Health.

Contact the Be Well Program as follows:

- Telephone: 1 (800) 952-1245
  TTY: 711, then 1 (800) 952-1245
- Website: one.telushealth.com
  Username: bewell
  Password: livewell

Family First: An Additional Caregiving Support Resource

If you are enrolled in the Citigroup Legal Benefits Plan, available through MetLife, you and your eligible dependents automatically have unlimited access to Family First's caregiving support services. Family First's multi-disciplinary team of highly trained experts provide the support you need to create a personalized caregiving plan for your loved one. See the *Legal Plan* section for details.

Supplemental Medical Plans

Citigroup offers three supplemental medical plans:

- Accident Plan – helps fill financial gaps when you have expenses related to an injury caused by a covered accident. Benefits are paid for initial and follow-up care, medical imaging, X-rays, dislocations, fractures, physical therapy and more.
- Critical Illness Plan – Offers two levels of coverage to help pay the out-of-pocket costs associated with the diagnosis of a critical illness. The plan pays cash benefits to you if you are diagnosed with a heart attack, stroke, end stage renal failure, invasive cancer and more, and;
- Hospital Indemnity Plan – Pays benefits to you for an inpatient hospital admission and daily hospital, rehabilitative, mental disorder and substance abuse confinements, and more.

While Citi offers comprehensive medical coverage, there are expenses associated with an accidental injury, critical illness and hospitalization that your medical plan may not cover. The supplemental medical plans add a layer of financial protection by paying cash directly to you to help cover out-of-pocket medical expenses, such as home health care and rehabilitation or copays, coinsurance and deductibles. You can also use the money to cover everyday expenses, such as childcare, mortgage payments and utility bills.

Coverage under the supplemental medical plans is insured under a group insurance policy through Aetna. You pay the full cost of coverage through after-tax payroll deductions and benefits are determined and paid entirely by Aetna.

You can enroll in one, two or all three supplemental medical plan coverages, even if you do not enroll in a Citi medical plan.

Important

Supplemental medical plans are not health insurance. They provide limited benefits and are not a substitute for comprehensive medical coverage. Lack of comprehensive medical coverage (or other minimum essential coverage) may result in an additional payment with your state taxes. Benefit payments are not intended to cover the full cost of medical care. The payments are in addition to any other applicable health coverage. Supplemental medical plans do not count as minimum essential coverage under the Affordable Care Act.

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Supplemental Medical Plans

Aetna Discount Programs

When you enroll in any of the supplemental plans, you can take advantage of Aetna Discount Programs, including blood pressure monitors, gym memberships, weight-loss programs, eye care, hearing and dental products and more. To learn more about available discounts, visit the member portal at https://www.myaetnasupplemental.com/ or call 1 (800) 607-3366.

Eligibility

You are eligible to enroll for coverage in a supplemental health plan if you work at least 20 hours per week. Your eligible dependents can enroll for coverage, too. Eligible dependents include your:

- Legal spouse;
- Domestic partner;
- Civil union partner; or
- Children under the age of 26 provided they meet the definition of a dependent child as defined by your plan

Eligible Dependents

When you enroll, you can also enroll these dependents on your plan:

- Your spouse
- An eligible dependent child who is: -
  - Unmarried, and
  - Under age 26, or
  - Over the age limit above who is: ▪
    - Not able to earn his or her own living due to an intellectual or physical disability which started prior to the date he or she reaches the limiting age, and ▪
    - Chiefly dependent on you for support.

Evidence of Insurability

You will not be required to provide proof of your good health – otherwise known as evidence of insurability – when you enroll for coverage.

Claims

Supplemental medical plans are determined and paid entirely by Aetna. To file a claim for benefits, submit your claim within three years from the date of service.

Register on the My Aetna Supplemental app or at myaetnasupplemental.com. Click "Report New Claim" and answer the questions needed for filing your claim. If you are a non-Aetna member, you will be prompted to upload a photo of your medical bill.

Claims and Appeal Procedures

If a benefit is payable, it will be paid no later than 60 days after the date the required written proof is received. All benefits are payable to you. If Aetna needs additional information, you have 45 days from the date of request to send them the additional information. If your claim is denied entirely or in part, this is called an "adverse claim decision." If Aetna makes an adverse claim decision, they will tell you in writing in 30 days. If you disagree, you can ask Aetna to re-review the adverse claim decision. This is called an appeal.

If you want to appeal, send it to Aetna within 180 calendar days from the time you receive the adverse claim decision. You can appeal by either:

- Calling Aetna at 1 (800) 607-3366
- Sending Aetna a written appeal to the address on the notice of adverse claim decision

When you send a written appeal, be sure to include:

- Your name
- The policyholder's name
- A copy of the adverse claim decision
- Your reasons for making the appeal
- Any other details you would like Aetna to know

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell Aetna if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling Aetna that you are allowing someone to appeal for you. You can get this form online at myaetnasupplemental.com. The form will tell you where to send it.

When Aetna receives your appeal, it will be handled by someone who was not involved in making the adverse claim decision.

Timeframe for deciding your appeal

Aetna will give you an appeal decision within 30 calendar days of receipt of your request for an appeal.

Fees and expenses

Aetna does not pay any fees or expenses incurred by you in pursuing an appeal or complaint.

Receiving Your Benefits

You can receive your benefit as a direct deposit to your checking account or as a check mailed to your home. Log on to your account at myaetnasupplemental.com or the My Aetna Supplemental app or, if you have Aetna medical coverage, aetna.com. Sign up for your preferred method of payment: direct deposit or a check mailed to your home.

Continuation of Coverage

If you leave Citi, you have the option to continue your supplemental medical plan coverage. Contact Aetna for more information.

Accident Plan

The Accident Plan complements your medical coverage by providing a cash benefit if you or your covered family members suffer an accidental injury that is covered under the plan. The cash benefit helps pay for out-of-pocket expenses, such as home health care, rehabilitation and medical plan copays. The Accident Plan provides the following.

What's Covered

	Covered	Benefit
Initial care	*Ambulance*	
	Ground ambulance	$300
	Air ambulance	$1,500
	Maximum ground and air ambulance trips combined per accident	1
	Initial treatment	
	Emergency room/Hospital	$200
	Physician's office/Urgent care facility	$200
	Walk-in clinic/Telemedicine	$50
	Maximum visits per accident, combined for all places of service	1
	Maximum visits per plan year, combined for all places of service	3
	X-ray	$150
	Lab	$75
	Medical imaging	$250
Follow-up care	*Accident follow-up*	
	Emergency room/Hospital	$100
	Physician's office/Urgent care facility	$100
	Walk-in clinic/Telemedicine	$50
	Maximum visits per accident, combined for all places of service	6
	Maximum visits per plan year, combined for all places of service	No maximum
	Appliances	
	Major: Back brace, body jacket, knee scooter, wheelchair, motorized scooter or wheelchair	$200
	Minor: Brace, cane, crutches, walker, walking boot, other medical devices to aid in your physical movement	$200
	Chiropractic treatment and alternative therapy	$50
	Chiropractic treatment and alternative therapy maximum visits per accident	10
	Chiropractic treatment and alternative therapy maximum visits per plan year	30
	Pain management (epidural anesthesia)	$50
	Prescription drugs	$10
	Therapy services – speech, occupational, physical therapy or cognitive rehabilitation	$75
	Therapy services – speech, occupational, physical therapy or cognitive rehabilitation maximum visits per accident	10

	Covered	Benefit
	Prosthetic device/Artificial limb	
	One limb	$750
	Multiple limbs	$1,500
	Maximum benefit per accident	1
	Repair and replace	25%
	Maximum benefit per plan year	1
Hospital care	*Hospital stay (initial day)*	
	Non-ICU admission	$2,000
	ICU admission	$4,000
	Hospital stay (daily)[1]	
	Non-ICU	$200
	ICU	$400
	Step down intensive care	$400
	Maximum days per accident (combined for all stays due to the same accident)	365
	Rehabilitation unit stay	$200
	Rehabilitation unit stay maximum days per accident	30
	Observation unit	$100
Surgical care	Blood/Plasma/Platelets	$400
	Eye injury: Surgical repair	$300
	Eye injury: Removal of foreign object	$100
	Surgery (without repair): Arthroscopic or exploratory	$350
	Surgery (with repair)	
	Cranial, open abdominal or thoracic	$1,500
	Hernia	$250
	Ruptured disc	$750
	Tendon/Ligament/Rotator cuff single repair	$750
	Tendon/Ligament/Rotator cuff multiple repairs	$1,500
	Torn knee cartilage	$750
	Non-specified inpatient	$750
	Non-specified outpatient	$750
	Maximum benefits per accident, combined for all surgery (without repair) and surgery (with repair)	2
Transportation and lodging assistance	Lodging per day for up to 30 days	$300
	Maximum days per accident	30
	Transportation	$500
Fractures and dislocations	***Dislocations (closed reduction)***[2]	
	Hip	$4,500
	Knee	$3,000
	Ankle bone or bones of the foot (other than toes)	$1,800
	Collarbone (sternoclavicular)	$2,250
	Lower jaw	$1,350
	Shoulder (glenohumeral)	$2,250
	Elbow	$900

	Covered	Benefit
	Wrist	$1,125
	Bones or bones of the hand (other than fingers)	$1,650
	Collarbone (acromioclavicular and separation)	$2,250
	Rib	$300
	One toe or one finger	$375
	Partial dislocation	25%
	Maximum dislocations per accident	3
	Fractures (closed reduction)[2]	
	Skull (except bones of the face or nose), depressed	$6,000
	Skull (except bones of the face or nose), non-depressed	$3,000
	Hip, thigh (femur)	$6,000
	Vertebrae, body of (excluding vertebral processes)	$5,400
	Pelvis (including ilium, ischium, pubis, acetabulum except coccyx)	$4,800
	Leg (tibia and/or fibula malleolus)	$3,750
	Bones of the face or nose (except mandible or maxilla)	$1,800
	Upper jaw, maxilla (except alveolar process)	$2,100
	Upper arm between elbow and shoulder (humerus)	$2,100
	Lower jaw, mandible (except alveolar process)	$2,400
	Collarbone (clavicle, sternum)	$2,400
	Shoulder blade (scapula)	$2,400
	Vertebral process	$1,500
	Forearm (radius and/or ulna)	$3,000
	Kneecap (patella)	$3,000
	Hand/Foot (except fingers or toes)	$3,000
	Ankle/Wrist	$3,000
	Rib	$525
	Coccyx	$525
	Finger, toe	$525
	Chip fracture	25%
	Maximum fractures per accident	3
Paralysis	Home and vehicle alteration	$2,000
	Complete, total and permanent loss	
	Quadriplegia	$20,000
	Trilegia	$15,000
	Paraplegia	$10,000
	Hemiplegia	$10,000
	Diplegia	$10,000
	Monoplegia	$5,000

	Covered	Benefit
Other accidental injuries	*Brain injury*	
	Concussion/Mild traumatic brain injury	$500
	Moderate/Severe traumatic brain injury	$1,000
	Burn	
	Second degree burn, greater than 5% of total body surface	$1,500
	Third degree burn, less than 5% of total body surface	$1,500
	Third degree burn, 5-10% of total body surface	$6,000
	Third degree burn, greater than 10% of total body surface	$25,000
	Burnt skin graft	50% of burn benefit
	Coma	
	Coma (non-induced)	$20,000
	PVS	$20,000
	Coma (induced)	$500
	Maximum days per incident	10
	Dental	
	Extractions	$75
	Crown	$225
	Laceration	
	Without stitches	$25
	With stitches, less than 7.5 centimeters	$100
	With stitches, 7.6 to 20.0 centimeters	$300
	With stitches, greater than 20.0 centimeters	$600
	Other	
	Posttraumatic stress disorder (PTSD)	$500
	Maximum PTSD benefit per lifetime	1
	Service dog	$2,500
	Maximum service dogs per lifetime	1

[1] All daily benefits for hospital stays begin on day one.

[2] Open reduction (surgical repair) pays two times the closed reduction benefit.

Additional Benefits

The following additional benefit applies:

- Organized Sports Benefit: If you sustain an accidental injury while playing as a registered member of an organized sports activity, your benefit will be increased by 25%. Benefits for burns, burn skin graft and service dog are not included in the organized sports benefit.

Exclusions and Limitations

Benefits for covered accidental injuries will be paid upon a diagnosis that satisfies the requirements of the policy and when all other policy requirements are met. Accident Plan benefits are not payable for any care, service or supply for an accidental injury related to:

- Certain competitive or recreational activities, including but not limited to: ballooning, bungee jumping, parachuting, and skydiving;

- Any semi-professional or professional competitive athletic contest, including officiating or coaching, for which you receive payment;
- Act of war, riot, or war
- Operating, learning to operate or serving as a pilot or crew member of any aircraft, whether motorized or not;
- Assault, felony, illegal occupation, or other criminal act;
- Bacterial infections that are not caused by a cut or wound from an accidental injury;
- Care provided by immediate family members or any household member;
- Elective or cosmetic surgery;
- Nutritional supplements;
- Suicide or attempt at suicide, intentionally self-inflicted injury, or any attempt at self-inflicted injury, or any form of intentional asphyxiation, except when resulting from a diagnosed disorder;
- Violating any cellular device use laws of the state in which the accident occurred, while operating a motor vehicle; or
- Accidental injury sustained while intoxicated or under the influence of any drug intoxicant, including those prescribed by a physician that are misused.

Benefits will not be paid for a service or supply rendered or received that are not specifically covered or not related to an accidental injury.

Any service, stay or visit must be on or after the effective date of coverage, while coverage is in force and take place in the United States or its territories.

Critical Illness Plan

The Critical Illness Plan provides cash benefits to help cover out-of-pocket costs that come after a covered critical illness, such as a heart attack, stroke or cancer. You can choose between two coverage levels:

- $15,000 Face Amount level; or
- $30,000 Face Amount level.

The plan pays benefits as a percentage of your Face Amount or in some cases, the plan pays a flat dollar benefit amount, no matter which coverage level you choose. Note: Benefits for covered child(ren) are 50% of the amount that would be paid to a covered employee or spouse.

Features

Covered Benefit	Percent of Face Amount
Subsequent critical illness diagnosis[1] *Minimum days between diagnosis of different condition*	100% 0 days
Recurrence of critical illness diagnosis *Minimum days between diagnosis of same condition*	100% 90 days
Recurrence of cancer (invasive) diagnosis *Minimum days between diagnosis of cancer (invasive)*[2]	100% 90 days
Recurrence of carcinoma in the original location of the diagnosis *Minimum days between diagnosis of carcinoma in the original location*[2]	100% 90 days

[1] The separation period is waived if the subsequent diagnosis is in a different benefit category. Benefit category is defined as either cancer or non-cancer benefits.

[2] In addition to the separation period, you must be treatment free during the separation period. Treatment does not include maintenance drug therapy or routine follow-up visits to a physician to confirm the initial cancer or carcinoma in situ has not returned.

What's Covered

	Coverage	Percent of Face Amount or Dollar Amount of Benefit
Autoimmune	Addison's disease (adrenal hypofunction)	25%
	Lupus	25%
	Multiple sclerosis	25%
	Myasthenia gravis	25%
Childhood condition	Cerebral palsy	100%
	Cleft lip or cleft palate	100%
	Congenital heart defect	100%
	Cystic fibrosis	100%
	Down syndrome	100%
	Sickle cell anemia	100%
	Spina bifida	100%
Chronic conditions	Posttraumatic stress disorder (PTSD)[1]	$1,000
	Primary sclerosing cholangitis (PCS)	25%
Infectious disease[2,3]	Cholera	25%
	Coronavirus	100%
	Creutzfeld-Jakob disease	25%
	Diphtheria	25%
	Ebola	25%
	Encephalitis	25%
	Hepatitis – occupational	25%
	Human immunodeficiency virus (HIV)	25%
	Legionnaire's disease	25%
	Lyme disease	25%
	Malaria	25%
	Meningitis – amebic, bacterial, fungal, parasitic, viral	25%
	Methicillin-resistant staphylococcus aureaus (MRSA)	25%
	Necrotizing fasciitis	25%
	Osteomyelitis	25%
	Pneumonia	25%
	Poliomyelitis	25%
	Rabies	25%
	Rocky mountain spotted fever (RMSF)	25%
	Septic shock and severe sepsis	25%
	Tetanus	25%
	Tuberculosis (TB)	25%
	Tularemia	25%
	Typhoid fever	25%
	Variant influenza virus (swine flu in humans)	25%

	Coverage	Percent of Face Amount or Dollar Amount of Benefit
Neurological	Amyotrophic lateral sclerosis (ALS)	100%
	Alzheimer's disease	100%
	Benign brain or spinal cord tumor	100%
	Coma (non-induced)	100%
	Huntington's disease	100%
	Parkinson's disease	100%
	Stroke	100%
	Transient ischemic attack (TIA)[1]	25%
Vascular	Coronary artery condition requiring bypass surgery	50%
	Heart attack (myocardial infarction)	100%
	Sudden cardiac arrest[1]	100%
Cancer[4]	Cancer (invasive)	100%
	Carcinoma in situ (non-invasive)	25%
	Skin cancer[1]	$1,000
Paralysis	Quadriplegia	100%
	Triplegia	75%
	Paraplegia	50%
	Hemiplegia	50%
	Diplegia	50%
	Monoplegia	25%
Other	Bone marrow donation surgery[1]	$1,000
	Bone marrow transplant[1]	$1,000
	End-stage renal or kidney failure	100%
	Health screening[5]	$50
	Loss of hearing	100%
	Loss of sight (blindness)	100%
	Loss of speech	100%
	Major organ failure	100%
	Muscular dystrophy	25%
	Third-degree burns	100%

1 The plan limits payment of benefits to once per lifetime.

2 The plan limits payments for infectious disease diagnosis to once per plan year.

3 The following infectious diseases require a hospital stay of at least five days: coronavirus, Creutzfeldt-Jakob disease, Ebola, pneumonia, septic shock and severe sepsis, tularemia and variant influenza virus (swine flu in humans)

4 If you were diagnosed with cancer before the effective date of your coverage under the Critical Illness Plan, and you receive a new cancer diagnosis while covered under the plan, your new diagnosis will be treated as an initial diagnosis.

5 The plan limits payment to once per year.

Exclusions and Limitations

Benefits will not be paid for a diagnosis related to:

- Act of war, riot, or war;
- Assault, felony, illegal occupation or other criminal act;
- Care provided by immediate family members or any household member;

- Suicide or attempt at suicide, intentionally self-inflicted injury, or any attempt at self-inflicted injury, or any form of intentional asphyxiation, except when resulting for a diagnosed disorder; or
- Being under the influence of a stimulant (such as amphetamines), depressant, hallucinogen, narcotic or any other drug intoxicant, including those prescribe by a physician that are misused (not taken as prescribed) by the covered person, except when resulting from a diagnosed disorder.

The critical illness date of diagnosis must be on or after the effective date of the certificate of coverage and while coverage is in force. The diagnosis must be given or received in the United States or its territories.

Hospital Indemnity Plan

Although Citi offers you the opportunity to enroll in comprehensive medical coverage, there are still expenses associated with a hospital stay that the plan may not cover. These include copays, coinsurance, prescription drug copays and other non-medical expenses such as childcare, mortgage payments and utility bills.

Through the Hospital Indemnity Plan, you can receive a lump sum cash payment if you or a covered family member is admitted to the hospital.

What's Covered

Inpatient Stay*	Benefit**
The initial day of your stay in a hospital	A lump sum benefit of: $1,000
Benefit begins on day 1 of your stay in a non-ICU room of a hospital	A daily benefit of: $250
Benefit begins on day 1 of your stay in an ICU room of a hospital	A daily benefit of: $500
The hospital stay after the birth of a newborn. Outpatient birth is not covered	A lump sum benefit of: $200
The initial day of your stay in an observation unit as a result of an illness or accidental injury (maximum of one day per plan year)	A lump sum benefit of: $100
Benefit for each day of your stay in a hospital or treatment facility for the treatment of substance abuse	A daily benefit of: $125
Benefit for each day of your stay in a hospital or mental disorder treatment facility for the treatment of mental disorders	A daily benefit of: $100
Benefit for each day of your stay in a rehabilitation unit immediately after your hospital stay due to an illness or accidental injury	A daily benefit of: $50

* Hospital admission is limited to 4 stays per plan year, separated by 30 consecutive days. Limited to a combined maximum of 30 days per plan year.

** Daily benefits begin on day one and count toward the calendar year maximum.

Waiver of Premium

If you miss 30 continuous days of work as a result of a hospital stay, your Hospital Indemnity coverage premium will be waived beginning on the first pay period that occurs after the 30th day of your absence, through the next six months of coverage. You must remain employed to qualify for a waiver of premium. This waiver of premium benefit does not apply to your covered dependents.

Exclusions and Limitations

Benefits will not be paid for any stay or other service for an illness or accidental injury related to:

- Certain competitive or recreational activities, including but not limited to: ballooning, bungee jumping, parachuting, and skydiving;
- Any semi-professional or professional competitive athletic contest, including officiating or coaching, for which you receive payment;
- Act of war, riot, or war;

- Operating, learning to operate or serving as a pilot or crew member of any aircraft, whether motorized or not;
- Assault, felony, illegal occupation, or other criminal act;
- Care provided by a spouse, parent, child, sibling or other household member;
- Cosmetic services and plastic surgery, with certain exceptions;
- Custodial care;
- Hospice services, except as specifically provided under the plan;
- Self-harm, suicide, except when resulting from a diagnosed disorder;
- Violating any cellular device use laws of the state in which the accident occurred, while operating a motor vehicle;
- Care or services received outside the United States or its territories;
- Experimental or investigational drugs, devices, treatments or procedures;
- Education, training or retraining services or testing;
- Accidental injury sustained while intoxicated or under the influence of any drug intoxicant;
- Exams except as specifically provided under the plan;
- Dental and orthodontic are and treatment;
- Family planning services;
- Any care, prescription drugs and medicines related to infertility;
- Nutritional supplements, including but not limited to: food items, infant formulas and vitamins;
- Outpatient cognitive rehabilitation, physical therapy, occupational therapy or speech therapy for any reason; and
- Vision-related care.

Federally Required Compliance Notice About Hospital Indemnity Insurance

IMPORTANT: This is a fixed indemnity policy, NOT health insurance. This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov or call 1 (800) 318-2596 (TTY: 1 (855) 889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Spending Accounts

Spending accounts allow you to pay for certain health care, dependent day care, 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 Plan with HSA (formerly known as the "High Deductible Health Plan"). If you enroll in the High Deductible Plan with HSA, you cannot enroll in the HCSA. If you elect the High Deductible Plan with HSA due to a qualified change in status and you were previously enrolled in the HCSA, you are allowed to retain the HCSA; however, you cannot continue to make contributions. 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 High Deductible Plan with HSA to pay for dental and 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.

Optum Financial Website

The Optum Financial website available through My Total Compensation and Benefits at www.totalcomponline.com makes it easy for you to manage your spending accounts. You can file claims, confirm which expenses are eligible, and check your account balance and more.

Note: For information about the HSA paired with the High Deductible Plan with HSA, see the "Health Savings Account" section in the *Medical* section.

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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 deducted from your pay as soon as administratively possible to pay for your transit and/or parking pass, which must be purchased online.

Need to File a Claim, Check Your Balance or Confirm if Expenses Are Eligible?

Access your spending account through My Total Compensation and Benefits. From the main page, click on "TRIP and Spending Accounts."

Once enrolled, you can obtain information about your account on the Optum Financial website through My Total Compensation and Benefits 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 if you enroll as a new hire on or before November 1:

- HCSA and LPSA: The entire amount of the 2025 contributions you elect will be posted to your account on January 1. You can be reimbursed up to the entire amount of your annual contribution at any time during the plan year for incurred eligible expenses, even if the entire 2025 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

Generally, 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.
- All changes must be made within 31 days of the qualified change in status.

Legal Requirement: Save Your Receipts from Optum Financial Payment Card Use

Participants in the HCSA and LPSA will receive a Optum Financial payment card. You have the option of using your Optum Financial payment card to pay for eligible health care expenses, or you may pay for health care expenses out of pocket and be reimbursed by submitting claims forms (via mail or fax) or submitting your claims online.

If applicable, each time you "swipe" the Optum Financial payment card (described in "Health Care Spending Account (HCSA)" on page 227), 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.* If a receipt is needed, you will be notified by email within 90 days of your payment card swipe (with a follow-up reminder mailed to your home address). If there is not a valid email address on file for you, all notification will be sent to your mailing address. You can also review online if your claim requires receipts by visiting the Optum Financial website, available through My Total Compensation and Benefits at www.totalcomponline.com and selecting "Payment Card Transactions" from the home page.

You have until June 30, 2026, to resolve any 2025 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 Optum Financial by the June 30 deadline, the amount of the transaction in dispute that was paid by using your Optum Financial payment card will be considered an "overpayment" and will be added to the amount of your 2025 earnings. Applicable taxes will be withheld and reported on your Form W-2 Wage and Tax Statement.

Reimbursements

If you do not use your Optum Financial payment card and submit your claims using claim forms (via mail or fax) or submit your claims online for reimbursements, your reimbursements for eligible HCSA/LPSA and DCSA expenses will be deposited directly into your bank account if you have a direct deposit account on file. If not, a check will be sent to your address of record. To add direct deposit account information, visit the Optum Financial website, available through My Total Compensation and Benefits 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 242.

Overpayments

In the event that you use your Optum Financial payment card to pay for an expense that is determined to be an ineligible health care expense (due to lack of substantiation of the expense), you will be notified of the expense ineligibility within 90 days of the transaction date. You must agree to reimburse Citi within 75 days for any amount owed. In connection with amounts owed under the HCSA/LPSA that exceed $50, your payment card will be suspended until acceptable documentation (showing that the expense is eligible) or repayment is received. Upon approval of documentation or repayment, the card will be reactivated within 48 hours. If repayment or acceptable documentation is never received, the funds paid for an ineligible expense will be deemed taxable income, and the suspension on the payment card will be lifted at the start of the new calendar year.

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. As such, 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 and dental 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 unless you elect to submit a claim for your out-of-pocket parking expenses.
Contribution limits	From $120 to $3,300 per year per employee;[2] money is deducted in equal amounts each pay period.	From $120 to $3,300 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 $325 per month before tax and up to $1,000 in after-tax dollars. Parking: Up to $325 per month before tax and up to $1,000 in after-tax dollars.
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 employment is terminated or if you transfer to an entity that is not 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.
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 2025 expenses so they are resolved no later than June 30, 2026.	You must file claims, including pertinent supporting documentation, for 2025 expenses so they are resolved no later than June 30, 2026.	You must file claims, including pertinent supporting documentation, for 2025 expenses so they are resolved no later than June 30, 2026.	You must file claims for Parking Cash Reimbursement, including pertinent supporting documentation, for 2025 expenses so they are resolved no later than June 30, 2026.

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 $3,300 to the HCSA or LPSA account.

Health Savings Account (HSA) Information

For information about the HSA paired with the High Deductible Plan with HSA, see “Health Savings Account” in the *Medical* section.

Health Care Spending Account (HCSA)

You can contribute between $120 and $3,300 per year on a before-tax basis to reimburse yourself for eligible out-of-pocket health care expenses. Contributions are deducted each pay period before federal and, in most locations, state and local taxes are withheld.

The $3,300 limit applies to each employee electing to participate in the HCSA. If you and your spouse/partner are both Citi employees, you can each contribute up to $3,300 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 during the 2025 plan year. You may enroll in the HCSA if you are *not* enrolled in the High Deductible Plan with HSA.

If you enroll in the High Deductible Plan with HSA, you cannot enroll in the HCSA. However, if you enrolled in the HCSA prior to a qualified change in status, then you are permitted to retain the HCSA, even if you elect a High Deductible Plan with HSA due to a qualified change in status. However, having enrolled in the HCSA precludes you from being eligible to establish or contribute to an HSA and/or enroll in the LPSA 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.

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. Be sure to save your receipts in case you are required at a later date to substantiate that your expense was eligible for reimbursement under the 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 copays;
- 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;
- Over-the-counter (OTC) drugs, medicines and biologicals for which you have a receipt ;
- 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.

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; 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 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.

Health Plan Claims with Optum Financial

Each time a claim is submitted to your health plan from a health care provider, Optum Financial receives the claim electronically from the plan. (Note: Electronic submission is not provided from the HMOs.) If there is no Optum Financial payment card swipe with a matching dollar amount on record, Optum Financial will load the claim into your account to be taken into consideration for future payment card transactions.

Visit the Optum Financial website through My Total Compensation and Benefits at www.totalcomponline.com to review your claims information and process reimbursements.

Your Optum Financial Payment Card

If you participate in the HCSA or LPSA, you will automatically receive an Optum Financial payment card after you enroll. Your Optum Financial payment card offers the following advantages:

- If you have both an HSA (due to enrollment in the High Deductible Plan with HSA) and an LPSA, you'll have one Optum Financial payment card to pay for all eligible health care expenses, and funds will be automatically deducted from the right account.
- With your Optum Financial payment card, you can pay for eligible health care expenses and reduce the need to pay out of pocket.
- You can call the Optum Financial toll-free number 24 hours a day if you need assistance.

Paying for Your Expenses Out of Pocket

For eligible health care expenses that are not submitted from a health care provider to the health plan, you may choose to pay out of pocket, instead of using the Optum Financial payment card, and submit a claim:

- online on the Optum Financial website;
- through the Optum Financial mobile app: or
- you can submit a paper claim to Optum Financial using the Optum Financial Manual Claim Form.

The claim-filing instructions are on the Optum Financial website, as well as on the Manual Claim Form (available on the Optum Financial website). 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 HCSA/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 documentation that a service provided in connection with a claim was medically necessary.

Regardless of whether a claim is paid or reimbursed, if you increase your contributions during the plan year because of a qualified change in status, you may pay for claims or be reimbursed for claims 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. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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. 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 Optum Financial payment card or a submitted claim (paper or online), 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. This may include documentation that a service provided in connection with a claim was medically necessary. All such documentation must be submitted and resolved by the June 30 deadline to avoid the amount being subject to forfeiture or included in taxable income in connection with the Optum Financial payment card. For example, you will have until June 30, 2026, to file claims for reimbursement of expenses incurred in 2025.

For the fastest results, use your Optum Financial payment card to directly pay for services at eligible health care locations. You can also submit claims as follows.

Online

- Log on to the Optum Financial website through My Total Compensation and Benefits at www.totalcomponline.com.
- To request reimbursement for an out-of-pocket expense, click on “I want to…reimburse myself.”
- Complete the online form.
- Follow the screen prompts to submit documentation, choosing either “upload documentation” or “fax documentation.” If you are faxing documentation, follow the screen prompts to print out the fax cover form to use when submitting the documentation.

Mobile App

- Download the Optum Financial mobile app from your app store.
- Log in using your online username and password. If you have never logged in before, click “New User Registration” to set your username and password.
- Tap the option to submit a new payment request.
- Follow the screen prompts to submit information.
- Follow the screen prompts to submit documentation using your camera or select an image from your mobile device.

Paper Claim Submission

- If you did not use your Optum Financial payment card and are unable to access the Internet, complete the Manual Claim Form.
- Fax the Manual Claim Form with itemized receipts or other documentation to 1 (443) 681-4602. Remember to keep the original claim form and supporting documents for your records.
- If you choose to mail your claim form and documentation instead of faxing, the address is:

  Optum Financial Claims Department
  PO Box 622317
  Orlando, FL 32862-2317

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 242.

For More Information

Call the Citi Benefits Center via ConnectOne at 1 (800) 881-3938. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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 Plan with HSA 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.

Rules and Features

You can contribute between $120 and $3,300 per year on a before-tax basis to reimburse yourself for eligible out-of-pocket dental, vision and preventive care medical expenses. Contributions are deducted each pay period before federal and, in most locations, state and local taxes are withheld.

The $3,300 limit applies to each employee electing to participate in the LPSA. If you and your spouse/partner are both Citi employees, you can each contribute up to $3,300 to your LPSA.

Because the LPSA is intended to be used in conjunction with a High Deductible Plan with 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). Be sure to save your receipts in case you are required at a later date to substantiate that your expense was eligible for reimbursement under the Plan.

OTC Drugs, Medicines and Biologicals

Expenses for over-the-counter drugs and medicine without a prescription are permitted to be reimbursed under the HCSA and LPSA.

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 copays, 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, that 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 High Deductible Plan with HSA, 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 High Deductible Plan with HSA will cover 100% of the 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 High Deductible Plan with HSA.

Generally, employees who enroll in the High Deductible Plan with HSA 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 High Deductible Plan with HSA).

Note: Employees who enroll in the High Deductible Plan with HSA generally are *not* eligible to enroll in an HCSA.

Plan Your LPSA Contributions Accordingly

Because network preventive care is covered at 100% in the High Deductible Plan with HSA, 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 High Deductible Plan with HSA will cover 100% of the 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. Be sure to save your receipts in case you are required at a later date to substantiate that your expenses were eligible for reimbursement under the Plan.

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:

- High Deductible Plan with HSA (preventive care only);
- Dental; and
- Vision.

You can use the Optum Financial payment card to pay for eligible expenses. Alternatively, you may pay for eligible expenses out of pocket and submit qualified expenses for reimbursement using the HCSA/LPSA Claim Form. You can submit a claim: (i) online on the Optum Financial website, available through My Total Compensation and Benefits at www.totalcomponline.com; (ii) through the Optum Financial mobile app, or: (iii) you can submit a paper claim to Optum Financial using the Optum Financial Manual Claim Form. The claim-filing instructions are on the Optum Financial website, as well as on the Manual Claim Form (available on the Optum Financial website).

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 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. 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 documentation that a service provided in connection with a claim was medically necessary. All such documentation must be submitted and resolved by the June 30 deadline to avoid the amount being subject to forfeiture or included in taxable income in connection with the Optum Financial payment card. For example, you will have until June 30, 2025, to file claims for reimbursement of expenses incurred in 2024.

For the fastest results, use your Optum Financial payment card to directly pay for eligible health care expenses. You can also submit claims as follows.

Online

- Log on to the Optum Financial website through My Total Compensation and Benefits at www.totalcomponline.com.
- To request reimbursement for an out-of-pocket expense, click on the "Reimburse Myself" button at the top of the page.
- Complete the online form.
- Follow the screen prompts to submit documentation, choosing either "upload documentation" or "fax documentation." If you are faxing documentation, follow the screen prompts to print out the fax cover form to use when submitting the documentation.

Mobile App

- Download the Optum Financial mobile app from your app store.
- Log in using your online username and password. If you have never logged in before, click "New User Registration" to set your username and password.
- Tap the option to submit a new payment request.
- Follow the screen prompts to submit information.
- Follow the screen prompts to submit documentation using your camera or select an image from your mobile device.

Paper Claim Submission

- To submit a paper claim, complete the Manual Claim Form.
- Fax the Manual Claim Form with itemized receipts or other documentation to 1 (443) 681-4602. Remember to keep the original claim form and supporting documents for your records.

- If you choose to mail your claim form and required documentation for reimbursement (instead of faxing), the address is:

  Claims Department
  PO Box 622317
  Orlando, FL 32862-2317

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 242.

For More Information

Call the Citi Benefits Center through ConnectOne at 1 (800) 881-3938. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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 per 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 236.

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.

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 children's 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 per 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 your DCSA. 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 per 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 Optum Financial website, available through My Total Compensation and Benefits at www.totalcomponline.com, available from the Citi intranet and the Internet, or through the Optum Financial mobile app, or you can submit a paper claim to Optum Financial using the Dependent Day Care Account Claim and Provider Documentation Form. The claim-filing instructions are on the Optum Financial website and the Dependent Day Care Account Claim and Provider Documentation 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 Citi day care subsidy available to you, if applicable. See “DCSA/Bright Horizons Day Care Center Use” on page 238 for more information related to the potential tax liability associated with using child day care facilities that charge below the fair market value for such services, like the Bright Horizons Day Care Center if the DCSA benefit and the discount on child care exceeds $5,000 annually.

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 2025 plan year. You must submit any eligible 2025 claims, including any pertinent supporting documentation, to establish that the claim is eligible to be reimbursed, no later than June 30, 2026.

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.

- If you are a sole financial provider or in a dual income household: Your benefits eligible pay *and* your total annual household income together do not exceed $90,000.

You must enroll for the subsidy during your Annual Enrollment period (or if you are enrolling as a new hire or newly eligible for benefits). 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 for 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.)

DCSA/Bright Horizons Day Care Center Use

At certain locations, Bright Horizons day care centers are available to provide regular and emergency/unplanned need child care services for Citi employees. Typically, this child care service is provided at a discount from the market rate of child care. For example, if the market rate for child care is $20/hour, Bright Horizons will charge $10/hour. The $10/hour discount may constitute taxable income if the discount in combination with the amount you contribute and utilize under the DCSA exceeds $5,000, the before-tax deferral maximum permitted under the Code for the plan year. If you incur child care expenses that are reimbursed or paid up to the DCSA limit of $5,000 (including the Citi DCSA subsidy) and you receive a discount in using the Bright Horizons day care center, you will incur taxable income in the amount of the discount that you received because the difference (from the market rate) is deemed to exceed the pre-tax benefit amount ($5,000) permitted under the Code. As such, it is taxable income to you, subject to imputed income tax. If possible, you may want to consider your use of the Bright Horizons day care center in determining how much to contribute to your DCSA to avoid incurring taxable income.

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. 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 deadline to avoid forfeiture of the funds in your DCSA.

Follow the instructions below to submit a claim based on the option you choose.

Online

- Log on to the Optum Financial website through My Total Compensation and Benefits at www.totalcomponline.com.
- To request reimbursement for an out-of-pocket expense, click on “Reimburse Myself.”
- Complete the online form.
- Follow the screen prompts to submit documentation, choosing either “upload documentation” or “fax documentation.” If you are faxing documentation, follow the screen prompts to print out the fax cover form to use when submitting the documentation.

Mobile App

- Download the Optum Financial mobile app from your app store.
- Log in using your online username and password. If you have never logged in before, click "New User Registration" to set your username and password.
- Tap the option to submit a new payment request.
- Follow the screen prompts to submit information.
- Follow the screen prompts to submit documentation using your camera or select an image from your mobile device.

Paper Claim Submission

- Obtain an itemized statement from your dependent care provider containing the required information (provider's name, dependent's name, service period, payment amount and type of care provided). Alternatively, ask your provider to complete the Provider Information section on the Dependent Care Account Claim and Provider Documentation Form.
- Fax the form with receipts and required documentation to 1 (443) 681-4602. Remember to keep the original claim form and supporting documents for your records.
- If you choose to mail your form and required documentation (instead of faxing), the address is:

  Claims Department
  PO Box 622337
  Orlando, FL 32862-2337

If your DCSA claim is denied, see "DCSA and TRIP Denials" on page 244.

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. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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 $325 of your transit and/or parking pass will be deducted from your pay before taxes are withheld. Any amount of your transit pass or parking pass that exceeds $325 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; and
- 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 generally 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 some transportation authorities, such as the Long Island Railroad and Metro-North Railroad, the deadline to enroll or change your TRIP participation is the 4th of every month (rather than the 10th 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, as well as vanpooling. 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 parking products in the same benefit month, online, depending on what is required for your commute to and from work. Note that funds for Transit and Parking are not interchangeable once purchased. For transit, you can select to receive a transit pass or a commuter check voucher redeemable for transit passes, tickets, cards, tokens and other fare media. For parking, you can elect to receive a voucher or direct pay to a parking provider. When you enroll, you can set up a recurring purchase, or you can arrange to purchase your pass/voucher each month. The pass or voucher will be mailed to your address of record with the TRIP provider in time for use beginning the 1st of the following month.

When you enroll, you can elect to have funds electronically loaded onto your existing Optum financial payment card (the same card you use for the HCSA/ LPSA and/or HSA).

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 Railroad (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 Optum Financial website, available as a link from My Total Compensation and Benefits at www.totalcomponline.com	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 so you have it before the 1st of the following month

Keep in mind, if your transit pass is lost in the mail, or if you received an incorrect transit product, you are eligible to submit a Refund Claim Form to receive reimbursement for the missing or incorrect product. The Refund Claim Form must be received by the 10th of the benefit month and a refund will only be approved once per calendar year.

Please note: Some transit authorities and products have their own unique refund or replacement policies and thus are not covered by the Refund Claim Policy. For additional detail, please review the Refund Claim Form.

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 Optum Financial website, or you can submit a paper claim to Optum Financial. Be sure to include your itemized receipts with the claim. Receipts must include the company name, dates of service and the amount paid. If using a check for documentation, you must include the front and back of the bank-cleared check, the check must be payable to a valid parking company, and the memo line should include the dates covered by the payment. Valid parking companies will include municipal parking.

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.

For more information about the cash reimbursement option, see the Transportation Reimbursement Incentive Program claim form or visit the Optum Financial website through My Total Compensation and Benefits at www.totalcomponline.com, available from the Citi intranet and the Internet.

Examples of Eligible Expenses	
Parking 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.	Transit Account • 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 • 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.	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, you are enrolled to purchase a parking pass and a train pass, but you plan to relocate in June of the plan year so that you require a bus pass only. If, by May 10, you cancel the train and parking pass purchase and purchase a bus pass, only your new bus pass will be mailed to your address of record for use as of June 1.

To enroll in TRIP or to change your election once enrolled, visit the Optum Financial website through My Total Compensation and Benefits 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 not 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)

Generally, an HCSA/LPSA claim must be filed by June 30 of the plan year following the year in which the claim was incurred. For the 2025 plan year, claims must be substantiated by June 30, 2026. To submit a claim for a benefit denied under the HCSA/LPSA, you must complete a claim form authorized by the Plans Administration Committee of Citigroup Inc. (the Committee), the Plan Administrator. To obtain a copy of the claims form, contact the Citi Benefits Center through ConnectOne at 1 (800) 881-3938.

If an HCSA/LPSA benefit is denied, in whole or in part, under the Employee Retirement Income Security Act of 1974, as amended (ERISA), you are entitled to appeal the denial of your claim by following the steps below.

Step 1: If your claim is denied, you will receive written notice from the Citi Benefits Center as soon as reasonably possible, but no later than 30 days after receipt of the claim. However, 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 initial 30-day period, if applicable. If the reason for the additional time is that you need to provide additional information, you will receive written notice of the requested information, and you will have 45 days from the notice of the extension to provide that information to the Citi Benefits Center. 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. If the requested information is not received within the 45-day period noted, a determination with respect to your claim will be made without the requested information.

Step 2: Once you have received your notice from the Citi Benefits Center, review it carefully. The notice will contain the following information:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures;
- A statement explaining your rights to bring civil action under Section 502(a) of ERISA after an Adverse Benefit Determination upon review;
- 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.

Step 3: If you disagree with the determination with respect to your claim, contact the Citi Benefits Center through ConnectOne at 1 (800) 881-3938 for assistance. If you are still unable to resolve your issue and have your claim approved, you may file an appeal. You may obtain an appeal form from the Citi Benefits Center spending account team by contacting them through ConnectOne at 1 (800) 881-3938. You should file your appeal no later than 180 days after receipt of the notice described in Step 1. Complete and return the appeal form along with any additional supporting documentation with respect to why you believe your claim should be approved, along with all the information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim to the address or fax number noted below for a determination on your appeal.

Citigroup Inc.
Plans Administration Committee of Citigroup Inc.
c/o Claims and Appeal Management Team
Dept 01488
PO Box 299107
Lewisville, TX 75029-9107
Fax: 1 (847) 554-1653

Step 4: The Committee or a designee of the Committee will conduct a full and fair review of your appeal. You and/or your representative may review the Plan Documents and submit written comments or a statement with your appeal. A determination with respect to the appeal of your denied HCSA/LPSA claim shall be reached within a reasonable period of time, but no later than 60 days after the receipt of appeal. If the HCSA/LPSA claim is denied, you will be notified in writing of the benefit determination upon review. The notice will be sent no later than 60 days after receipt of the appeal by the Citi Benefits Center.

Step 5: Once you have received your notice of the benefit denial upon appeal from the Citi Benefits Center, review it carefully. The notice will contain the following information:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, or have reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
- A statement explaining your rights to bring civil 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.

You and the HCSA/LPSA may have other voluntary alternate 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 or your state insurance regulatory agency.

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 is under consideration by the appropriate fiduciary.

DCSA and TRIP Denials

The Dependent Day Care Spending Account (DCSA) and Transportation Reimbursement Program (TRIP) are not subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, and as such, benefit determinations are not subject to the claims and appeals procedures set forth under ERISA.

If you would like to dispute a denied benefit under the DCSA or TRIP, write a letter (including any supporting documentation) and mail it to Citi Global Benefits, 388 Greenwich Street, 15th Floor, New York, NY 10013. Citi will review the appeal and alert Optum Financial of the outcome.

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 LTD insurance certificate at www.citibenefits.com under "Forms and Documents," which is also part of the Disability Plan. 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. See the *For More Information* section for detailed instructions, including TDD and international assistance.

Need to Report a Disability Leave?

To learn more about how to report a disability and what happens to your benefits coverage while you are on a leave of absence, visit www.citibenefits.com.

Definition of Years of Service for the Plan

For purposes of LTD benefits (and STD benefits initiated prior to June 1, 2024), your years of service are based on your actual time providing services to Citi as an employee. Please refer to the Citi Employee Handbook for more details about how service is calculated.

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Short-Term Disability (STD)

Having a Baby?

Explore the different programs Citi has to offer. Visit Citi For You (intranet only) or contact Health Advocate at 1 (866) 449-9933. If you are enrolled in a Citi medical plan, additional benefits may be available. Contact your carrier for more information.

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. See the *For More Information* section for detailed instructions, including TDD and international assistance. 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 Short-Term Disability (STD) summary on citibenefits.com.

If you became disabled on or after June 1, 2024:

STD pays 100% of base salary (not benefits eligible pay) during an approved disability of up to 13 weeks. For newly hired and rehired employees (regardless of prior service), there is a 30-day waiting period before disability benefits are payable.

For more information about Paid Pregnancy Leave (PPL), Paid Parental Bonding Leave (PBL), Caregiver Leave, or other leaves available under the Family and Medical Leave (FML), refer to the Citi Employee Handbook and/or Citi's FML Policy for more details on Citi For You (intranet only).

If you became disabled prior to June 1, 2024:

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, unless otherwise indicated. 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, unless otherwise indicated):

STD Schedule of Benefits for Benefits Eligible 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
More than 90 days but less than 1 year	1	12	13
1 year but less than 2 years	4	9	13
2 years but less than 3 years	6	7	13
3 years but less than 4 years	8	5	13
4 years but less than 5 years	10	3	13
5 years or more	13	0	13

When STD Benefits Are Payable

STD benefits are payable if you incur a total disability while an "Active Employee."

You are an "Active Employee" if you:

- Are an Eligible Employee working for Citigroup doing all the material duties of your occupation at (i) your usual place of business; or (ii) some other location that your Citigroup requires you to be; and
- Are not a temporary or seasonal employee.

You will be deemed an Active Employee if:

- You meet the above conditions; and
- You are absent from work solely due to vacation days, holidays, scheduled days off, or approved leaves of absence not due to Disability.

A “total disability” is defined as a serious health condition, pregnancy, injury, recovery from a procedure 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 cannot 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 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.

STD benefits may be offset by any monies owed to Citi and/or by any state benefits, including Workers’ Compensation and Social Security disability benefits. However, the Disability Plan does not subrogate STD payments.

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 it was reasonably possible.

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 or 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. See the *For More Information* section for detailed instructions, including TDD and international assistance. 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 (predisability earnings) determined on the day before your approved STD. Your "predisability earnings" under the MetLife disability insurance certificate 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, will not 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 will 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 My Total Compensation and Benefits at www.totalcomponline.com, during Annual Enrollment for the cost.

Option to Decline LTD Coverage

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 in LTD coverage. If you elect to decline LTD coverage within the first 90 days following your enrollment, you will receive a refund of your paid premiums. You can also decline LTD coverage after the initial 90-day period; however, premiums will not be refunded to you.

Note: If you decline LTD coverage and then 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.

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 do not pay taxes on the benefit you receive from MetLife.

[1] If your benefits eligible pay increases to 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 (new hire enrollment commences with employment). Effective January 1 of the following year, contributions will be deducted from your pay (new hire deductions occur upon employment). If you do not want LTD coverage, 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 to opt out. If you opt out within this 90-day period, these contributions will be refunded to you. You can also opt out after the 90-day period; however, premiums will not be refunded.

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 STD 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
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 insurance 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.

Pre-existing Condition

The LTD portion of 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. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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 an LTD benefit, 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 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 are 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 will not be offset for any SSDI cost-of-living adjustments. If you are approved for SSDI retroactively and receive a lump-sum SSDI award, you are required to submit any overpayment of benefits to MetLife. Any other income you receive while you are receiving LTD benefits may be used to offset your LTD benefit as described in the LTD insurance certificate at https://citibenefits.com. 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 and relevant forms, and may request ongoing medical and financial information be provided to certify your continued disability under the Disability Plan.

Claims and Appeals

You should file a 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 and follow the prompts to report a disability. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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, email 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 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 described in "Initial Determination" on page 251 and "Appealing the Initial Determination" on page 252.

Initial Determination

After you submit a claim for disability benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Disability Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45-day period (or prior to the expiration of the first 30-day extension period if a second 30-day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee;
- Name of the Plan;
- Reference to the initial decision; and
- An explanation why you are appealing the initial determination.

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45-day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based, and notifying you of your right to bring an action under Section 502(a) of ERISA in connection with this determination. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

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/partner;
- Supplemental AD&D insurance for you and your spouse/partner;
- Term Life and Supplemental AD&D insurance for your children; and
- Business Travel Accident/Medical (BTA/BTM) insurance.

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 benefits claims and appeals procedures and are responsible for paying claims.

Did You Know?

If you are enrolled in GUL coverage, you receive Will Preparation and Estate Resolution services at no cost when you work with an in-network attorney through MetLife Legal Plans. Will Preparation includes Wills, Powers of Attorney and Living Wills. Estate Resolution covers probate services only. Call MetLife Legal Plans at 1 (800) 821-6400 and provide the Citi group number 1137000 to get more information. This does not cover consultations for any other legal matters that would be included under the *MetLife Legal Plans*.

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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 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 forgo 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.

Benefits Eligible Pay at or Above $200,000

Once your benefits eligible pay is equal to or exceeds $200,000, you are no longer eligible for Basic Life and Basic Accidental Death and Dismemberment (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 GUL 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 continue your Basic Life coverage on an individual basis. Refer to "Continuing Basic Life and Basic AD&D on an Individual Basis" on page 257.

How Benefits Will Be Paid

If the benefit amount payable to a beneficiary is $5,000 or more, the claim may be paid by the establishment of a Total Control Account (TCA). The TCA is a settlement option or method used to pay claims in full. MetLife establishes an interest-bearing account that provides your beneficiary with immediate access to the entire amount of the insurance proceeds. MetLife pays interest on the balance in the TCA from the date the TCA is established, and the account provides for a guaranteed minimum rate. Your beneficiary can access the TCA balance at any time without charge or penalty simply by writing drafts in an amount of $250 or more. Your beneficiary may withdraw the entire amount of the benefit payment immediately if he or she wishes. Please note the TCA is not a bank account nor a checking, savings or money market account.

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; see the *For More Information* section for detailed instructions, including TDD and international assistance;
- 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 My Total Compensation and Benefits 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.

How Benefits Will Be Paid

If the benefit amount payable to a beneficiary is $5,000 or more, the claim may be paid by the establishment of a Total Control Account (TCA). The TCA is a settlement option or method used to pay claims in full. MetLife establishes an interest-bearing account that provides your beneficiary with immediate access to the entire amount of the insurance proceeds. MetLife pays interest on the balance in the TCA from the date the TCA is established, and the account provides for a guaranteed minimum rate. Your beneficiary can access the TCA balance at any time without charge or penalty simply by writing drafts in an amount of $250 or more. Your beneficiary may withdraw the entire amount of the benefit payment immediately if he or she wishes. Please note the TCA is not a bank account nor a checking, savings or money market account.

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 will receive a Health and Welfare Benefits Conversion/Portability Notice from the Citi Benefits Center once you lose eligibility.

The conversion for Basic Life insurance is administered by Barnum Financial Group and is time sensitive. If you are interested in converting your group coverage, call 1 (877) 275-6387 within 31 days after you become ineligible to begin this process. You will be put in contact with Barnum Financial Group who will work with you and help explain your options.

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 convert your Basic Life coverage into an individual policy to continue your coverage — 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 one 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.

Learn More about GUL Coverage

For more information about GUL Coverage, call MetLife at 1 (888) 830-7380.

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.

If your benefits eligible pay is reduced, your GUL amount will continue to be based on the higher benefits eligible pay. If you would like to decrease your coverage, you may call MetLife at 1 (888) 830-7380 to elect a lower multiple of your highest benefits eligible pay. Once you reduce coverage, you can increase it by electing additional multiples of your higher 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.

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

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

You can change the amount of your CAF contribution at any time. Note: A decrease in 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.

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. Afterward, 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 do not wish to continue GUL insurance. If you do not have a CAF account, or your CAF becomes depleted and you do not pay the premiums to MetLife, your GUL coverage will end.

Did You Know?

If you are enrolled in GUL coverage, you receive Will Preparation and Estate Resolution services at no cost when you work with an in-network attorney through MetLife Legal. Will Preparation includes Wills, Powers of Attorney and Living Wills. Estate Resolution covers probate services only. Call MetLife Legal Plans at 1 (800) 821-6400 and provide the Citi group number 1137000 to get more information. This does not cover consultations for any other legal matters that would be included under the MetLife Legal Plan benefit.

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.

Assignment

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

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

MetLife is not responsible for the validity of an assignment.

Naming a Beneficiary

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

Your spouse/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/Partner

You can enroll in GUL insurance coverage, provided by MetLife, for your spouse/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/partner.

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

If you enroll in GUL coverage at any other time, your spouse/partner must provide evidence of insurability for *any* amount of spouse/partner coverage.

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

If you leave Citi or terminate your marriage, or partnership, your spouse/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 termination of your employment, your divorce, or termination of your partnership.

Life Insurance for Your Children

If you have enrolled in GUL insurance coverage for you or your spouse/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 My Total Compensation and Benefits 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 any child to the Citi Benefits Center through ConnectOne at 1 (800) 881-3938 within 31 days of the birth or adoption. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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

- You, if you survive the dependent;
- 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 My Total Compensation and Benefits at www.totalcomponline.com.

How Benefits Will Be Paid

If the benefit amount payable to a beneficiary is $5,000 or more, the claim may be paid by the establishment of a Total Control Account (TCA). The TCA is a settlement option or method used to pay claims in full. MetLife establishes an interest-bearing account that provides your beneficiary with immediate access to the entire amount of the insurance proceeds. MetLife pays interest on the balance in the TCA from the date the TCA is established, and the account provides for a guaranteed minimum rate. Your beneficiary can access the TCA balance at any time without charge or penalty simply by writing drafts in an amount of $250 or more. Your beneficiary may withdraw the entire amount of the benefit payment immediately if he or she wishes. Please note the TCA is not a bank account nor a checking, savings or money market account.

Supplemental Accidental Death and 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 one 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 the 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 MyBenefits site available through My Total Compensation and Benefits 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/partner in increments of $10,000 to a maximum of $100,000 at any time without providing evidence of insurability. You do not need to buy Supplemental AD&D insurance for yourself to elect coverage for your spouse/partner. You may enroll your spouse/partner for Supplemental AD&D coverage at any time without providing evidence of insurability.

Once you or your spouse/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 26, or earlier if you lose eligibility for coverage.

If you leave Citi or terminate your marriage or partnership, you and your spouse/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 and 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 in 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 the same hand: 25% of the principal sum;
- Loss of all the toes of the same foot: 20% of the principal sum;
- Loss of sight in 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; and
- Coma: 1% monthly beginning on the seventh 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 or 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

Seat Belt and Air Bag Benefit

- Seat belt benefit: 10% of the principal sum subject to a maximum benefit of $25,000; and
- Air bag benefit: 5% of the principal sum subject to a maximum benefit of $10,000.

Additional Supplemental AD&D Benefits

Seat Belt and Air Bag Benefit

- Seat belt benefit: 10% of the principal sum subject to a maximum benefit of $25,000; and
- Air bag benefit: 5% of the principal sum subject to a maximum benefit of $10,000.

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 Center 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 four consecutive years, not to exceed an annual maximum of $10,000, and an overall maximum of 5% of the principal 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, the child 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 principal 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 semiannually 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 three 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 principal 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 semiannually 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 that 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 principal 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 pay benefits for only 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. Payments 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 or a dependent dies 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 principal sum.

Benefit Payment

For loss of your life, MetLife will pay benefits to your beneficiary. For 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, or 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; or
- Infection, other than infection occurring in an external, accidental wound;
- Loss caused by or contributed to as a result of 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;
  - Intoxication; benefits will not be paid for any loss in which the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident. Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred;
  - 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/partner 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/partner'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 will receive a letter from MetLife describing your options for continuing your coverage. Your monthly premium may be significantly higher than the Citi group 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 BTA, the BTM program provides non-routine and emergency medical coverage while traveling on business for Citi outside your home country or country of permanent assignment.

- Coverage is provided by Chubb. All regular full-time and part-time employees have BTA coverage equal to five times their salary to a maximum benefit of $2 million. Your spouse/partner and/or dependent children are considered covered persons and have BTA coverage while accompanying you on a business or relocation trip. An eligible spouse/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, you can designate a beneficiary by visiting Your Benefits Resources™. You can link to Your Benefits Resources™ through My Total Compensation and Benefits at www.totalcomponline.com. If you do not designate a beneficiary, any benefit will be payable in equal shares to: (1.) your spouse/partner, (2.) your children, (3.) your parents, and (4.) your siblings. Finally, if there are no survivors in any of these classes, any benefit will be payable to your estate.

Converting to an Individual Policy

You can convert your BTA coverage to an individual Accidental Death and 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 on your last day of employment with Citi.

Filing a Claim

You must provide notice — either written, authorized electronic (i.e., fax, email) or telephonic — 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/BTM insurance, you or your beneficiary may call the Citi Benefits Center. Call ConnectOne at 1 (800) 881-3938. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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 and 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.

Claims and Appeals

If you file a claim for benefits under the Basic Life, Basic Accidental Death and Dismemberment, Business Travel Accident/Medical, Group Universal Life or Supplemental Accidental Death and Dismemberment 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). 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 the Employee Retirement Income Security Act of 1974, as amended (ERISA) if your claim is denied on review; and
- A statement disclosing any internal rule, guideline, 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. 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).

Notice of Benefit Determination on Appeal

You will receive a written or an 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 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.

Legal Plan

Citigroup offers you the Citigroup Legal Benefits Plan (“MetLife Legal Plan” or “the Plan”), offered through MetLife. The Plan provides you and your family access to an affordable network of experienced attorneys in the United States. The Plan provides coverage for attorney fees for routine legal services related to personal or family legal issues. Most services authorized by the Plan are covered at 100% when you use network attorneys. A reimbursement schedule applies to fees charged by out-of-network attorneys.

Through MetLife’s partnership with Family First, you also have access to a range of caregiving solutions when you enroll in the Plan. Family First’s multi-disciplinary team will partner with you to create a holistic plan for your loved one, regardless of your loved one’s age. There is no added cost for this service.

This section of the handbook will explain how the Plan coverage works, including when benefits are paid.

For more information about the Plan, you can contact MetLife Legal Plans at 1 (800) 821-6400 or https://members.legalplans.comshar. Your membership number will be mailed to you along with a welcome letter from MetLife after your initial enrollment.

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Benefits at a Glance

The following table summarizes the Plan services available to you and your eligible dependents:

Features	Highlights
Benefits of Participating	• The Plan offers you and your family access to a network of attorneys for routine legal services related to personal and family legal issue. • Most services are covered at 100% when you use in-network attorneys. In-network services are available only in the continental United States, U.S. Virgin Islands, Puerto Rico and Hawaii. A reimbursement schedule applies to fees charged by out-of-network attorneys. • Attorneys will only provide services for U.S. legal issues solely. • Through MetLife's partnership with Family First, you and your family have unlimited, no cost support in finding a customized solution for your child and adult caregiving needs.
Covered Services	• Covered legal services include all of the following: Advice and consultation; Consumer protection; Debt matters; Defense of civil lawsuits; Document preparation and review; Family law; Immigration; Real estate matters; Traffic and criminal matters; and Wills and estate matters. • Please see the list of covered services on page 274 for details.
Pre-Existing Legal Matters Excluded	• Any legal matter for which an attorney-client relationship existed prior to you joining the Plan will be excluded, and no benefits will apply.
Who's Covered	• If you enroll for coverage, the Plan provides coverage for you and all of your eligible dependents. • The Plus Parents option allows you to purchase coverage for up to eight parents (parent/step parent and parent/step parent of the employee and parent/step parent and parent/step parent of the spouse/domestic partner for a total of 8).
Costs	• You pay the full cost of your coverage on an after-tax basis. There is a flat rate of $15 per month for coverage; $21 per month for the Plus Parents enhancement — your cost per pay period is the same regardless of how many of your dependents are covered.
Enrolling and Making Changes	• Enrolling: You can only enroll for coverage during Annual Enrollment or when you first become eligible (generally, as a newly hired employee or newly eligible to enroll in benefits coverage). Because there is one contribution level for legal coverage (including caregiving services through Family First), your cost for coverage does not increase if you add dependents (e.g., if you marry/enter into a partnership, or have a baby). They will be considered covered as of the date of the event. You must enroll in the MetLife Legal Plans in order to enroll your parents under the Plus Parents option. • Changing Coverage: You may not drop coverage during the plan year. You can only make changes to your coverage during Annual Enrollment. Midyear changes due to a Qualified Status Change are not permitted under this Plan. When you enroll, your participation is in effect throughout the plan year. You will continue to be a participant unless you (i) drop coverage during a subsequent Annual Enrollment; (ii)cease to be a benefits eligible employee; or (ii) your employment terminates.
Claims Administrator	• The Plan's claims administrator is MetLife Legal Plans, a MetLife Company.

How the Plan Works

Who's Covered?

If you enroll in the Plan, the Plan automatically covers you, your spouse/partner, and all eligible dependent children. For details about your eligible dependents, please see the *Eligibility and Participation* section of this handbook.

To further support your ability to take care of your family at every stage of life, the Plus Parents option can provide valuable help for the legal needs of the parents in your life.

You must be enrolled in the MetLife Legal Plans to add or have the Plus Parents coverage. With the Plus Parents coverage, your parents and parents-in-law have access to legal guidance for issues related to estate planning, elder care, identity theft and more.

The Plus Parents coverage accommodates extended and blended families, with coverage for up to eight parents (parent/step parent and parent/step parent of the employee and parent/step parent and parent/step parent of the spouse/domestic partner for a total of 8).

Cost of Coverage

You pay the entire cost for coverage — $15 per month and $21 per month with enhanced Plus Parents coverage — under the Plan with after-tax contributions. Your cost is the same regardless of how many dependents are covered under the Plan.

Your contributions toward the cost of coverage start when your coverage begins. Your contributions are automatically deducted from your pay.

If you have coverage but are away from work because of an unpaid sickness or leave of absence, you must pay for coverage on an after-tax basis through direct billing with Citi.

How to Enroll

You can only enroll for coverage when you first become eligible (generally, as a newly hired employee or newly eligible for benefits) or during Annual Enrollment. Unlike other Citi benefits, you cannot enroll, change, or cancel your coverage during the plan year, even if you have a Qualified Status Change, as defined in the *Eligibility and Participation* section of this Handbook. Participation in the Plan is optional. You must enroll to have coverage.

If you are enrolling as a new hire, or a newly eligible employee, you will need to enroll within 31 days of your hire date.

Once you are enrolled, your participation will continue as long as you remain eligible, unless you elect to drop coverage during a subsequent Annual Enrollment period.

When Coverage Begins

If You Are an Employee

If you enroll during Annual Enrollment, your coverage will be effective January 1 and you will continue to participate for the full calendar year (January through December). Once you enroll, your coverage will continue unless you decline coverage during a subsequent Annual Enrollment or you terminate employment.

Your Membership

MetLife Legal Plans will send your membership number to you after you enroll. You will need this number to get services and file claims for benefits. Please retain this number.

If You Are a Newly Hired or Newly Eligible Employee

If you enroll, coverage will be effective on your hire date.

You will continue to participate from the effective date through the end of the calendar year.

No Midyear Changes

Midyear changes are not permitted under this Plan, even if you have a Qualified Status Change that allows you to change other Citi benefits. Once you elect coverage, you cannot drop coverage during the plan year. However, any new family member (i.e. spouse/partner and/or eligible dependent children) are automatically covered under the Plan.

You can only make changes to your coverage during Annual Enrollment.

Continuing MetLife Legal Plans Coverage

If you were enrolled, your coverage ends on your termination date. You have the option to enroll in individual legal coverage by visiting MetLife.com/individual-legal-plans or contacting MetLife Legal Plans at 1 (800) 821-6400. You can make convenient monthly premium payments through ACH deductions.

Services in Progress Continue

Even if you don't continue group legal coverage, any services in progress before your coverage end date will be provided.

About the Plan

The Plan provides coverage for attorney fees for certain routine, U.S.-related legal services for personal or family legal issues.

The Plan offers access to a network of U.S. attorneys who provide a wide range of legal services. In-network services are available only in the United States, U.S. Virgin Islands, and Puerto Rico. Most services authorized by the Plan are covered at 100% when you use network attorneys.

A reimbursement schedule applies to fees charged by out-of-network attorneys.

Finding Network Attorneys

You can call MetLife Legal Plan's' Call Center at 1 (800) 821-6400 to find a network attorney. A Client Service Representative will ask you to identify yourself as a Citi employee and will request your membership number, which is located in your welcome letter MetLife Legal Plan sends to you after you elect coverage, and your home zip code.

Your spouse/ partner and any eligible child may use the Plan. Those family members will be required to provide your membership number when requested, to verify their eligibility.

The Plan Call Center

The Client Service Representative is responsible for all of the following:

- Verifying eligibility for services over the phone;
- Making an initial determination of whether and to what extent your case is covered (the Plan attorney will make the final determination of coverage);
- Providing a case number, which is similar to a claim number (each case is assigned a new case number);
- Providing the telephone number of the Plan attorney(s) most conveniently located near you; and
- Answering any questions you have about the Plan.

Following your initial phone call, you may schedule an appointment with a Plan attorney. Evening and Saturday appointments are available, if requested.

When you call a Plan attorney related to services covered under the Plan, he or she will provide a recommended course of action related to your legal needs. Ask the Plan attorney pertinent questions to ensure that you will receive comprehensive services, including, but not limited to the following: (i) if there are any limitations on the representation; (ii) if the Plan attorney will represent you in court in the event of litigation; (iii) if there are any related post litigation issues, in the event of litigation; and (iv) if there are any expenses you may incur to have a more complete representation, if there are limitations.

Plan and Out-of-Network Attorneys

When you use a Plan (in-network) attorney, all attorney's fees for covered services are paid in full by the Plan (except for certain limits shown in "What Is Covered" on page 274).

If you choose to seek legal services from an out-of-network attorney, the Plan will reimburse you for out-of-network attorneys' fees in accordance with a set fee schedule. Please see "What Is Covered" on page 274.

For services to be covered, you or your eligible dependents must establish an attorney-client relationship while you are an enrolled member of the Plan.

Your use of legal services provided by the Plan are totally confidential.

The Role of Plan Attorneys

The Plan attorney is required to maintain the strict confidentiality of a traditional attorney-client relationship. The attorney's relationship is exclusively with you. Citi will not receive information about your legal issues or the services you use under the Plan. In addition, no one will interfere with your Plan attorney's independent exercise of professional judgment when representing you.

The attorney will adhere to the rules of the Plan. MetLife Legal Plans, or the law firm providing services under the Plan, is responsible for all services provided by their attorneys.

Citigroup has no liability for the conduct of any Plan attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Plan. If you have a complaint about the legal services you have received or the conduct of an attorney, you can register a complaint by calling MetLife Legal Plan. Your complaint will be reviewed, and you will receive a response within two business days of your call.

Plan attorneys will refuse to provide services if the matter is clearly without merit, frivolous, or for the purpose of solely harassing another person.

What Is Covered

The following fee schedule describes the maximum amounts that the Plan will pay for covered legal services provided if you use an in-network attorney or reimburse you for if you use an out-of-network attorney. Only one fee category per case-type applies to each matter — the fee category that best describes the services that were provided.

The Plan provides only for the personal legal matters listed below. However, the Plan covers up to four hours of attorney services at $100 per hour for non-covered legal matters each year. Once you receive services from an out-of-network attorney, you cannot use an in-network Plan attorney for the same matter.

If you or your non-network attorney have any questions regarding coverage or exclusions, please visit the Plan website at https://members.legalplans.com or call 1 (800) 821-6400 and ask to speak with MetLife's Payment Administrator before services are provided.

The services listed with "(includes Plus Parents)" notation are available to parents and parents-in-law through the Plus Parents option. The list of covered services may change at any time.

Advice and Consultation

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Office Consultation and Telephone Advice	100%	$70 (If no further covered services are provided)

Consumer Protection

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Consumer Protection Matters Excludes disputes over real estate, construction or insurance. Disputed amount exceeds small claims limit and is evidenced by writing.		
Correspondence and Negotiation	100%	$500
Filing of Suit, Ending in Settlement or Judgement	100%	$2,000, plus Trial Supplement*
Property Protection		
Counseling, Document Review and Assistance	100%	$125
Small Claims		
Counseling on Preparing Small Claims Complaint and Trial Preparation This service does not cover a Plan attorney's attendance or representation at a small claims trial, collection activities after the judgment or any services related to post judgment actions.	100%	$200

* Trial Supplement — In addition to the fees indicated, the Plan will pay the attorney's fees for representation in trial beyond the third day of trial, up to a maximum of $800 per day up to $100,000 total trial supplement maximum.

Debt Matters

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Debt Collection Defense (Consumer Debts) Excludes defense of matters arising from divorce or post-decree actions. Includes repossession and garnishment.		
Negotiation and Settlement	100%	$350
Negotiation and Settlement after Complaint and Answer Filed	100%	$600
Trial	100%	$1,050 plus Trial Supplement *
Debt Collection Defense (Foreclosures)		
Negotiation	100%	$500
Complaint and Answer Filed, Settlement Negotiations	100%	$850
Trial	100%	$1,500 plus Trial Supplement *
Identity Theft	100%	
Correspondence/Notice to Creditors	100%	$250
Personal Bankruptcy or Wage Earner Plan		
Chapter 7 Individual or Member/Spouse/Partner	100%	$850
Chapter 13 Individual or Member Spouse/Partner	100%	$1,400
Tax Audits		
Negotiation and Settlement	100%	$500
Audit Hearing (Includes Negotiation & Settlement)	100%	$1,200

Defense of Civil Lawsuits

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Administrative Hearing Representation and Incompetency Defense Excludes defense of matters arising from divorce, post-decree actions or other family law matters, or job related incidents		
Negotiation and Settlement	100%	$500
Contested Hearings ending in Settlement or Judgement	100%	$1,800 plus Trial Supplement *
Civil Litigation Defense Excludes defense of matters arising from divorce, post-decree actions or other family law matters or job related incidents .		
Negotiation and Settlement	100%	$650
Filing Answer, Litigation Ending in Settlement or Judgment	100%	$1,800, plus Trial Supplement *

* Trial Supplement — In addition to the fees indicated, the Plan will pay one half of the attorney's hourly rate fees for representation in trial beyond the third day of trial, for up to a maximum of $800 per day up to a $100,000 total trial supplement maximum.

Document Preparation and Review

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Affidavits (includes Plus Parents)	100%	$75
Deeds (includes Plus Parents)	100%	$100
Demand Letters (includes Plus Parents) Negotiations and Plan Attorney representation in litigation are not included	100%	$75
Document Review (includes Plus Parents)	100%	$100
Elder Law Matters (includes Plus Parents) (Counseling and document review of only documents pertaining to the participant's parents as affecting the participant)	100%	$140
Mortgages (includes Plus Parents)	100%	$70
Promissory Notes (includes Plus Parents)	100%	$70

Family Law

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Adoption and Legitimization		
Uncontested	100%	$650
Contested	100%	$1,500, plus Trial Supplement*
Guardianship or Conservatorship		
Uncontested	100%	$650
Contested	100%	$1,500, plus Trial Supplement*
Name Change	100%	$400
Prenuptial Agreement Available to Eligible Plan Member only	100%	$750
Protection from Domestic Violence Available to Eligible Plan Member only (eligible dependents are not covered) Preparation of Paperwork and Attendance at Hearing	100%	$425

* Trial Supplement — In addition to the fees indicated, the Plan will pay the attorney's fees for representation in trial beyond the third day of trial, up to a maximum of $800 per day up to $100,000 total trial supplement maximum.

Immigration

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Immigration Assistance Counseling on Preparing Forms and Hearing Preparation Plan Attorney attendance and representation in court is not covered.	100%	$500

Real Estate Matters

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Boundary or Title Disputes (Primary Residence)		
Negotiation and Settlement	100%	$500
Trial	100%	$1,500, plus Trial Supplement*
Eviction and Tenant Problems (Primary Residence - Tenant only)		
Correspondence and Negotiations	100%	$280
Eviction Trial Defense	100%	$840, plus Trial Supplement*
Home Equity Loan (Primary Residence) Applies only to attorney who represents the plan member, not the attorney representing the lending institution	100%	$350
Home Equity Loan (Second or Vacation Home) Applies only to attorney who represents the plan member, not the attorney representing the lending institution	100%	$350
Property Tax Assessment (Primary Residence)		
Negotiation and Settlement	100%	$270
File Request for hearing with Attendance at Hearing	100%	$620 plus Trial Supplement *
Refinance of home (Primary Residence, Second or Vacation home) Applies only to attorney who represents the Plan member, not the attorney representing the lending institution.	100%	$350
Sale or Purchase of Home (Primary Residence, Second or Vacation Home) Applies only to attorney who represents the plan member, not the attorney representing the lending institution	100%	$500
Security Deposit Assistance This service does not include Plan Attorney representation in lawsuit against a landlord, including an action for the return of a security deposit. Additionally, it does not cover a Plan attorney's attendance or representation at a small claims trial, collection activities after the judgment or any services related to post judgment actions.		
Counseling on Preparing Small Claims Complaint and Trial Preparation	100%	$150
Demand Letter/Negotiations	100%	$250
Zoning Applications		
Preparation of Documentation	100%	$250
Documentation / Attending Hearing	100%	$500

* Trial Supplement — In addition to the fees indicated, the Plan will pay the attorney's fees for representation in trial beyond the third day of trial, up to a maximum of $800 per day up to $100,000 total trial supplement maximum.

Traffic and Criminal Matters

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Driving Privileges/Restoration of Suspended License	100%	$250
Juvenile Court Defense		
Negotiation and Settlement	100%	$500
Trial	100%	$1,200 plus Trial Supplement*
Traffic Ticket Defense (No DUI)		
Plea or Trial at Court form Minor Moving Violations	100%	$250
Plea or Trial at Court for Serious Moving Violations Resulting in Jail Time or License Suspension	100%	$500, plus Trial Supplement*

* Trial Supplement — In addition to the fees indicated, the Plan will pay the attorney's fees for representation in trial beyond the third day of trial, up to a maximum of $800 per day up to $100,000 total trial supplement maximum.

Wills and Estate Matters

Case Type	In-Network	Out-of-Network The Plan Will Pay Up to
Living Wills (includes Plus Parents)		
Individual	100%	$75
Member and Spouse	100%	$80
Powers of Attorney (includes Plus Parents)		
Individual	100%	$65
Member and Spouse	100%	$75
Trusts		
Individual	100%	$325
Member and Spouse	100%	$450
Wills and Codicils (includes Plus Parents)		
Individual	100%	$150
Member and Spouse	100%	$200

If there is any question about whether a service would be included or excluded, or the extent of coverage of a service, it is important to call MetLife Legal and receive confirmation as to whether and for how much a service is covered.

Plan Attorneys will handle probate matters at a fee of 10% less than the prevailing rate — subject to applicable law and court rules. The Covered Person must pay the reduced fee and all costs.

Plan Attorneys will handle personal injury matters whether the covered person is the plaintiff at a maximum fee of 25% of the gross award. The covered person is responsible for paying the attorney's fee and all costs.

About Caregiving Services

Through MetLife's partnership with Family First, the Plan provides for the cost of services associated with developing a personalized caregiving solution. When you contact Family First, a dedicated Care Expert with an average of 20 years' experience will work with you and a multi-disciplinary, nationwide network of highly-trained experts, such as physicians, social workers and counselors, to develop a comprehensive solution to your caregiving challenges. Services are covered at 100%.

Contact Family First by calling 1 (800) 821-6400 or by visiting https://members.legalplans.com and selecting "Caregiving Support & Resources". You will be redirected to the Family First home page. You can also access Family First through the mobile app.

What Is Not Covered

The Plan does not cover the following:

- Employment-related matters, including company or statutory benefits;
- Matters involving Citigroup, Citibank, N.A. and affiliates., MetLife® and affiliates, and Plan attorneys;
- Matters in which there is a conflict of interest between employee and spouse/ partner or children, in which case services are excluded for the spouse/ partner and children;
- Appeals and class actions;
- Farm and business matters, including rental issues when the participant is the landlord;
- Patent, trademark, and copyright matters;
- Amounts due to third parties such as:
  - Court costs, filing fees or recording fees;
  - Fines;
  - Judgements;
  - Witness fees; or
  - Transcripts.
- Frivolous or unethical matters; and
- Matters for which an attorney-client relationship exists prior to the participant becoming eligible for Plan benefits.

This list may change at any time.

Pre-Existing Legal Matters

Any legal matter for which an attorney-client relationship existed prior to your becoming eligible for services under the MetLife Legal Plan will be excluded and no benefits will apply.

Items Not Listed and Not Excluded

If there is any question about whether a service would be included or excluded, or the extent of coverage, it is important to call MetLife Legal and receive confirmation as to whether a service is covered and the extent to which such a service is covered.

Claiming Benefits

The following explains when and how to file claims for covered expenses under the Plan. For more information on your rights with respect to claims, please see the *Administrative Information* section of this Handbook.

How to File Claims

Rules regarding claims depend on whether you receive your services in- or out-of-network, as shown below:

Source of Benefits	Claims Process
In-Network Benefits	You do not need to file a claim form.
Out-of-Network Benefits	Contact MetLife Legal Plans, the claims administrator, to obtain an out-of-network claim form. (See contact information below under “Where to Submit Claims”.

To have your claim considered for benefits, you must notify MetLife Legal Plans. MetLife will send you a claim form. After the matter is finished, the claim form must be completed and returned to MetLife with the attorney's final bill. Within 60 days of MetLife's receipt of the completed claim form and final bill, MetLife will pay the covered person up to the amount stated in the Non-Plan Attorney Fee Schedule. The covered person receiving services from the non-Plan Attorney will be responsible for making payment to the non-Plan Attorney for any expenses or fees incurred in excess of the amount paid by MetLife.

Where to Submit Claims

The claims administrator is MetLife Legal Plans, Inc.:

MetLife Legal Plans, Inc.
1111 Superior Avenue
Cleveland, OH 44114

1 (800) 821-6400

8 a.m. to 8 p.m. Eastern Time

Claims and Appeals

If you file a claim for benefits under the Citigroup Legal Benefits Plan (the "Plan"), 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). 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 the Employee Retirement Income Security Act of 1974, as amended (ERISA) if your claim is denied on review; and
- A statement disclosing any internal rule, guideline, 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. 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).

Notice of Benefit Determination on Appeal

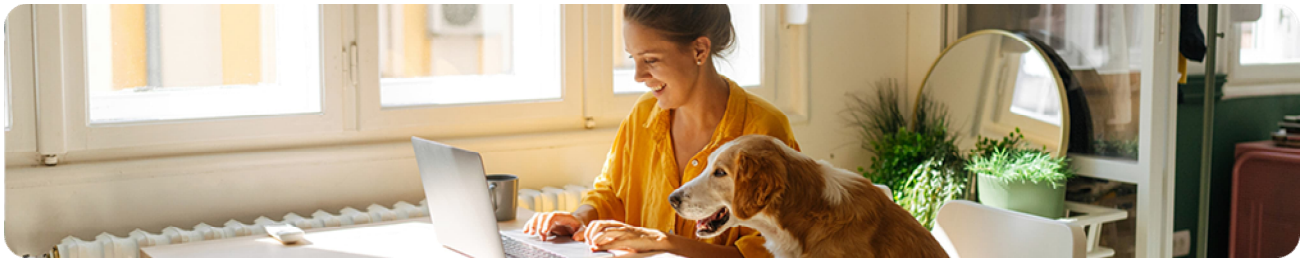
You will receive a written or an electronic notice of the benefit determination upon review. In the event your claim is denied on appeal, the notice will provide:

- 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 Plan 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 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 Plan or any shorter period is specified in the rules of the Claims Administrator, that period will apply to proceedings against the insurer or with regard to the ruling of that Claims Administrator, respectively.

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



Administrative Information

This section contains general information about the administration of the Citi health and insurance plans, the Plan Sponsors and Claims Administrators.

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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.

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 change in status or special enrollment right — to enroll. Visit the *Eligibility* 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, Citi Be Well Program, 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 285 for more information. You can obtain a copy of the notice by contacting the Citi Benefits Center through ConnectOne at 1 (800) 881-3938. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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 benefits 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 individuals 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, books 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 who 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 ("firewall"). 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 Be Well 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 C.F.R. 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. This notice also describes your rights regarding the Component Plans' use and disclosure of protected health information that includes substance use disorder information to the extent a Component Plan receives, maintains or transmits records that are subject to the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 ("Part 2").

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 as instructed under "Contact Information" on page 290. 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 290.

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 of, disclosure of or request for PHI to the extent practical 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 another 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 a 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 are 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 288). 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, or that treating such person as your personal representative could endanger you, or if 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.

Confidentiality of Substance Use Disorder Records

The Component Plans will comply with Part 2 regarding the confidentiality of your substance use disorder patient records to the extent a Component Plan receives, maintains or transmits such records, ensuring that disclosures are made only as permitted by law. If you have provided a single consent for all future uses and disclosures for treatment, payment, and healthcare operations, the Component Plans may use and disclose your Part 2 records for treatment, payment, and healthcare operations, as described earlier in this notice, until you revoke such consent in writing. However, the Component Plans will not use or disclose your Part 2 records in a civil, criminal, administrative, or legislative proceeding without either your written consent or a court order after you are provided notice and an opportunity to be heard. Further, the Component Plans will never use your Part 2 information for fundraising purposes.

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 290.

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 290.

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 290.

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 have a copy PHI that may be used to make decisions about you. 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, email 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 290, 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 290. 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 290.

Notwithstanding the permitted disclosures noted above, all participants' PHI is deemed confidential and shall be protected to the fullest extent possible under applicable law. Such disclosure, beyond permitted payment and health care operations, shall not be authorized unless the specific request strictly complies with HIPAA requirements (i.e., court order, subpoena, etc.) with respect to the requested information, and is subject to review by the plan administrator.

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 290. 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 email address you provided to such Component Plan).

Effective Date

This Notice of HIPAA Privacy Practices became effective April 14, 2003, and was last reviewed and revised effective August 20, 2025.

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
388 Greenwich St. 15th Floor
New York, NY 10013

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	The Citi Benefits Center through ConnectOne at 1 (800) 881-3938. From the ConnectOne "benefits" menu, choose the "health and insurance benefits as well as TRIP and spending accounts" option and speak to a Citi Benefits Center representative.
Citi Be Well Program Health Care Spending Account Limited Purpose Health Care Spending Account	From outside the United States, Puerto Rico and Canada: Call 1 (469) 220-9600. Press 1 when prompted. From the ConnectOne "benefits" menu, choose the "health and insurance benefits as well as TRIP and spending accounts" 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.

Section 1557 of the Affordable Care Act

Notice on Non-Discrimination and Accessibility:

Discrimination is Against the Law

Citigroup Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Citigroup Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Citigroup Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Citi Global Benefits Department through the Citi Benefits Center via ConnectOne at 1 (800) 881-3938 (or call the Telecommunications Relay Service at 711 and then call ConnectOne).

If you believe that Citigroup Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Citigroup Inc.
Citi Global Benefits Department
388 Greenwich Street 15th Floor
New York, NY 10013

Phone: Contact Citi Benefits Center via ConnectOne at 1 (800) 881-3938, TTY:711.

You can file a grievance with the Citi Global Benefits Department in person or by mail (as described below under "Grievance Procedure"). If you need help filing a grievance, Citi Global Benefits Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, which is available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1 (800)-368-1019 or 1 (800)-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is also available at Citigroup Inc.'s website at https://citibenefits.com/Forms-and-Documents.

Grievance Procedure

It is the policy of Citigroup not to discriminate on the basis of race, color, national origin, age, disability or sex. Citigroup has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act ("Section 1557") and its implementing regulations, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, age, disability, or sex in certain health programs and activities. Section 1557 and its implementing regulations may be requested from the Citi Global Benefits Department, 388 Greenwich Street, 15th Floor, New York, NY 10013.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, age, disability or sex may file a grievance under this procedure. It is against the law for Citigroup to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Grievances must be submitted to the Citi Global Benefits Department (the Section 1557 Coordinator) within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

The Citi Global Benefits Department (or its designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Citi Global Benefits Department will maintain the files and records of Citigroup relating to such grievances. To the extent possible, and in accordance with applicable law, the Citi Global Benefits Department will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

The Citi Global Benefits Department will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

The person filing the grievance may appeal the decision of the Citi Global Benefits Department by writing to the Citi Global Benefits Department (Section 1557 Administrator) within 15 days of receiving the decision. The Section 1557 Administrator shall issue a written decision in response to the appeal no later than 30 days after its filing.

Citigroup will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings.

The availability and use of this Grievance Procedure do not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, age, disability or sex in court or with the U.S. Department of Health and Human Services, Office for Civil Rights.

Assistive Technology

Arrangements for auxiliary aids and services or language assistance services can be made if needed to fully access this information. For assistance, please call the Citi Benefits Center via ConnectOne at 1 (800) 881-3938 (or call the Telecommunications Relay Service at 711 and then call ConnectOne).

Language Assistance

For language assistance in your language call the number on your medical plan ID Card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

.)الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية(،)اللغة العربية(للمساعدة في Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

انگلیسی. برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید(Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)

For More Information

Online: Visit Your Benefits Resources(YBR)™ available through My Total Compensation and Benefits at www.totalcomponline.com.

Phone: Call the Citi Benefits Center via ConnectOne at 1 (800) 881-3938, from the “Benefits” menu, select the appropriate option. 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.

Representatives are available from 9 a.m. to 6 p.m. ET on weekdays, excluding holidays. For expatriate staff employees and from outside the United States, Puerto Rico and Canada, if unable to connect through ConnectOne, call 1 (469) 220-9600. Representatives are available from 10 a.m. to 4 p.m. ET on weekdays.

For text telephone services, call the Telecommunications Relay Services at 711 (employees located in Puerto Rico should call 1 (866) 280-2050), then call 1 (800) 881-3938 and follow the instructions to enter ConnectOne 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” on page 294.

Creditable Coverage Disclosure Notice

For Employees and Former Employees Enrolled in a 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. See the *For More Information* section for detailed instructions, including TDD and international assistance.

* 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 later. 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 to 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. 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 (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 is not 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. ET, 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 (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. See the *For More Information* section for detailed instructions, including TDD assistance.

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 Insurance 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 policies, as applicable, 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, your spouse/partner or your 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 299.

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 per 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 306.

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

Cross-Plan Offsets

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive (an ”Overpayment”), the Plan has the right to be repaid. The Plan has the right to reduce by the amount of the Overpayment, any future benefit payment made to you or your dependents. The Plan may also recover Overpayments by reducing future payments to a provider by the amount of the Overpayment under a process referred to as a “cross-plan offset.” These future payments may involve this Plan or other health plans that are administered by the Plan’s third-party administrator(s) (“TPA”). Under this process, the TPA reduces future payments to providers by the amount of the Overpayments they received, and then credits the recovered amount to the plan that made the overpayment.

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 "Plan Information" on page 308.

Subrogation, Reimbursement and Right of Recovery

By enrolling in the Plan and applying for benefits from the Plan, you and your covered dependents (including minor dependents), agree and acknowledge that benefits are not payable to or on behalf of a covered person or dependent when the injury or illness occurs through an act or omission of another person, party, or entity, and any such payments made or advanced by the Plan are subject to the following terms and conditions.

No application of "make whole," "double recovery," and "common fund" rules

The Plan's provisions concerning subrogation/right of recovery, equitable liens, and other equitable remedies (outlined above and more fully below) supersede the applicability of the federal common law and equitable doctrines commonly referred to as the "make whole" rule, the "double-recovery" rule and the "common fund" rule. These doctrines have no applicability to the Plan's right of recovery hereunder.

Assignment of Rights (Subrogation)

By accepting benefits from this Plan, you and your covered dependents automatically assign to the Plan any rights you or they may have to recover all or part of the same covered expenses of the benefits paid on behalf of you and/or your covered dependents from another source, including another group health plan, insurer or individual, limited, however, to the amount of covered expenses the Plan has paid on behalf of you and/or your covered dependents. This assignment also grants the Plan a right to recover from your no-fault auto insurance carrier in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

By virtue of this assignment, the Plan is entitled to recover 100% of the amounts paid, or to be paid, by the Plan on behalf of you or your covered dependents (including minor dependents) from all recoveries by you or your covered dependents from any other party (whether by lawsuit, mediation, arbitration, settlement, award, judgment, order, insurance or otherwise) ("Recovered Funds"). This assignment includes, without limitation, the assignment to the Plan of a right to any Recovered Funds paid by any other party to you or your covered dependents (including minor dependents and wrongful death beneficiaries) or paid on behalf of you or your covered dependents (including minor dependents and wrongful death beneficiaries), or on behalf of the estate of any covered person.

You and your covered dependents are required to reimburse the Plan on a first-dollar basis (which means that the Plan will have a first priority claim to any Recovered Funds), regardless of whether the Recovered Funds amount to a full or partial recovery. Further, the Plan is entitled to recovery regardless of how the Recovered Funds are characterized (e.g., pain and suffering, punitive damages, benefits, lost wages, loss of future earnings, medical expenses, costs and/or expenses, attorneys' fees) and regardless of whether the recovery is designated as payment for medical services or expenses. The Plan's share of the recovery will not be reduced because you or your covered dependent (including your minor dependent) has not received the full damages claimed, unless the Plan agrees in writing to a reduction. Any reduction is subject to prior written approval by the Plan, or agent of the Plan who administers the Plan's subrogation, reimbursement recoveries.

This assignment also allows the Plan to pursue any claim that you or your covered dependent (including your minor dependent) may have against any third party, or its insurer, whether or not you or your covered dependent choose to pursue that claim. In the event you or your covered dependent elects not to pursue your claim(s) against a third party, the Plan shall be equitably subrogated to your (or your covered dependent's) right of recovery.

When you, or your covered dependent – and not the Plan – pursue and obtain any Recovered Funds, you or your covered dependent shall be responsible for all expenses involved in obtaining that recovery (whether obtained by lawsuit, mediation, arbitration, settlement or, award, judgment, order, insurance or otherwise), including but not limited to, all attorneys' fees, costs, and expenses; which fees, costs, and expenses shall not reduce the amount that you or your covered dependents (including minor dependents) are required to reimburse the Plan, and the Plan's rights shall not be reduced due to covered person's own negligence. For purposes of clarity, the Plan is not subject to any state laws or equitable doctrine, and the Plan's first claim on the recovery operates on every dollar received from a third party, even those covering your or your covered dependent's litigation costs and attorneys' fees.

Equitable Lien and Other Equitable Remedies

By accepting benefits from this Plan, you agree that the Plan has established an equitable lien against any money or property you or your covered dependents (or any individual or entity acting on your or their behalf such as a legal representative or agent) recover from any other party, including but not limited to, an insurer (including but not limited to third-party, no-fault, med-pay, uninsured, or underinsured motorist), another group health plan or another individual, sufficient to reimburse the Plan in full for benefits advanced. For purposes of clarity, this equitable lien also attaches to any payment received from workers' compensation, whether by judgment, award, settlement or otherwise, where the Plan has paid benefits prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers will be deemed to mean that such a determination has been made.

The Plan's lien exists at the time the Plan pays benefits, and if you or your covered dependents file a petition for bankruptcy, you and your covered dependents agree that the Plan's lien existed prior to the creation of the bankruptcy estate.

You further agree to hold any reimbursement or recovery received by you or your covered dependents (or any legal representative or agent) in trust on behalf of the Plan to cover all benefits paid by the Plan.

The Plan reserves all rights to seek enforcement of its rights hereunder, including but not limited to, the right to file a lawsuit against you or your covered dependent or any other party possessing or controlling any Recovered Funds, and the right to recoup amounts owed in any other manner prescribed by law.

Obligation to Assist in the Plan's Reimbursement Activities

As a participant in this Plan, the covered person is required to cooperate with efforts to recover benefits paid under the Plan. The covered person must also notify the Plan Administrator within 45 days of the notice which is given to a third party of the intention to recover damages due to the covered person's illness or injury.

This cooperation includes providing the Plan with relevant information (including information concerning any other applicable insurance coverage that may be available such as automobile, home and other liability insurance coverage and coverage under another group health plan), providing the identity of any other person or entity and their insurers, if applicable) that may be obligated to provide payments or benefits on account of the same illness or injury for which the Plan made payments, signing and delivering documents the Plan reasonably requests, and obtaining the Plan's consent before releasing any party from liability. If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the Plan's subrogation and reimbursement rights.

Failure by you or your covered dependents to cooperate with the Plan in the exercise of these rights may result, at the discretion of the Plan or the Plan Administrator, in a denial or reduction of future benefit payments available to you or your covered dependents under the Plan by an amount, up to the aggregate amount paid by the Plan that was subject to the Plan's equitable lien, but for which the Plan was not reimbursed.

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. See the *For More Information* section for detailed instructions, including TDD and international assistance.

You can file your QMCSO by mailing it to:

Citigroup
Qualified Order Center
PO Box 299082
Lewisville, TX 75029-9107

Phone: 1 (800) 881-3938. Choose the "health and insurance benefits as well as TRIP and spending accounts" option.

Fax: 1 (847) 554-1614

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 310.

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 304.

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

- Medical, dental and vision claims must be filed within 12 months from 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 (i.e., all substantiating documentation must be submitted) 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.
- Supplemental Medical Plan claims must be filed within three years from the date of service.
- Business travel accident/medical claims must be filed within 365 days of the accident.

How to File a Claim	
Medical	
In-Network Only Plan, Choice Plan and High Deductible Plan with HSA (non-HMOs)	Use one of the following forms, available in the "Forms and Documents" section of Citi Benefits Online at www.citibenefits.com, to file a claim for a covered out-of-network expense: • Aetna claim form (for In-Network Only Plan, Choice Plan and High Deductible Plan with HSA participants) • Anthem BlueCross BlueShield claim form (for In-Network Only Plan, Choice Plan and High Deductible Plan with HSA)
HMO participants	Call your HMO for any claim-filing information.
Prescription Drugs	
CVS Caremark (prescription drug program related to all non-HMO medical plans including the In-Network Only Plan, Choice Plan and High Deductible Plan with HSA)	Use the CVS Caremark Prescription Drug claim form, available in the "Forms and Documents" section of Citi Benefits Online at www.citibenefits.com, www.caremark.com, or the CVS mobile app to file a claim for a covered out-of-network expense. To access mail order forms, log in to www.caremark.com Or call CVS Caremark at 1 (844) 214-6601 if you need assistance
Dental	
MetLife Preferred Dentist Program (PDP)	MetLife Dental claim form, available in the "Forms and Documents" section of Citi Benefits Online at www.citibenefits.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 "Forms and Documents" section of Citi Benefits Online at www.citibenefits.com. • Call the Aetna Vision Plan at 1 (877) 787-5354.
Health Care Spending Account (HCSA) and Limited Purpose Health Care Spending Account (LPSA)	If you do not use your debit card for eligible HCSA or LPSA expenses, you can file a claim by using the Health Care Spending Account/Limited Purpose Health Care Spending Account claim form. If a receipt is needed, you will be notified within 30 days. Claim forms are available in the "Forms and Documents" section of Citi Benefits Online at www.citibenefits.com, or submit a claim online via the Optum Financial website. You can access Optum Financial through My Total Compensation and Benefits 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 "Forms and Documents" section of Citi Benefits Online at www.citibenefits.com.
Transportation Reimbursement Incentive Program (TRIP) *TRIP parking participants enrolled in the cash reimbursement option only*	To file a claim, the Transportation Reimbursement Incentive Program (TRIP) claim form is available on the Optum Financial website through My Total Compensation and Benefits at www.totalcomponline.com. From the main page, click on "TRIP and Spending Accounts."
Supplemental Medical Plan claims	The Aetna Simplified Claims Experience™ is available online on the My Aetna Supplemental app, or member portal at Myaetnasupplemental.com. You can also view your coverage and sign up for direct deposit. If you are also an Aetna medical member (enrolled in the In-Network Only Plan, Choice Plan, High Deductible Plans with HSA) you won't have to provide any medical documents to file your claim. If you're not enrolled in an Aetna plan, the process is the same, but you will be prompted to provide medical documents, like an itemized bill. Call Aetna Voluntary Member Services with any questions or for a paper claim form at 1 (800) 607-3366 (TTY: 711), Monday through Friday, 8 AM to 6 PM.
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. See the *For More Information* section for detailed instructions, including TDD and international assistance.
Basic Life and Basic AD&D insurance	To file a claim, your beneficiary may call the Citi Benefits Center through ConnectOne at 1 (800) 881-3938. See the *For More Information* section for detailed instructions, including TDD and international assistance.
GUL and Supplemental AD&D insurance	To file a claim, your beneficiary may call the Citi Benefits Center through ConnectOne at 1 (800) 881-3938. See the *For More Information* section for detailed instructions, including TDD and international assistance.
Business Travel Accident/Medical (BTA/BTM) insurance	To file a claim, call Chubb, the claims administrator, at 1 (800) 336-0627 for claims within the U.S. or 1 (302) 476-6194 for claims outside of the U.S. You may also email Chubb at ChubbAandHClaims@Chubb.com. .
MetLife Legal Plans	• You do not need to file a claim for in-network services. • To file an out-of-network claim, contact MetLife Legal Plans, the claims administrator, at 1 (800) 821-6400 to obtain an out-of-network claim form.

To file a claim or appeal, you must use the designated form in accordance with the applicable Citigroup Health and Insurance Plan procedures. By participating in the Citigroup Health and Insurance Plans, you and your beneficiaries agree that you cannot commence a legal action against any of the Citigroup Health and Insurance 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 Insurance 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 306 and the list of Claims Administrators under "Claims Administrators" on page 310.

Note: The Health Savings Account (HSA) associated with the High Deductible Plan with HSA 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 one of the Citigroup Health and Insurance Plans, you must first go through the Citigroup Health and Insurance 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), the Supplemental Medical Plans, 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/ Limited Purpose Health Care Spending Account (HCSA/LPSA), the Supplemental Medical Plans 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 appeals rules. The primary difference is the time frame within which claims and appeals must be determined.

1. Preservice claim: A claim is a preservice claim if the receipt of the benefit is conditioned, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined below. Benefits under any Plan that require approval in advance are specifically noted as being subject to preservice authorization (also called prior authorization).
2. Urgent care claim: A claim involving urgent care is any preservice claim for medical care or treatment to which the application of the time periods that otherwise apply to preservice 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 preservice 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 preservice claim or an urgent care claim.
4. Concurrent care claim: A concurrent care decision occurs when the Claims Administrator approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims:

   (a) Where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and

   (b) Where an extension is requested beyond the initially approved period of time or number of treatments.

Deciding Initial Medical Benefits 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 preservice claim, the claimant shall be notified as soon as possible but no later than five days following the receipt of the incorrectly filed claim, and (b) in the case of an incorrectly filed urgent care claim, you will be notified as soon as possible but no later than 24 hours following receipt of the incorrectly filed claim.

The Claims Administrator will decide an initial preservice claim within a reasonable time appropriate to the medical circumstances but no later than 15 days after receipt of the claim.

The Claims Administrator will decide an initial urgent care claim as soon as possible, taking into account the medical urgencies, but no later than 72 hours after receipt of the claim.

However, if a claim is a request to extend a concurrent care decision (defined above) involving urgent care and if the claim is made at least 24 hours prior to the end of the initially approved period of time or number of treatments, the claim will be decided within no more than 24 hours after the receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable time frames for preservice, urgent care or post-service claims.

A decision by the Claims Administrator to reduce or terminate an initially approved course of treatment is an adverse benefit decision that may be appealed by the claimant, as explained below. Notification to the claimant of a decision to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow you to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.

An initial post-service claim shall be decided within a reasonable time but no later than 30 days after the receipt of the claim.

Despite the specified time frames, nothing prevents you from voluntarily agreeing to extend the above time frames. In addition, if the Claims Administrator is not able to decide a preservice or post-service claim within the above time frames due to matters beyond its control, one 15-day extension of the applicable time frame is permitted, provided that you are notified in writing prior to the expiration of the initial time frame applicable to the claim. The extension notice shall include a description of the matter beyond the Plan's control that justifies the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

If an urgent care claim is incomplete, the Claims Administrator shall notify you as soon as possible but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally, unless you request a written notice, and it shall describe the information necessary to complete the claim and shall specify a reasonable time, no less than 48 hours, within which the claim must be completed. The Claims Administrator shall decide the claim as soon as possible but no later than 48 hours after the earlier of (a) receipt of the specified information or (b) the end of the period of time provided to submit the specified information.

If a preservice or post-service claim is incomplete, the Claims Administrator may deny the claim or may take an extension of time, as described above. If the Claims Administrator takes an extension of time, the extension notice shall include a description of the missing information and shall specify a time frame, no less than 45 days, in which the necessary information must be provided. The time frame for deciding the claim shall be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided to the Claims Administrator. If the requested information is provided, the Plan shall decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

Notification of Initial Benefit Decision by Plan

You will receive written notification of an adverse decision on a claim, and it will include the following:

- The specific reasons for the denial;
- The specific reference to the Plan documentation that supports these reasons;

- The additional information you must provide to perfect your claim and the reasons why that information is necessary;
- The procedure available for a further review of your claim, including a statement regarding your right to bring action under Section 502(a) of ERISA if your claim is denied on review;
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical circumstances or (b) a statement that such explanation will be provided at no charge upon request; and
- In the case of an urgent care claim, an explanation of the expedited review methods available for such claims.

Written notification of the decision on a preservice or urgent care claim will be provided to you whether or not the decision is adverse. Notification of an adverse decision on an urgent care claim may be provided orally, but written notification will be furnished no later than three days after the oral notice.

Appeals

You have the right to appeal an adverse decision under these claims procedures. The appeal of an adverse benefit decision must be filed within 180 days following your receipt of the notification of the 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 299) must be filed within 30 days of your receipt of the notification of the decision to reduce or terminate.

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

The appeal of a preservice claim shall be decided within a reasonable time appropriate to the medical circumstances but no later than 30 days after receipt of 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 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 299) shall be decided before the proposed reduction or termination takes place. The appeal of a denied request to extend a concurrent care decision shall be decided in the appeal time frame for a preservice, urgent care or post-service claim as 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.
- 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 Drugs* 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 claims 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 (see the *For More Information* section for detailed instructions, including TDD and international assistance). Return the completed form to the Committee:

Plans Administration Committee of Citigroup Inc.
c/o Claims and Appeals Management Team
Dept 01488
PO Box 299107
Lewisville, TX 75029-9107

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 Legal 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 Determination

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. For disability claims, if no internal rules or protocols are used to deny a claim, the notice should state that none exist.
- With respect to a disability benefit denial, the notice shall include the following:
  - Why the decision differs from (i) the views presented by the treating physician's report, (ii) the advice of the medical or vocational experts consulted by the Plan with respect to your Adverse Benefit Determination, even if the advice wasn't a factor in the decision, or (iii) a disability determination made by the Social Security Administration (SSA) that you presented as part of the claim.

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).

In order for the Claims Administrator to provide a full and fair review of your disability claim and appeal, before the Plan makes a final decision on appeal, you must be affirmatively provided any new or additional evidence considered by the Claims Administrator, and any new or additional rationale on which the denial is based. Not only must the new evidence or rationale be provided as soon as possible, but you must receive it in enough time ahead of the final decision to have a reasonable opportunity to respond to it.

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; and
- 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 nondiscriminatory basis and shall apply uniform rules to all persons similarly situated. Except to the extent superseded by laws of the United States, the laws of New York will control in all matters relating to the Plans.

Notwithstanding any provision to the contrary herein or other documentation governing the administration of the Plans, Citigroup Inc.'s Head of Total Rewards and Head of Benefits (or such successor roles, however designated) shall be solely responsible, jointly or severally, for determining the scope of disclosure (if any) of information maintained by the Plans to any person (including corporations, state and local governments, and governmental agencies) in response to any state and/or local law, regulation, or enforcement activity mandating disclosure that purports to apply to self-funded ERISA plans. Citigroup Inc.'s Head of Total Rewards and Head of Benefits may delegate some or all of this authority to another person(s) in Total Rewards, Benefits, Human Resources or other business or corporate function.

Compliance with Law

Citigroup intends to operate the Plan in compliance with the transparency, surprise billing and other applicable requirements in the relevant provisions of the Consolidated Appropriations Act, 2021 ("CAA") and the Transparency-In-Coverage Regulations as they become effective, based on a good faith, reasonable interpretation of the statute, existing regulations and other official guidance. Additionally, as final guidance becomes available and applicable, Citigroup will modify the Plan accordingly.

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 and Addiction Equity Act, as amended by the CAA, 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 Account 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 practical.

Plan Information

Item	Details
Plan Sponsor	Citigroup Inc. 750 Washington Boulevard, 8th 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 Dept 01488 PO Box 299107 Lewisville, TX 75029-9107 Fax: 1 (847) 554-1653 Call 1 (800) 881-3938 (ConnectOne). See the *For More Information* section for detailed instructions, including TDD assistance. From outside the United States, Puerto Rico and Canada: Call 1 (469) 220-9600. See the *For More Information* section for detailed instructions, including TDD assistance.
Type of Administration	The Plans are administered by the Plans Administration Committee of Citigroup Inc. through agreements entered into with the Claims Administrators. However, final decisions on the payment of claims rest with the Claims Administrators.
Agent for Service of Legal Process	General Counsel Citigroup Inc. 388 Greenwich St., 15th floor New York, NY 10013
Plan Year (for all Plans)	January 1-December 31
Plan names and numbers	
Medical Plans (self-funded In-Network Only Plan, Choice Plan and High Deductible Plan with HSA), including prescription drugs 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
Be Well Program	Citigroup Be Well Program Plan number 521

Item	Details
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)
Supplemental Medical Plans	Citigroup Supplemental Medical Plans Plan number 802777
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
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. See the *For More Information* section for detailed instructions, including TDD and international assistance. Plan number 508
MetLife Legal Plans	Citigroup Legal Benefits Plan Plan number 515
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: • In-Network Only Plan (administered by Aetna and Anthem BlueCross BlueShield) • Choice Plan (administered by Aetna and Anthem BlueCross BlueShield) • High Deductible Plan with HSA (administered by Aetna and Anthem BlueCross BlueShield) 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 • Be Well Program • Health Care Spending Account (HCSA) • Limited Purpose Health Care Spending Account (LPSA) • Supplemental Medical Plans	The cost of the Vision Plan, medical spending accounts and Supplemental Medical Plans is provided by employee contributions. Citigroup pays for the Be Well Program. The Vision Plan is funded through an insurance contract. The medical spending accounts and the Be Well Program are funded from the general assets of Citigroup. The Supplemental Medical plans are fully insured and funded through an insurance contract.
• 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. Portions of the Basic Life insurance may be funded under a trust qualified under Section 501(c)(9) of the Code. 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 are provided through employee contributions.
• Disability Plan	STD benefits are paid from the general assets of the Company. STD coverage is provided by Citigroup; no employee contributions are required. LTD benefits are fully insured. The Claims Administrator, not Citigroup, is responsible for paying claims. LTD coverage is provided either through employer or employee contributions.
• MetLife Legal Plans	Legal Plan benefits are fully insured. The cost of MetLife Legal Plans 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	
In-Network Only Plan	Aetna Citigroup Claims Division PO Box 981106 El Paso, TX 79998-1106 1 (800) 545-5862 Anthem BlueCross BlueShield PO Box 105187 Atlanta, GA 30348-5187 1 (855) 593-8123
Choice Plan	Aetna Citigroup Claims Division PO Box 981106 El Paso, TX 79998-1106 1 (800) 545-5862 Anthem BlueCross BlueShield PO 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 Plan with HSA	Aetna Citigroup Claims Division PO Box 981106 El Paso, TX 79998-1106 1 (800) 545-5862 Anthem BlueCross BlueShield PO Box 105187 Atlanta, GA 30348-5187 1 (855) 593-8123
Health Savings Account (HSA) (not subject to ERISA)	Contact Optum Financial through ConnectOne at 1 (800) 881-3938
For fully insured HMOs	Call the HMO directly at the telephone number on your ID card.
Prescription Drug Program	
Paper claims address	CVS Caremark P.O. Box 52136 Phoenix, Arizona 85072-2136 1 (844)-214-6601
Mail Order service	CVS Caremark PO Box 659541 San Antonio, TX 78265-9541 1 (844)-214-6601

Plan	Administrator Contact Information
Dental Plan	
MetLife Preferred Dentist Program (PDP)	Metropolitan Life Insurance Co. MetLife Dental Claims Unit PO Box 981282 El Paso, TX 79998-1282 1 (888) 830-7380 *To submit an appeal:* MetLife Group Claims Review PO Box 14589 Lexington, KY 40512-4093
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 PO Box 8504 Mason, OH 45040-7111 1 (877) 787-5354 Members: www.aetnavision.com
Spending Accounts • Health Care Spending Account • Limited Purpose Health Care Spending Account • Dependent Day Care Spending Account (not subject to ERISA) • Transportation Reimbursement Incentive Program (not subject to ERISA)	Contact Optum Financial through ConnectOne at 1 (800) 881-3938.
Supplemental Medical Plans	Aetna Voluntary Plans PO Box 14079 Lexington, KY 40512-4079 1 (888) 772-9682 Fax: 1 (859) 455-8650
Other Insurance	
Short-Term Disability (STD) *Long-Term Disability (LTD)*	Metropolitan Life Insurance Co. PO Box 14590 Lexington, KY 40511-4590 1 (888) 830-7380
Basic Life	Metropolitan Life Insurance Company — Group Life Claims PO Box 6100 Scranton, PA 18505-6100 1 (800) 638-6420
Basic and Supplemental Accidental Death and Dismemberment (AD&D)	Metropolitan Life Insurance Company — Group Life Claims PO Box 6100 Scranton, PA 18505-6100 1 (800) 638-6420
Business Travel Accident/Medical	Chubb USA PO Box 5124 Scranton, PA 18505-0556 ACEAandHClaims@chubb.com 1 (800) 336-0627
Group Universal Life (GUL)	Metropolitan Life Insurance Company — Group Life Claims PO Box 6100 Scranton, PA 18505-6100 1 (800) 638-6420
MetLife Legal Plans	Metropolitan Life Insurance Company. 1111 Superior Avenue Cleveland, OH 44114 1 (800) 821-6400

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 who 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, and 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 whom 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 employee's 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 the MAA is calculated varies depending on which plan option you are enrolled in and which carrier you have. Contact your Plan for more details.

If your carrier is Aetna ,the term Maximum allowed amount (MAA) means an amount determined by Aetna, or its third-party vendors, based on data resources selected by Aetna which may reflect (among other factors) typical competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided.

- An amount determined by Aetna, or its third-party vendors, based on data resources selected by Aetna, reflecting typical competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided.

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 a 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, substance use disorder 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 a plan. No benefit will be paid for services that are not considered medically necessary, if applicable.

Network provider: A health care provider on a list of providers contracted with the Claims Administrator. Coinsurance or copays 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 and 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 him- or herself and/or dependents as defined by the applicable plans.

Once the maximum out-of-pocket amount has been met, a 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.

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 In-Network Only Plan;
  - Aetna Choice Plan;
  - Aetna High Deductible Plan with HSA~~)~~;
  - Anthem BlueCross BlueShield In-Network Only Plan;
  - Anthem BlueCross BlueShield Choice Plan;
  - Anthem BlueCross BlueShield High Deductible Plan with HSA~~)~~;
  - Fully insured health maintenance organizations (HMOs); and
  - Citigroup Prescription Drug Program administered by CVS Caremark;
- Supplemental Medical Plan:
  - Accident Plan;
  - Critical Illness Plan; and
  - Hospital Indemnity Plan
- Citigroup Dental Benefit Plan:
  - Cigna Dental HMO; and
  - MetLife Preferred Dentist Program (PDP);
- Citigroup Vision Benefit Plan;
- Citigroup Wellness Benefits;
- Citigroup Be Well Program;
- Citigroup Disability Plan;
- 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;
  - Basic Accidental Death and Dismemberment (AD&D) insurance;
  - Group Universal Life (GUL) insurance; and
  - Supplemental AD&D insurance;
- Citigroup Business Travel Accident/Medical (BTA/BTM) insurance; and
- Citigroup Legal Benefits Plan (MetLife Legal Plans).

Plan Administrator: The Plans Administration Committee of Citigroup Inc.

Plan year: January 1-December 31.

Precertification/prior authorization: A requirement that a participant calls his or her health plan option to coordinate any inpatient (i) surgery; (ii)hospitalization; (iii) mental health; or (iv) substance use disorder treatments and certain outpatient (i) diagnostic/surgical procedures; (ii) mental health; or (iii) substance use disorder treatments. 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.

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 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, a physician assistant, a nurse practitioner, a chiropractor, an institution, a facility, a primary care center, a patient-centered medical home, a clinic, an ambulatory surgical center, an outpatient center, an urgent care center or a 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 Benefit Plan (the "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 the delivery of children following a normal, uncomplicated pregnancy and that fully meets one of the following two tests:

- Is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Meets all the following requirements:
  - Is operated and equipped in accordance with any applicable state law;
  - Is equipped to perform routine diagnostic and laboratory exams, such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity;
  - Has available, to handle foreseeable emergencies, trained personnel and necessary equipment, including, but not limited to, oxygen, positive pressure masks, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders;
  - Is operated under the full-time supervision of a licensed doctor of medicine (MD), doctor of osteopathy (DO) or registered nurse (RN);
  - Maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications;
  - 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
  - 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 Benefits 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, CVS Caremark 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:

- Is approved by Medicare as a comprehensive outpatient rehabilitation facility; or
- Meets all the following tests:
  - 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;
  - 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;
  - Has a requirement that every patient be under the care of a physician; and
  - 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 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 the 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 that may lead to severe psychological or physical dependence. Examples of Class II narcotics include hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®, Percocet®), 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 spouse/partner (which includes legal spouse, domestic partner and civil union partner) and/or the employee's 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 the provider 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.
  - 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 its proposed use.

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 ingredients 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 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 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 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 services 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 Plan 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 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 a CVS Caremark 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 an 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 Choice Plan.

Preadmission tests: Tests performed on a covered person in a hospital before confinement as a resident inpatient, provided the tests meet all 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.

Residential treatment center/facility

For Aetna a Residential Treatment Center/Facility is defined as follows:

- A facility that provides mental health disorder services or substance related disorder services and meets the following requirements:
  - Is licensed and operated in accordance with applicable state and federal law
  - Provides treatment under the direction of an appropriately licensed physician for the level of care provided
  - Maintains a written treatment plan prepared by a licensed behavioral health provider (RN or master's level) requiring full-time residence and participation
  - Has a licensed behavioral health provider, (RN or master's level) on-site 24 hours per day 7 days per week, and is:
    - Credentialed by Aetna, or
    - Accredited by The Joint Commission (TJC); The Committee on Accreditation of Rehabilitation Facilities (CARF); The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP); or The Council on Accreditation (COA)

For Anthem: An inpatient facility that provides multidisciplinary treatment for mental health and substance use disorder conditions. The facility must be licensed as a Residential Treatment Center in the state in which it is located, must satisfy Anthem's accreditation requirements, and be approved by Anthem.

The term Residential Treatment Center/Facility does not include a provider, or that part of a provider, used mainly for nursing care, rest care, convalescent care, care of the aged, custodial care or educational care.

Room and board: Housing and meals, general-duty nursing, intensive nursing care by whatever name called and any other services regularly furnished by a 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 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:

- 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.

For Aetna, Nursing Facility Services is defined as a facility that provides skilled nursing care and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law;
- Provides treatment under the direction of an appropriately licensed physician for the level of care provided;
- Maintains a written treatment plan prepared by a licensed provider (RN or master's level) requiring full-time residence and participation; and
- Has a licensed provider (RN or master's level) on-site 24 hours per day 7 days per week, and is:
  - Credentialed by Aetna, or
  - Certified by Medicare, or
  - Accredited by The Joint Commission (TJC) or The Committee on Accreditation of Rehabilitation Facilities (CARF).

Skilled nursing facilities also include rehabilitation hospitals, and portions of a rehabilitation hospital and a hospital designated for skilled or rehabilitation services.

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- Custodial care services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of mental health disorders or substance related disorders. Facilities that primarily provide treatment or services for mental health or substance use disorders are governed by the Plans' provisions for residential treatment facilities or centers.

For Anthem: An Inpatient Facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a Skilled Nursing Facility in the state in which it is located, satisfy Anthem's accreditation requirements, and be approved by Anthem.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care, or domiciliary care, or a place for rest, educational, or similar services.

It does not include institutions that primarily provide for the care and treatment of mental health disorders or substance related disorders. Facilities that primarily provide treatment or services for mental health or substance use disorders are governed by the Plans' provisions for residential treatment facilities or centers.

Specialty drug: A drug for the treatment of complex chronic diseases, such as, but not limited to, multiple sclerosis, hemophilia, cancer and rheumatoid arthritis.

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 an 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 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.
- 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 at 1 (800) 881-3938. When prompted, enter your ConnectOne ID and PIN. If you do not have a ConnectOne PIN, follow the prompts to designate a PIN. Once you designate a PIN, you can use ConnectOne immediately. Representatives are available from 9 a.m. to 6 p.m. ET, Monday through Friday.

- From outside the United States, Puerto Rico, Canada and Guam: Call HR Shared Services (HRSS) at 1 (469) 220-9600.
- If you are hearing impaired and use a TDD in the United States: Call the Telecommunications Relay Service at 711 and 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 My Total Compensation and Benefits website at www.totalcomponline.com, available from the Citi intranet and the Internet. From the main page, click on "Health and Insurance (YBR)". You will then be linked to the YBR™ Health and Insurance page.

Keep in mind that if you are an active employee and visit the My Total Compensation and Benefits website from outside the Citi network, you will need to use Multi-Factor Authentication (MFA) to view your benefits information. You will be prompted to enter a one-time password that you will receive by text message or 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 as applies to our banking customers. For more information on MFA, please visit the My Total Compensation and Benefits website and click on the MFA link on the login page.

If you are no longer employed by Citi, you will need to visit the My Total Compensation and Benefits website and access the appropriate link. You will be asked to provide the last four 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 require only the user ID and password you have created.

For Information About These Topics, Plans or Programs	Contact	Telephone Number/Website
Be Well Program	TELUS Health	1 (800) 952-1245 711 (TDD), then 1 (800) 952-1245 one.telushealth.com Username: bewell Password: livewell
Beneficiary designations for: • Basic Life insurance, Basic Accidental Death and Dismemberment (AD&D) insurance, Citi Retirement Savings Plan (for U.S. and Puerto Rico) and Citigroup Pension Plan	Citi Benefits Center	Call ConnectOne at 1 (800) 881-3938. From the ConnectOne "benefits" menu, choose the "pension or retiree health and insurance or survivor support" option.
• Group Universal Life (GUL) and Supplemental AD&D insurance	MetLife	Call MetLife at 1 (888) 830-7380. Visit the MetLife MyBenefits website through My Total Compensation and Benefits at www.totalcomponline.com.
Benefits (health and insurance)	Citi Benefits Center	Call ConnectOne at 1 (800) 881-3938. From the ConnectOne "benefits" menu, choose the "health and insurance benefits as well as TRIP and spending accounts" option.
COBRA coverage (Consolidated Omnibus Budget Reconciliation Act)	Citi Benefits Center	Call ConnectOne at 1 (800) 881-3938. From the ConnectOne "benefits" menu, choose the "health and insurance benefits as well as TRIP and spending accounts" option.

For Information About These Topics, Plans or Programs	Contact	Telephone Number/Website
Dental Plans	MetLife Preferred Dentist Program (PDP)	1 (888) 830-7380 Visit the MetLife MyBenefits website through My Total Compensation and Benefits at www.totalcomponline.com.
	Cigna Dental HMO	1 (800) 244-6224 www.myCigna.com (participants only) 1 (800) 244-6224 (pre-enrollment information)
Dependent Day Care Spending Account (DCSA)	Optum Financial/Citi Benefits Center	Call ConnectOne at 1 (800) 881-3938. From the ConnectOne "benefits" menu, choose the "health and insurance benefits as well as TRIP and spending accounts" option, followed by the "spending accounts" option. Visit the Optum Financial website through My Total Compensation and Benefits at www.totalcomponline.com. From the main page, click on "TRIP and Spending Accounts."
Disability To report a disability or apply for a Family Medical Leave	MetLife	Call ConnectOne at 1 (800) 881-3938. From the ConnectOne "benefits" menu, choose the "disability or FMLA-related absences" option; or Contact MetLife directly at 1 (888) 830-7380. Visit the MetLife MyBenefits website through My Total Compensation and Benefits at www.totalcomponline.com.
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 "benefits" menu, choose the "health and insurance benefits as well as TRIP and spending accounts" option.
GUL insurance	MetLife	1 (888) 830-7380 Visit the MetLife MyBenefits website through My Total Compensation and Benefits at www.totalcomponline.com.
Health and insurance coverage verification for: • Child support; • Medicaid or other premium assistance; • Medicare; • Social Security Administration; and • Etc.	Citi Benefits Center	Call ConnectOne at 1 (800) 881-3938. From the ConnectOne "benefits" menu, choose the "health and insurance benefits as well as TRIP and spending accounts" option.
Health Care Spending Account (HCSA)	Optum Financial/Citi Benefits Center	Call ConnectOne at 1 (800) 881-3938. From the ConnectOne "benefits" menu, choose the "health and insurance benefits as well as TRIP and spending accounts" option, followed by the "spending accounts" option. Visit the Optum Financial website through My Total Compensation and Benefits at www.totalcomponline.com. From the main page, click on "TRIP and Spending Accounts."
Health Savings Account (HSA)	Optum Financial/Citi Benefits Center	Call ConnectOne at 1 (800) 881-3938. From the ConnectOne "benefits" menu, choose the "health and insurance benefits as well as TRIP and spending accounts" option, followed by the "spending accounts" option. Visit the Optum Financial website through My Total Compensation and Benefits at www.totalcomponline.com. From the main page, click on "TRIP and Spending Accounts."
Insurance • Basic Life; • Basic AD&D; and • Business Travel Accident/Medical.	Citi Benefits Center	Call ConnectOne at 1 (800) 881-3938. From the ConnectOne "benefits" menu, choose the "health and insurance benefits as well as TRIP and spending accounts" option. Visit YBR™ through My Total Compensation and Benefits at www.totalcomponline.com.

For Information About These Topics, Plans or Programs	Contact	Telephone Number/Website
Limited Purpose Health Care Spending Account (LPSA)	Optum Financial/Citi Benefits Center	Call ConnectOne at 1 (800) 881-3938. From the ConnectOne "benefits" menu, choose the "health and insurance benefits as well as TRIP and spending accounts" option, followed by the "spending accounts" option. Visit the Optum Financial website through My Total Compensation and Benefits at www.totalcomponline.com. From the main page, click on "TRIP and Spending Accounts."
Live Well at Citi Program	Health Advocate Personify Health (formerly Virgin Pulse) and medical carriers	1 (866) 449-9933 Visit www.citibenefits.com, then Live Well at Citi. 1 (855) 814-5595 (Personify Health) Visit My Total Compensation and Benefits at www.totalcomponline.com, then click on "Personify Health" (Health Assessment & Rewards).
Medical (HMOs)	Various sources	Refer to the list in "2025 Insured HMOs" under the *Medical* section.
Medical (non-HMO plans)	Aetna (In-Network Only, Choice Plan, High Deductible Plan with HSA)	1 (800) 545-5862 1 (800) 628-3323 (TDD) www.aetna.com Teladoc: 1 (800) 545-5862; 1 (800) 628-3323 (TDD)
	Anthem BlueCross BlueShield (In-Network Only, Choice Plan, High Deductible Plan with HSA)	1 (855) 593-8123 — Anthem Health Guide Member Services www.anthem.com • 24/7 NurseLine: 1 (800) 700-9184 • Precertification: 1 (888) 953-6703 • Coverage While Traveling: 1 (800) 810-2583 • High-Tech Image/Sleep Mgmt.: 1 (888) 953-6703 • Virtual Care: www.livehealthonline.com
MetLife Legal Plans	MetLife Legal Plans Family First	1 (800) 821-6400 Members: https://members.legalplans.com 1 (800) 821-6400 Members: https://member.legalplans.com. Select "Caregiving Support & Resources" to be redirected to the Family First home page
Prescription drug program (Choice Plan, In-Network Only Plan, High Deductible Health Plan) To refill a CVS Caremark Mail Order prescription using the automated system, for instructions on how your physician can fax your prescription to CVS Caremark and to arrange credit card payment for all your CVS Caremark Mail Order prescriptions	CVS Caremark	1 (844) 214-6601 1 (800) 863-5488 (TDD) www.caremark.com (participants only)
• For prior authorization		1 (844) 214-6601
• For the CVS Caremark Specialty drug pharmacy		1 (800) 237-2767 Available 6:30 a.m. to 8:00 p.m. (CT), Monday through Friday.
• For the PrudentRx copay assistance program		1 (800) 578-4403
Supplemental AD&D insurance	MetLife	1 (888) 830-7380 Visit the MetLife MyBenefits website through My Total Compensation and Benefits at www.totalcomponline.com.
Supplemental Medical Plans • Accident Plan • Critical Illness Plan • Hospital Indemnity Plan	Aetna	1 (800) 607-3366 (TTY: 711), Monday through Friday, 8:00 a.m. to 6:00 p.m. Visit the member portal at https://www.myaetnasupplemental.com/

For Information About These Topics, Plans or Programs	Contact	Telephone Number/Website
Transportation Reimbursement Incentive Program (TRIP)	Optum Financial/Citi Benefits Center	Call ConnectOne at 1 (800) 881-3938. From the ConnectOne "benefits" menu, choose the "health and insurance benefits as well as TRIP and spending accounts" option, followed by the "spending accounts" option. Visit the Optum Financial website through My Total Compensation and Benefits at www.totalcomponline.com. From the main page, click on "TRIP and Spending Accounts."
Vision Plan For Plan information and laser vision correction providers/arrangements	Aetna	1 (877) 787-5354 Members: www.aetnavision.com
Workers' Compensation	Constitution State Services Co.	1 (800) 243-2490

Citi On-Site Medical Clinics	
Jacksonville, FL	
14000 Citicards Way	1 (904) 954-8262
Medical emergency number	1 (904) 954-8911
Tampa, FL	
Citibank Center, Bldg., 1st Floor	1 (813) 604-4333
Medical emergency number	611
O'Fallon, MO	
1000 Technology Drive, 1st Floor	1 (636) 261-6030
Medical emergency number	1 (636) 261-4000
Jersey City, NJ	
480 Washington Blvd., 8th Floor	1 (201) 763-1111
Medical emergency number	1 (201) 763-0263
New York City	
388 Greenwich St., 5th Floor, New York City	1 (212) 816-1460
Medical emergency number	1 (212) 816-1300
San Antonio, TX	
100 Citibank Drive, Bldg. 3	1 (210) 357-8275
Irving (Dallas), TX	
6460 Las Colinas Blvd.	1 (972) 655-5000
Florence, KY	
4600 Houston Road, Bldg. 2, 1st Floor	1 (859) 283-3613