About Your Retiree Health Care Benefits

For coverage effective January 1, 2023

Introduction

Citigroup Inc. and its participating employers (hereafter referred to as Citi or Citigroup) offer different types of benefits to eligible retirees.

This document is a component of the plan documents for the Citigroup Retiree Medical Benefit Plan, the Citigroup Retiree Dental Benefit Plan and the Citigroup Retiree Vision Benefit Plan (referred to as the "Plans" or the "Health Plan," "Dental Plan" or "Vision Plan"), which provide benefits for eligible retirees of Citi and its participating businesses. The plan documents also serve as the Summary Plan Description (SPD).

Retiree coverage is neither fixed or guaranteed under the Plans. Citi reserves the right to amend, terminate, suspend or otherwise change the Plans provided to retirees at any time for any reason.

In addition to the information provided here, the individual plan documents for the network-based health care plans include the network provider directory, available upon request.

The benefits and programs described in this document are in effect as of January 1, 2023. The terms and conditions of the 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.

This document is intended to comply with the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and other applicable laws and regulations. In addition, benefits provided under the Plans described in this document are not in any way subject to you or your dependents' debts or other obligations and may not be voluntarily or involuntarily sold, transferred, alienated or encumbered.

As you read the document you will see some terms that are bold and underlined. This means that the term is a reference to another section of the document or in the Glossary.

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

The provisions of this document apply to employees who retired on or after January 1, 2023. Individuals who retired prior to January 1, 2023, may be subject to different eligibility requirements.

How to Call the Citi Benefits Center

If you have any questions about this document or any provisions of the Plans or if you want to update your home address on Citi records, call the Citi Benefits Center.

- **Call ConnectOne at 1 (800) 881-3938.** When prompted, enter your ConnectOne ID number and PIN (personal identification number). Your ConnectOne ID is your Citi GEID (Global Enterprise ID).
- **If you do not have or do not remember your GEID:** Call ConnectOne at **1 (800) 881-3938**. Enter your Social Security number when prompted, followed by #. The automated telephone system will provide your GEID, which you should write down for future use.
- **If you do not have a ConnectOne PIN:** Call ConnectOne at **1 (800) 881-3938**. Follow the prompts to establish a PIN. After you establish a PIN, you can use ConnectOne immediately.

From the ConnectOne main menu, select the “benefits” option and then the “retiree health and insurance” option.

Citi Benefits Center representatives are available from 8 a.m. to 8 p.m. ET Monday through Friday, excluding holidays.

If you are calling from outside the United States, Puerto Rico, Guam, or Canada: Call **1 (469) 220-9600**. From the ConnectOne main menu, select the “benefits” option and then the “retiree health and insurance” option.

For text telephone service from the United States: Call the Telecommunications Relay Services at 711, then call ConnectOne as instructed above.

For text telephone service in Puerto Rico, call **1 (866) 280-2050**, then call ConnectOne at **1 (800) 881-3938**, and follow the instructions above to reach a Citi Benefits Center representative.

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Eligibility for Retiree Health Coverage

Citi provides health care coverage for you, your spouse/partner and/or eligible dependents, each herein referred to as a "covered person." To participate, you and any dependents you want to cover must be eligible. If you have questions about eligibility for dependents, see "Eligibility for Dependents" on page 9.

The Medical Plan offers:

- **Before age 65 and not Medicare-eligible:** benefits similar to the benefits provided to active employees.
- **Before age 65 and Medicare-eligible (disabled; end-stage renal disease):** coverage under the Aetna Red, White and Blue Retiree Medical Plan.
- **Beginning at age 65:** access to individual medical, prescription drug, dental and vision coverage through Via Benefits, as explained in "Plans for Medicare-Eligible Retirees" on pagesd 18.

In general, to be eligible for the Medical and Vision Plans (as defined on page 2):

- You must have been eligible for coverage as an active employee immediately prior to retirement, regardless of whether you were enrolled;
- You must have attained age 50, with at least five years of service; and
- Your age plus years of service equal at least 60.

Eligibility for the Retiree Dental Benefit Plan will depend on the business from which you retired and the Plan options in effect at the time you retired. Please see the **Retiree Dental Plan SummaryPlan Description** for detailed information.

Call the Citi Benefits Center, as instructed on page 2, for more information.

For individuals who are 65 or older and Medicare eligible, Citi has engaged the services of Via Benefits, a Willis Towers Watson company, to assist such Medicare-eligible retirees and their family with obtaining medical (including prescription drug coverage), dental and vision coverage in the individual Medicare health insurance market. For information on eligibility and terms of enrollment in plans through Via Benefits, please contact the Citi Benefits Center through ConnectOne at **1 (800) 881-3938.**

Disabled Medicare-eligible retirees who have not attained age 65 and their disabled Medicare-eligible spouse(s)/partner(s) and eligible dependents who have not attained age 65, as applicable, may utilize the services of Via Benefits to obtain coverage in the individual market, unless such retiree has end-stage renal disease. If such retiree elects coverage in the individual insurance market, such retiree will be precluded from electing coverage under the Plans in the future. However, such retiree shall be permitted to elect coverage through Via Benefits until he/she attains age 65.

A retiree and his/her spouse/partner (regardless of gender) and eligible dependents who are not eligible for Medicare, other than as noted above, will not be impacted by this change.

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 program at any of the following times:

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

Alternatively, if (a) you are eligible for coverage under the U.S. Separation Pay Plan and (b) you are projected to meet the age and service requirements for retiree health coverage eligibility within 12 months after your termination date, but choose not to enroll in Citi COBRA coverage upon termination, you will later have a one-time opportunity to enroll in Citi's retiree health programs, currently available, at the time you meet the age and service requirements for Citi's retiree health programs, currently available, 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 will not 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 programs; the 12-month rule described above is not available.

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

If you have questions about eligibility for retiree health plan coverage, call the Citi Benefits Center as instructed on page 2. If you have questions about plan benefits or claims, contact your insurance provider.

If Both You and Your Spouse/Partner Worked for Citi

If you and your spouse/partner were employed by Citi, each of you may be covered under the Plans as either a retiree or a dependent, but not both. You may pick one plan to cover both of you, or you may each elect your own plan. Either of you may cover your children, but they cannot be covered by both of you.

Eligibility for Dependents

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

- Your lawfully married spouse, or your common-law spouse if you live in a state that recognizes common-law marriages, or your registered partnership, if you live in a state that recognizes such partnerships[1]; if you are legally separated or divorced, your spouse is not an eligible dependent unless mandated by state law;
- Your domestic partner (see "Coverage for Domestic Partners" beginning on page 10 for details);
- Your domestic partner's eligible dependents (see "Coverage for Domestic Partners") beginning on page 10 for details;
- Your children up to age 26 who are:
  - Your biological children;
  - Your legally adopted children;
  - Your stepchildren; and
  - Any other child for whom you are the legal guardian in accordance with the laws of the state in which you reside.

You can cover your children beyond the age of 26 if they:

- Were covered under the Plans before age 26, and became incapable of self-sustaining employment due to a disability while covered, in which case the eligible dependent may be eligible for coverage beyond such age; or
- Are disabled adults when you began employment with Citi and you enrolled them when you were first eligible to do so; you must have a letter from the Social Security Administration declaring that your dependent is disabled; if you do not have such a letter, then the Plans will evaluate your dependent before providing benefits.

Qualified Medical Child Support Orders

As required by the Omnibus Budget Reconciliation Act of 1993, any child of a Plan participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) will be considered as having a right to dependent coverage under the Plans. In general, QMCSOs are state court orders requiring a parent to provide medical support to an eligible child; for example, in the case of a divorce or separation.

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 as instructed on page 2.

You can file your QMCSO by mailing it to:

Citi QMCSO Administration
2300 Discovery Drive
P.O. Box 785004
Orlando, FL 32878-5004

[1] Because registered partnerships are recognized by certain states and generally provide the same protection as marriage, registered partnerships are not subject to the domestic partnership certification process.

Dependent Documentation

The first time you enroll in the Retiree Health Plan you will be asked for 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. *Without this information on file, you cannot enroll in any dependent coverage.*

If you were enrolled in a Health Plan as an active employee, information about your eligible dependents will appear on your Personal Enrollment Worksheet. During your initial enrollment, you will need to identify any eligible dependents whom you want to cover under the Plans.

If your dependent does not have a Social Security number at the time of enrollment, you can enter dependent information and report the Social Security number after you obtain it. If you are enrolling a dependent who is Medicare-eligible, Citi is required to have your dependent's Social Security number.

You must also keep your dependent information current:

- When you enroll during the Annual Enrollment period, you will be prompted to make changes to your dependent information, if needed; and
- You must report changes in dependent information to the Citi Benefits Center when you want to make changes to your coverage or coverage category as a result of a qualified status change.

When Dependent Eligibility Ends

Your spouse/partner is eligible for coverage until the last day of the month in which you become legally separated, divorced, dissolve your registered partnership or submit a Domestic Partnership Termination Form. Call the Citi Benefits Center, as instructed on page 2, to report the termination of your marriage or partnership.

Coverage for Domestic Partners

The information in this section is a general description of the requirements under the Plans for unregistered domestic partner coverage. Certain Plans may have different eligibility criteria. If you have any questions after reading this section, call the Citi Benefits Center as instructed on page 2.

At any time, you cannot cover more than one person as your spouse/partner. To enroll a domestic partner in an unregistered domestic partnership and/or his/her children, you and your partner must first complete forms attesting to your domestic partnership. You can obtain the required documents by calling the Citi Benefits Center.

A domestic partner and his/her dependents must be enrolled upon your initial election. If you waive coverage for your domestic partner and, if applicable, his/her dependents upon your initial election, you will not be permitted to enroll the same domestic partner and his/her dependents at a later date. In addition, if you enter into a domestic partner relationship subsequent to your initial enrollment, such domestic partner and his/her dependent children shall not be eligible to enroll for benefits under the Plans.

Qualifications for Domestic Partner Coverage

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 reqistered, you will need to complete a form that certifies the following:

- You have lived together for at least six consecutive months prior to enrollment;
- You are financially interdependent, or your partner is dependent on you for financial support;

- Neither you nor your domestic partner is in a domestic partner relationship with anyone else;
- 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 in Citi coverage even though all other bullet points may apply to your relationship;**
- Neither you nor your domestic partner is legally married to another person;
- You have mutually agreed to be responsible for each other's common welfare; and
- You are in a relationship that is intended to be permanent and in which each of you is the sole domestic partner of the other.

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

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

If your domestic partnership ends, you and your domestic partner must attest to the termination of your domestic partnership.

Termination of Relationship

If you have enrolled your domestic partner and his/ her children for coverage under the Plans and you terminate your domestic partnership, you must notify Citi within 31 days of the event by calling the Citi Benefits Center as instructed on page 2. As a result, your domestic partner will be eligible to continue coverage under the Plans at his/her expense for 36 months.

In the event you terminate your registered partnership, continued medical coverage will be available to your partner and his/her eligible dependent at his/her expense for 36 months as well.

This coverage will be similar to COBRA coverage offered to spouses and other covered dependents. See "COBRA" on page 30 for more information.

Enrollment in Retiree Coverage

Your "retirement" date under the Plans is the date when you terminate employment with Citi or the date when you first lose coverage under the active employee health Plans.

When you retire and if you are eligible, you will receive information about the Plans. The Plans available to you will be listed on your Personal Enrollment Worksheet along with your enrollment deadline and instructions on how to enroll. Generally, you are required to elect coverage under the Plans within the time indicated in your enrollment package. If you do not elect coverage under the Health Plan and the Dental Plan during that time period, you will not be permitted to enroll at a later date.

Annual enrollment will provide retiree coverage on a calendar year basis, January 1 through December 31. Retirees will be provided with an annual enrollment period during the Autumn of each year to elect benefits for the following calendar year.

Coverage Categories

You must choose a coverage catergory when you enroll in the Plans. The coverage catergories are "retiree only" and "retiree plus dependents." Each category has a different cost. You will find the coverage categories and costs on your Personal Enrollment Worksheet.

Coverage Through Another Employer

If you are eligible for health care coverage elsewhere, for example, through your spouse's/partner's employer's plan, compare the Plans' coverage and costs with such other coverage.

If you are enrolling in similar 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 23 for the guidelines on which plan pays first.

When Coverage Begins

If you, your spouse/partner, or any other eligible dependents enroll within 31 days of your initial eligibility, your coverage and contributions will be retroactive to your date of retirement.

Changing Your Coverage

In general, Plan coverage and the coverage category you choose when you first enroll remain in effect until you drop coverage or your participation otherwise ends. Once you have selected a retiree Health Plan or Dental Plan from the options available to you, you may change that coverage only during annual enrollment. If you move to an area where your Plan is no longer available, your current coverage will end and you will need to make new plan elections. You will need to contact the Citi Benefits Center by phone at **1 (800) 881-3938** and select the 'pension and retiree health and welfare" option to provide your new address to a Representative. At that time you should also verify if you can continue to be covered by the same health plan or if you will need to make new plan elections. For more information about changes to plan coverage, call the Citi Benefits Center.

You may cancel your coverage at any time. If you are enrolled in the Plans, you can drop coverage in different Plans at the same time or at different times. However, if you or your dependent drops coverage in a Health Plan (including prescription drug coverage) or Dental Plan you cannot re-enroll in these Plans at a later date.

If you drop coverage in the Vision Plan during annual enrollment while continuing coverage in a Health Plan or Dental Plan, you can re-enroll in vision coverage during any Annual Enrollment. If you drop vision coverage midyear, or you are enrolled only in vision coverage, and then drop vision coverage, you cannot re-enroll in this coverage at a later date.

If you have any questions, speak to a Citi Benefits Center representative by following the instructions on page 2.

In general, if you choose to waive coverage under the Plans when initially eligible, you will not be able to enroll at a later date.

COBRA Election/Waiver of Retiree Health Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, ("COBRA") is a federal law requiring that most employers who sponsor group health plans offer to employees and eligible dependents the opportunity for a temporary extension of active health coverage (called "continuation coverage") at group rates in certain instances (called "qualifying events") when coverage under the plans would otherwise end.

The following provisions of COBRA apply if you elect continuation coverage through the active employee ("active") health plans and waive coverage under the Plans: You must elect coverage under the Plans (within the time indicated in your enrollment package), which may be before you are required to elect COBRA (generally, within 60 days after your employment is terminated or, if later, 60 days from the day the COBRA information is sent to you). *Be mindful of this timing difference in making your election.* The provisions of COBRA, noted later in this document, are applicable if coverage under the Plans is elected.

You may elect to continue the medical, dental and/or vision coverage you had as an active employee under COBRA. In general, if you are eligible for coverage under the Plans upon your retirement or termination of employment and you elect COBRA continuation coverage, you will waive your right to coverage under the retiree Plans.

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

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

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

You must pay the entire contribution (Citi's contribution and the employee contribution) plus a 2% administrative fee for continuation coverage. A grace period of at least 60 days applies to the payment of the regularly scheduled contribution. Your initial payment must be made within 60 days of the date you make your election.

Who Is Covered Under COBRA

You have a right to choose continuation coverage if:

- You are enrolled in active Citi medical, dental, vision or Health Care Spending Account ("HCSA")/Limited Purpose Health Care Spending Account ("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 are the spouse/partner of an employee and are covered by an active Citi-sponsored medical, dental or vision plan (or your claims can be reimbursed through your spouse's HCSA/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;
2. The termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse's entitlement to Medicare.

If you are a covered dependent child of an employee covered by an active Citi-sponsored medical, dental, or vision plan or HCSA/LPSA on the day before the qualifying event and you lose coverage under an active 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 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/LPSA.

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

According to the terms of the employer-sponsored group health plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Citi of the birth or adoption.

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

Separate Elections

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

Electing COBRA

Several weeks after your COBRA-qualifying event, you automatically will receive COBRA election information from the Citi Benefits Center. Citi considers the date of the qualifying event as the last day of the month in which your employment was terminated or other 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 previously 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 plan to similarly situated employees or family members. If the coverage for similarly situated employees or family members is modified, your coverage will also be modified. "Similarly situated" refers to a current employee or dependent who has not had a qualifying event.

Important COVID-19-Related Updates

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, the Agencies extended deadlines that might have been missed during the National Emergency, which ended on May 11, 2023. The temporary extension of the deadlines expired on July 10, 2023, 60 days after the end of the National Emergency.

- **Notification Deadline Extension**: If you have a COBRA qualifying event and your initial or secondary qualifying event deadline occurred during the National Emergency (March 1, 2020 – May 11, 2023), you have exhausted the applicable deadline to notify the Plans.
- **Enrollment Deadline Extension**: If your enrollment deadline occurred during the National Emergency (March 1, 202 – May 11, 2023), you have exhausted the applicable deadline to enroll in COBRA.

Duration of COBRA

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

COBRA continuation coverage is available for up to 36 months when the qualifying event is the death of the covered employee, divorce or legal separation, the covered employee becoming entitled to Medicare or a dependent child's loss of eligibility as a dependent child.

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

If you lose coverage because of a termination of employment or a reduction in hours, these events can, but do not always, result in an extension of an 18-month continuation period to 36 months for your spouse and dependent children. However, in no event will COBRA coverage last beyond 36 months from the date of the event that originally allowed a qualified beneficiary to elect such coverage. You must notify the Citi Benefits Center if a second qualifying event occurs during your continuation coverage period. Call the Citi Benefits Center as instructed on page 2.

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

Special Rule for HCSA and LPSA

Unless required by law, continuation coverage for HCSA and LPSA will not be available beyond the end of the year in which the qualifying event occurs (end of the calendar year in which your employment is terminated).

Special Rules for Disability

The 18 months may be extended to 29 months if the employee or covered family member is determined by the Social Security Administration (SSA) to be disabled (for Social Security disability purposes) at any time during the first 60 days of continuation coverage.

This 11-month extension is available to all family members who are qualified beneficiaries due to termination 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 Entitlement

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

Early Termination of COBRA

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

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

Your Duties

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

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

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

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

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

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

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

Citi's Duties

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

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

Cost of 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 may be required to pay up to 150% of the premium beginning with the 19th month of continuation coverage.

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

The initial payment for continuation coverage is due 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 30 days.

Important COVID-19-Related Changes that Extend COBRA Payment Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issued guidance that temporarily extended the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, the Agencies extended deadlines that might have been missed during the National Emergency, which ended on May 11, 2023. The temporary extension of the deadlines expired on July 10, 2023, 60 days after the end of the National Emergency.

If enrolled in COBRA, you have 60 days to submit payment for your initial bill and 60 days to submit payment for subsequent bills. If your initial payment deadline occurred during the National Emergency (March 1, 2020 – May 11, 2023), you have exhausted the applicable deadline to submit your initial payment.

For More Information About COBRA Coverage

If you have any questions about COBRA coverage or the application of the law, contact Citi's 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 Plans, you must notify the COBRA administrator in writing immediately at the address below.

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

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

You may also call the COBRA administrator through ConnectOne at **1 (800) 881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Please 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.

Plans for Medicare-Eligible Retirees

The type of retiree medical coverage available to you and your eligible dependents depends on your age and eligibility for Medicare.

When you or your enrolled dependent attains age 65 and becomes Medicare eligible, your Citi retiree health coverage will end. Retirees approaching age 65 Medicare eligibility will be sent information about enrolling through Via Benefits 90 days before reaching Medicare eligibility.

During the next annual enrollment period, you will be able to enroll in retiree medical, prescription drug, dental and vision plans through Via Benefits, a private Medicare plan exchange that Citi has partnered with to ensure you receive support as you transition to retiree health plans available directly with insurance companies.

Via Benefits is a resource that combines access to a wide variety of individual Medicare plans with personal assistance, offering objective advice from independent licensed benefit advisors whose compensation is never connected to the plan or insurance company you choose. Their priority is to match you with a plan that fits your needs and budget. Via Benefits provides:

- Assistance reviewing medical plans available in your area as well as prescription drug, vision and dental plans;
- Education about the types of individual plans available to you, how much they cost and the benefits they provide;
- Help understanding your Health Reimbursement Account (HRA), if applicable, including how it works and how to set up automatic reimbursement of eligible expenses;

- Decision-making assistance, based on your current coverage and future needs, for coverage alternatives beyond Medicare Parts A and B;
- Step-by-step enrollment into the plans that you select; and
- Ongoing support after enrollment, including help with coverage, claims and network issues.

Benefit advisors are available from 8 a.m.to 9 p.m. ET, Monday through Friday, toll-free at **1 (888) 427-8835**. When you call Via Benefits, you will talk with a benefit advisor who has been trained to support Medicare-eligible Citi retirees.

If You Do Not Enroll in Citi Retiree Coverage

If you do not enroll in the Plans when first eligible and you are not eligible for deferred benefits (see list below), you waive your right to coverage under the Plans. You, your spouse/partner or any other eligible dependents will not be able to enroll in the Plans at a later date.

The following retiree groups can defer enrollment in the plans:

1. The following retirees and employees of Travelers Property Casualty and Travelers Life and Annuity can defer their retiree medical election up to their 65th birthday: retirees of Travelers Property Casualty and Travelers Life and Annuity who retired prior to January 2, 2002, and Travelers Insurance Company Transitional Employees (employees who were active on December 31, 1993, and who were within five years of retirement eligibility).
2. Retirees and employees eligible for retiree benefits under Salomon, Basis, or Phillip Brothers retiree medical and life insurance plans can defer their retiree medical election one time upon termination of employment.
3. Grandfathered Associates retirees who met the requirements to be included in the first wave "List" and whose employment was involuntarily terminated before meeting their retirement eligibility date are allowed to enroll in retiree medical coverage when they are at least age 55. "List" employees were within three years of attainment of eligibility for retiree medical coverage under the Associates Medical/Dental/Vision Plan as of November 30, 2000. Eligibility required attaining age 55 and completing a service requirement. The service required was 10 or 15 years. Retirees must begin retiree medical coverage on the same date they begin to receive their pension.
4. Grandfathered Associates retirees who were already retired as of November 30, 2000, and are legacy grandfathered retirees; grandfathered AVCO retirees; grandfathered Northern retirees; or grandfathered Associates retirees who are part of the select "List" group can defer their retiree medical election, but they must begin retiree medical coverage on the same date they begin to receive their pension.
5. Employees or retirees with a written employment or termination agreement specifying the right to defer election of retiree medical benefits can defer their retiree medical election in accordance with the terms of the agreement.
6. U.S. employees who are part of the Phibro divestiture and who at the close are a minimum of age 50 with at least 5 years of service, and age plus years of service equal at least 60, can defer retiree medical elections up to two years from the close.
7. Employees who were involuntarily terminated, as noted on page 8.

Medicare

When you, your spouse/partner, or other enrolled eligible dependents become eligible for Medicare (generally at age 65 for retirees), medical coverage under the Plans you elected will end as of the last day of the month in which you, your spouse/partner, or other enrolled eligible dependents reach age 65, regardless of whether you actually enroll in Medicare.

Medicare becomes the primary payer and any other medical coverage you have becomes the secondary payer. This means that Medicare pays benefits before any other medical plan pays benefits.

Up to 90 days before your 65th birthday, the Citi Benefits Center will send you information about enrolling for medical, dental and/or vision coverage through Via Benefits. If you do not enroll through Via Benefits, all Citi health plan coverage ends when your turn age 65. If you turn age 65 before your spouse/partner, your spouse/partner or any other eligible dependents can be enrolled in the Citi retiree medical (including prescription drug coverage), dental and/or vision plans.

Retirees who are eligible for and elect coverage through Via Benefits must be enrolled in Medicare Parts A and B in order to be enrolled in a medical plan.

You are automatically enrolled in Medicare Part A (hospitalization) when you reach age 65 if you are receiving Social Security benefits at that time. If you are not receiving Social Security benefits when you reach age 65, you must enroll in Medicare Part A. When you enroll in Medicare Part A, you will be automatically enrolled in Medicare Part B (medical) unless you decline the coverage. In general, most people are not charged a premium for Medicare Part A; however, you will pay a small monthly premium for your Medicare Part B coverage. Note, if you decline Medicare Part B coverage, you will not be permitted to enroll in a Medicare plan through Via Benefits.

Citi retiree health care coverage is secondary to any other coverage, including COBRA, that you or your dependents have through other employers.

What Is Medicare?
Medicare is the federal government's health insurance program that provides coverage during retirement or disability. Medicare has three parts: hospital insurance (Part A), medical insurance (Part B), and prescription coverage (Part D).

Call the Social Security Administration at **1 (800) 772-1213** to determine when you are eligible for Medicare, to enroll in Medicare, or to obtain information on programs that may assist you with the payment of your Medicare Part B monthly premium.

For information on the benefits provided by Medicare, visit the Medicare website at **www.medicare.gov** or call **1 (800) 633-4227**.

Notification Process

If you, your spouse, or your partner becomes eligible for Medicare, you must notify Citi by calling the Citi Benefits Center as instructed on page 2.

Medicare-Approved Amounts

Medicare pays only a specified portion of the approved amounts for covered expenses.

The Medicare-approved charge for doctors' services covered by Medicare Part B is based on a national fee schedule. The schedule assigns a dollar value to each service based on work performed, practice costs, and malpractice insurance costs. Each time you go to a doctor for a service covered by Medicare, the amount Medicare will recognize for that service will be taken from its national fee schedule. Medicare generally pays 80% of that amount.

For Doctors Who Accept Assignment of Medicare Payments

When a doctor accepts assignment, his/her total charges cannot exceed the Medicare-allowable charge (the maximum amount on which reimbursement is based.) Medicare will pay 80% of the allowable charge after your deductible; the doctor can bill you for the deductible and the 20% not covered by Medicare but for no more than the Medicare-allowable charge. In brief, these doctors agree to accept the Medicare-approved charge as payment in full.

For Doctors Who Do Not Accept Medicare Assignment

Medicare has limited the amount that a doctor can bill above the Medicare allowable charge. For most medical services, a doctor can legally charge up to 115% of the Medicare allowable charge. Generally, the Plan will pay 80% of the expense, less the amount paid by Medicare.

For Doctors Who Enter into "Private Contracts"

Doctors or practitioners may enter into so-called "private contracts" with you to provide specified items or services. Under these private contracts, doctors and practitioners are free to charge and collect fees that are higher than those that would be permitted under Medicare. The Social Security Act authorizes such agreements but provides that Medicare may not pay for any of these items or services. In general, if you enter into a private contract with a medical provider and Medicare does not pay for the medical service, the Health Plan may not pay for the service either.

How Medicare Coverage Works with the Red, White and Blue Plan

The benefits provided under the Red, White and Blue Plan are coordinated with Medicare and are generally limited to the amount (if any) by which the benefit payable under the Health Plan exceeds the Medicare-approved amount. See "Coordination of Benefits" on page 23 for more information.

With the exception of the retiree Health Plan options identified later in this section, the Red, White and Blue Plan coordinates benefits with Original Medicare as follows: The amount Medicare will pay depends on whether the charge is hospital-based (Part A of Medicare) or office-based (Part B of Medicare). When you go to a provider who accepts a Medicare assignment, he/she agrees to accept the Medicare-approved amount for that service.

How Benefits Are Paid

Generally, when you submit a claim for covered services:

1. The Red, White and Blue Plan determines the amount it would have paid **in the absence of Medicare**.
2. The amount the Red, White and Blue Plan would have paid **in the absence of Medicare** is compared with the amount that Medicare pays.
    a. If the amount that the Red, White and Blue Plan would have paid is less than or equal to the amount that Medicare pays, then the Red, White and Blue Plan pays nothing.
    b. If the amount that the Red, White and Blue Plan would have paid is greater than the amount that Medicare pays, then the Red, White and Blue Plan pays the difference, if any, according to the terms of the plan.
3. If the provider does not accept Medicare assignment, you pay the amount (if any) that remains after the Medicare and the Red, White and Blue Plan benefits are coordinated.
4. The amount that you pay for covered services is applied toward any annual deductible and out-of-pocket limits required under the Red, White and Blue Plan.

Remember, the benefits provided by the Red, White and Blue Plan are processed as if you were enrolled in Medicare Part B (even if you are not enrolled), so you should enroll in Medicare Part B as soon as you are eligible.

How the Red, White and Blue Plan Coordinates with Medicare

The Red, White and Blue Plan pays benefits based on amounts that Medicare recognizes as maximum allowed amount. In most cases the plan will pay a percentage of the balance of Medicare-allowed expenses that Medicare does not pay. If you incur more than $1,000 of Medicare-allowed expenses in any calendar year, the Plan will pay 100% of the balance of Medicare-allowed expense after Medicare.

Health Advocate

Health Advocate is a free, personalized service designed to help you and your family with health-related questions. If you are enrolled in a Citi retiree health care program, you are eligible to use Health Advocate's services.

Whenever you have questions about a diagnosis or treatment plan, you need a referral, you have questions about Medicare or other health care insurance, or you need help with other health-related issues, call Health Advocate at **1 (866) 449-9933**, 24/7. A Personal Health Advocate, typically a registered nurse supported by a staff of medical directors and benefits and claims specialists, will work with you to help find solutions to your health care and Medicare concerns.

Clinical Support Services

Health Advocate offers a range of services so you can get the right information and support when making important health care decisions.

- **Talk with a medical expert** — Doctors, nurses and other experts can answer your questions about your medical condition and research the latest, most advanced approaches to care.
- **Get expert second opinions** — Arrange referrals to leading specialists and medical centers to confirm your diagnosis and treatment plan. Health Advocate will also handle the transfer of medical records, lab results and X-rays.
- **Find the right doctors** — Health Advocate can help you find the right doctor or specialist for your condition and even make the appointment, with a focus on in-network providers so you can maximize your plan benefits. Health Advocate will also handle the transfer of medical records, lab results and X-rays prior to a scheduled appointment with a new doctor.
- **Understand treatment options** — Experts can help you understand tests and explain diagnoses and treatment options, so you can make decisions about your care. They are also available to provide ongoing support and guidance.
- **Get assistance with prescription drugs** — Health Advocate can provide assistance on prescription drug issues, including formulary and benefit questions. Health Advocate services are designed to help you: (i) better understand your pharmacy benefit plan; (ii) provide information for renewing prescriptions; (iii) locate lower-cost sources for prescription drugs that are not covered by your health plan; (iv) provide information about generic drugs; (v) get assistance with mail-order prescriptions; and (vi) resolve questions between you and your pharmacy regarding the amount of product requested and the amount dispensed.
- **Locate care facilities and support** — Experts can help you: (i) research local adult day care; (ii) research assisted living and long-term care facilities; (iii) locate in-home care and nursing support resources; and (iv) help facilitate transportation to your medical appointments. Health Advocate can also coordinate hospice and other services for terminally ill members.

Administrative Support Services

Health Advocate offers a range of benefit support services to help you.

- **Get guidance about health insurance coverage** — Health Advocate can provide help with understanding your health insurance choices before becoming eligible for Medicare. After you become eligible for Medicare, Health Advocate can explain Medicare coverage, costs and plan options and how Medicare coordinates with your employer-provided insurance.
- **Get support with insurance-related issues** — Specialists can work with you to review your employer-provided retiree health benefits, and help resolve billing and claims issues and related paperwork problems. Some examples include:
  - Research your outstanding out-of-pocket responsibilities and resolve errors with providers and/or your health plan;
  - Review questionable bills to identify duplicate or erroneous charges;
  - Resolve questions about whether services are condition-specific or related to preventive care;
  - Provide payers with additional information required to correctly pay a claim or apply a benefit;
  - Resolve coordination of benefits disputes between multiple carriers; and
  - Identify and resolve errors in the application of deductibles and copayments.
- **Fee negotiation** — Health Advocate can attempt to negotiate fees with providers to lower your out-of-pocket costs, usually prior to receiving services not covered by insurance.
- **Appeals advice** — Get assistance with filing a complaint or grievance with a health insurer or health plan, including providing information about your appeal rights.

Note: If you are calling on behalf of a family member, Health Advocate may request a copy of a Power of Attorney. If a family member is calling on your behalf, Health Advocate may request a copy of your Power of Attorney. As an alternative, if you are calling on behalf of a family member who can complete and sign a HIPAA release of Information Form, Health Advocate will accept the form.

Cost of Retiree Coverage

Your cost for coverage will depend on the business from which you retired, the length of your service with Citi, the Plan in which you enroll, and the coverage category you choose. Cost for a domestic partner is the same as the cost of coverage for a spouse. The cost of coverage for a partner's child(ren) is the same as the cost for your dependent child(ren).

Costs are shown on your Personal Enrollment Worksheet and, generally, increase each year.

Retiree coverage is neither fixed or guaranteed under the Plans. Citi reserves the right to amend, terminate, suspend or otherwise change the Plans provided to retirees at any time for any reason.

Call the Citi Benefits Center, as instructed on page 2, for more information on your premium payment options.

Coordination of Benefits

Payments under the Health Plan described in this document and any of the accompanying documents will be coordinated with benefits payable under any other group benefit plans that cover you and/or your covered dependent(s), including Medicare or Medicaid. Coordination of benefits prevents duplication of payments.

When you or your covered dependent(s) are eligible for benefits under another group plan, the eligible expenses under the applicable plan will be determined. One of the plans — the primary plan — will pay benefits first and the other plan(s) — the secondary plan(s) — will pay benefits next.

The following definitions apply to terms used in this section:

- **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.

In general, the Health Plan will be the primary plan on claims for the following individuals, except if you have (or are eligible for, even if you have not applied for) Medicare coverage:

- 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, the birthdays of the parents are used to determine which plan is primary when your dependent children are covered under both of their parents' plans. The plan of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary plan. For example, if your spouse's birthday is in January and your birthday is in May, your spouse's plan is the primary plan for your dependent children. If both parents have the same birthday, then the plan that has been in effect the longest is the primary plan. This rule applies only if the parents are married to each other.

If the Health Plan is the primary plan, it will pay benefits first. Benefits will be calculated according to the terms of the Health Plan without taking into account benefits payable under other plans.

With regard to any government health care coverage provided during a military leave, any health care coverage provided under the Plans (including any such coverage required under USERRA,[2] COBRA, or other law or under any Citi military leave of absence policy) will be secondary to government heath care coverage.

If the Health Plan is the secondary plan, benefits under the Health Plan may be reduced. The Claims Administrator will determine the amount the Health Plan normally would pay. Then the amount payable under the primary plan for the same expenses will be subtracted from the amount the Health Plan would have normally paid. The Health Plan will pay you the difference, if any, according to the terms of the Plan. If the Health Plan is secondary, you will never be paid more for the same expenses under both the Health Plan and the primary plan than the Health Plan would have paid alone.

When the Health Plan is secondary and the patient is covered under an HMO, benefits under the Health Plan will be limited to the copayment, if any, for which you would have been responsible under the HMO, whether or not the services provided are rendered by the HMO.

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[2] Uniformed Services Employee and Re-Employment Rights Act of 1994.

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. Otherwise, the Health Plan will be secondary. When a child's parents are legally separated or divorced and there is no court decree, then benefits will be determined in the following order:

- The plan of the parent with custody of the child;
- The plan of the spouse of the parent with custody of the child; and
- The plan of the parent not having custody of the child.

If a legal conflict exists over which plan is primary, the plan that has covered the patient for the longer time will be considered the primary plan. When a plan does not have a coordination of benefits provision, such plan is automatically considered the primary plan.

As a pre-65 retiree, your coverage under the Health Plan is always primary unless you are covered as an employee by another plan or you are disabled and Medicare has become the primary payer. Your spouse's/partner's plan (through his/her employer) is considered secondary. The primary plan pays benefits first, up to that plan's limits. The secondary plan will *not* pay benefits until the primary plan pays a portion or denies a claim. The total benefits paid from both plans cannot be greater than the benefits under the plan that provides the greater benefits.

If You or a Family Member Is Medicare-Eligible

If you or your eligible dependents are Medicare-eligible because of disability or end-stage renal disease and are covered by the Red, White and Blue Plan (even if you have not applied for Medicare coverage), Medicare is generally the primary payer for medical coverage.

If you are Medicare-eligible and you have coverage under your spouse's/partner's plan (through his/her employer), such coverage is considered your secondary plan coverage. The primary plan pays benefits first, up to that plan's limits. The secondary plan will *not* pay benefits until the primary plan pays a portion or denies a claim. The total benefits paid from both plans cannot be greater than the benefits under the plan that provides the greater benefits.

Note: For certain individuals who first become covered by Medicare because of end-stage renal disease (ESRD), the Health Plan is the primary plan for the first 30 months of Medicare entitlement.

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

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 Health Plan will pay covered expenses not payable under the no-fault automobile insurance according to the coordination-of-benefit rules described above.

Facility of Payment

When benefit payments that would have been made under the Health Plan have been made under another plan, the Health 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 Health Plan and, to the extent of such payments, is required.

Example: If Medicare pays as primary and the Health Plan is truly the primary plan, the Health Plan will reimburse Medicare directly for any payments that should have been made by the Health Plan as the primary plan.

Right of Recovery

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

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

Release of Information

Certain facts are needed to apply the rules of this provision. The Claims Administrator has the right and discretion 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 Plan participants only as appropriate for Plan administration and only as permitted by applicable law.

Recovery Provisions

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

Refund of Overpayments

At any time when payments have been made by the applicable Plan for covered or non-covered expenses in a total amount in excess of the maximum amount payable under Plan provisions, the covered person(s) must:

- Repay the applicable Plan the difference between the amount paid by the Plan and the proper amount payable under Plan provisions; and
- Help the Plan obtain a refund from any other person or organization to whom an excess payment was made.

If the covered person(s) or any other person or organization that was paid an excess amount does not promptly refund the full amount of the excess payment, the Plan may reduce the amount of any future benefits that are payable to the covered person(s) or any other person or organization that received the excess payment. The reductions will be equal to the amount of the excess payment. In the case of recovery from a source other than the Plan, the amount of the refund shall equal the difference between the excess payment and the amount recovered from such other source. The Plan may have other rights in addition to the right to reduce future benefits.

Reimbursement

This section applies when a covered person recovers damages — by settlement, verdict or otherwise — for an injury, sickness, or other condition. If the covered person has made such a recovery, including a recovery from an insurance carrier, the Plan will not cover either the

reasonable value of the services to treat such an injury, sickness, or other condition or the treatment of such injury, sickness or other condition.

However, if the Plan pays or provides 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, verdicts or insurance proceeds received by the covered person (or by the legal representatives, estate or heirs of the covered person) to the extent that medical and other benefits have been paid for or provided by the Plan to the covered person.

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

The covered person must also 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/her insurance company) in connection with or related to the conduct of another party.

The covered person must also 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/her action.

The covered person also agrees that the Plan Administrator may withhold any future benefits paid by the Plan or any other Health Plan maintained by Citi or its participating businesses 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 to make the Plan whole; and
- Assigns to the Plan any benefits the covered person may have under any automobile policy or other insurance coverage. The covered person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such lien or to effect such assignment of benefits.

The covered person will cooperate with the Plan and its agents and will:

- Sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement;
- Provide any relevant information; and
- Take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the value of the benefits provided.

If the covered person does not sign and deliver any such documents for any reason (including but not limited to the fact that the covered person was not given an agreement to sign or is unable or refused to sign), the Plan Administrator, in its sole discretion, may or may not advance benefits to the covered person under the Plan. If the Plan Administrator has advanced benefits, it has the right

to subrogation and reimbursement whether or not the covered person has signed the agreement. The covered person shall not take any action that prejudices the Plan's right of reimbursement.

Subrogation

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

The Plan is subrogated to all the rights of the covered person against any party liable for the covered person's injury, sickness or other condition or for the payment for the treatment of such injury, sickness or other condition (including any insurance carrier), to the extent of the value of the benefits provided to the covered person under the Plan. The Plan may assert this right independently of the covered person.

The covered person is obligated to cooperate with the Plan and its agents to protect the Plan's subrogation rights. Cooperation means:

- Providing the Plan or its agents with any relevant information requested by them;
- Signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim; and
- Obtaining the consent of the Plan or its agents before releasing any party from liability for payment.

If the covered person enters into litigation or settlement negotiations regarding the obligations of other parties, the covered person must not prejudice, in any way, the subrogation rights of the Plan under this section.

The costs of legal representation retained by the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation retained by the covered person shall be borne solely by the covered person.

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.

When Coverage Ends

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

- The date any of the retiree Plans are terminated or discontinued;
- The date you are no longer enrolled in or eligible for the coverage;
- The last day for which the necessary contributions are made;
- The last day of the month in which you die or you otherwise cease to be eligible for coverage; or
- The date benefits paid on behalf of a participant equal the lifetime maximum benefit under any of the Plans; coverage for eligible dependents who have not reached their lifetime maximum will not be affected.

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

- The date any of the retiree Plans are terminated or discontinued;
- The last day of the month in which your coverage terminates;
- The date you elect to terminate your eligible dependent's coverage (termination must be in accordance with Plan terms and applicable law);
- The last day for which the necessary contributions are made;
- The date the eligible dependent(s) ceases to be eligible for coverage (in general, coverage will remain in effect through December 31 of the year in which the child reaches the maximum age);
- The date the eligible dependent(s) is covered as an employee under another Citi Plan;
- The date the eligible dependent(s) is covered as the dependent of another employee under another Citi Plan;
- The date the eligible dependent(s) enters the armed forces of any country or international organization;
- The date the dependent is no longer eligible for coverage under a Qualified Medical Child Support Order (QMCSO); or
- The date of the dependent's death.

Your eligible covered dependents may be able to continue coverage under COBRA. See "COBRA" on page 30 for more information.

Coverage for Surviving Dependents

When a covered retiree dies, his/her surviving covered spouse/partner and/or dependent children will be eligible for continued coverage. The surviving spouse/partner and/or dependent children will be eligible to continue coverage on the same terms as when the retiree was alive.

In all cases, coverage for your surviving dependents will end as follows:

- Coverage for surviving children will end when eligibility otherwise ends; or
- Coverage will end when any required contributions cease or when they are paid later than the grace period.

Once survivor coverage ends, it may not be restored. If applicable, COBRA continuation coverage may then be elected. See "COBRA" on page 30 for more information.

Coverage will not be provided to new dependents if the surviving spouse remarries.

All survivor coverage is subject to Citi's right to amend, terminate or otherwise change in any way the benefits provided to Plan participants and their dependents (for example, by reducing or eliminating benefits or by instituting charges for some or all of the costs of such benefits).

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires most employers sponsoring group health plans to offer retirees and their eligible dependents covered under the Plans the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plans would otherwise end (called "qualifying events"). The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of the law.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to eligibility for coverage. Citi reserves the right to terminate coverage retroactively if you are determined to be ineligible under the terms of the Plans.

You will have to pay the entire premium plus a 2% administrative fee for your continuation coverage. Your first premium must be paid within 60 days of the date you elect COBRA coverage. A grace period of at least 30 days applies to the payment of the regularly scheduled premiums.

Who Is Covered

If you are the spouse or partner of a retiree and are covered by any of the Plans on the day before the qualifying event, you are a qualified beneficiary and have the right to choose continuation coverage for yourself if you lose group health coverage under any of the Plans for any of the following reasons:

- Divorce or legal separation from the retiree;
- The retiree becomes entitled to Medicare; or
- The retiree dies.

If you are a covered dependent child of a retiree covered under any of the Plans on the day before the qualifying event, you are a qualified beneficiary and have the right to continuation coverage if group health coverage under any of the Plans is lost for any of the following reasons:

- You cease to be a "dependent child" as defined under the Plans;
- The retiree becomes entitled to Medicare; or
- The retiree dies.

Separate Elections

Each qualified beneficiary has an independent election right for COBRA continuation coverage. For example, if there is a choice among types of coverage offered to similarly situated individuals who have not had a qualifying event, each qualified beneficiary who is eligible for continuation coverage is entitled to make a separate election among the types of coverage. However, when the qualifying event first occurs the qualified beneficiary can elect only the coverage in effect immediately before the qualifying event.

COBRA Coverage in the Event of Bankruptcy

If the employer from which you retired should file for bankruptcy under Title 11 of the United States Code and there is a loss or a substantial elimination of retiree medical coverage within one year before or after such bankruptcy filing, you and your eligible dependents are entitled to COBRA continuation coverage.

You and your eligible dependents are entitled to COBRA continuation coverage for your lifetime. After your death, your surviving spouse and dependents are entitled to an additional 36 months of COBRA continuation coverage. If, at the time of the bankruptcy filing, you are deceased but your surviving spouse is covered by the Plans (and loses coverage as described above), your surviving spouse is entitled to lifetime COBRA continuation coverage.

Your Duties

Under the law, the retiree or a family member is responsibile for informing Citi of a divorce, legal separation or a child's loss of dependent status under the Plans. This notice *must* be provided to Citi within 60 days from the date of the divorce, legal separation or child's loss of dependent status (or, if later, the date coverage would normally be lost because of the event).

If the retiree or a family member fails to provide this notice to Citi within this 60-day notice period, any family member who loses coverage will *not* be offered the option to elect continuation coverage. The notice must be in writing. Send the notice to:

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

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

Citi's Duties

Qualified dependents will be notified of the right to elect continuation coverage automatically (without any action required by the retiree or a family member) if either of the following events occurs that will result in a loss of coverage:

- The retiree becomes entitled to Medicare; or
- The retiree dies.

Electing COBRA

To elect or inquire about COBRA coverage, call the Citi Benefits Center as instructed on page 2.

Under the law, qualified beneficiaries must elect continuation coverage within 60 days from the date they would lose coverage because of one of the events described earlier, or, if later, 60 days after Citi provides them notice of their right to elect continuation coverage. *A qualified beneficiary who does not choose continuation coverage within the time period described above will lose the right to elect continuation coverage.*

If you choose continuation coverage, Citi is required to provide you with coverage that is identical to the coverage provided under the Plans to similarly situated retirees or family members. If the coverage for similarly situated individuals is modified, your coverage will be modified. A "similarly situated" individual refers to a current retiree or dependent who has not had a qualifying event.

Important COVID-19-Related Changes that Extend Benefit Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issued guidance that temporarily extended the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, the Agencies extended deadlines that might have been missed during the National Emergency, which ended on May 11, 2023. The temporary extension of the deadlines expired on July 10, 2023, 60 days after the end of the National Emergency.

- **Notification Deadline Extension**: If you have a COBRA-qualifying event and your initial or secondary qualifying event deadline occurred during the National Emergency (March 1, 2020 – May 11, 2023) you have exhausted the applicable deadline to notify the Plan.
- **Enrollment Deadline Extension**: If your enrollment deadline occurred during the National Emergency (March 1, 2020 – May 11, 2023), you have exhausted the applicable deadline to enroll in COBRA.

Duration of COBRA

A qualified beneficiary can elect COBRA continuation coverage for 36 months, unless the qualified beneficiary lost group health coverage because of a bankruptcy filing. Specific qualifying events and the duration of COBRA continuation coverage associated with them are listed in the following table.

Duration of COBRA Coverage			
	Maximum Continuation Period for Each Qualified Beneficiary		
Qualifying Event	**Retiree**	**Spouse/Partner**	**Child**
Death of the retiree; retiree and spouse become legally separated or divorced; termination of domestic partnership	Not applicable	36 months	36 months
Child no longer qualifies as a dependent	Not applicable	Not applicable	36 months
Bankruptcy	Lifetime	Retiree's lifetime plus 36 months following the death of the retiree	Retiree's lifetime plus 36 months following the death of the retiree

When COBRA coverage ends, generally you cannot convert your coverage into an individual medical policy. However, some HMOs may offer conversion to individual coverage. Call your HMO for information.

Early Termination of COBRA

The law provides that COBRA continuation coverage may end prior to the expiration of the 36-month or other applicable period for any person who elected COBRA for any of the following reasons:

- Citi no longer offers any group health care coverage;
- The premium for continuation coverage is not paid on time (or within the applicable grace period);

- The person who elected COBRA becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation for any pre-existing condition of that covered individual; or
- The person who elected COBRA becomes covered by Medicare after the date COBRA continuation coverage is elected.

In addition, the Plan Administrator reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

Cost of Coverage

Under the law, you may be required to pay up to 102% of the premium for your 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.

COBRA continuation coverage is not effective until you elect it and make the required payment. 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 30 days. If you do not make timely payments, your COBRA continuation coverage will be terminated as of the last day of the month for which you made timely payment.

Important COVID-19-Related Changes that Extend COBRA Payment Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issued guidance that temporarily extended the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, the Agencies extended deadlines that might have been missed during the National Emergency, which ended on May 11, 2023. The temporary extension of the deadlines expired on July 10, 2023, 60 days after the end of the National Emergency.

If enrolled in COBRA, you have 60 days to submit payment for your initial bill and 60 days to submit payment for subsequent bills. If your initial payment deadline occurred during the National Emergency (March 1, 2020 – May 11, 2023), you have exhausted the applicable deadline to submit your initial payment.

If you have any questions about COBRA coverage or the application of the law, contact Citi's COBRA administrator at the address below. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). The address and phone number of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa**.

If your marital status has changed, or you, your spouse/partner, or a dependent has changed addresses or a dependent ceases to be a dependent eligible for coverage under the terms of the Plans, you must notify the COBRA administrator in writing immediately at the address listed below.

Once you have elected COBRA continuation coverage, all notices and other communications regarding COBRA and any of the Plans should be directed to:

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

Your HIPAA Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law enacted to provide improved privacy, portability and continuity of health insurance coverage for dependents. HIPAA provides you with special enrollment rights.

Special Enrollment Rights

In the event that an eligible retiree gets married or has a child or adopts a child, HIPAA permits such a retiree to enroll such an individual within the 30 days after such an event occurs.

You may enroll your spouse under the Plans, and the effective date of coverage will be the first day of the calendar month following the date the completed request for enrollment was received. In the event of the birth of a child, adoption or placement for adoption of a child, the coverage will be effective as of the child's date of birth or the date the of the adoption or the placement for adoption.

Important COVID-19-Related Changes that Extend Benefit Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issued guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, the Agencies extended deadlines that might have been missed due to the National Emergency, which ended on May 11, 2023. The temporary extension of the deadlines expired on July 10, 2023, 60 days after the end of the National Emergency.

If you experienced a qualified change in status that is a HIPAA Special Enrollment event, and your 31-day notification period occurred during the National Emergency (March 1, 2020, through May 11, 2023), you have exhausted the applicable deadline to report your 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. For qualified changes tied to financial assistance or loss of coverage under the Children's Health Insurance Program (CHIP) or Medicaid, the timing is based on the 60-day notification period, rather than 31 days. You have exhausted the applicable deadline to report a change of status and change your benefits.

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 Health Plan to provide you with a notice of the Health Plan's legal duties and privacy practices with respect to your health information. The notice will describe how the Health Plan 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 Health Plan's privacy notice for more information on page 36. You can obtain a copy of the notice by contacting the Citi Benefits Center as instructed on page 2.

The Plan Sponsor shall use and disclose individually identifiable health information ("protected health information") as defined in 45 C.F.R. Parts 160 and 164, and specifically 45 C.F.R. sec. 164.504(f) (the "HIPAA Privacy Rule"), only to perform administrative functions on behalf of the 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 Health Plan shall disclose protected health information to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Health Plan document has been amended to incorporate the provisions herein. The Plan Sponsor shall ensure that any agents, including subcontractors, to whom it provides protected health information received from any of these plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. The Plan Sponsor shall not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. The Plan Sponsor shall report to the Health Plan any use or disclosure of protected health information that is inconsistent with the uses or disclosures provided for herein of which it becomes aware.

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

The Plan Sponsor shall make its internal practices, books and records relating to the use and disclosure of protected health information received from the Health Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Health Plan with the HIPAA Privacy Rules; the Plan Sponsor shall notify the Health Plan 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 protected health information received from the Health Plan 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 Health Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

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

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

Notice of HIPAA Privacy Practices

This Notice of Privacy Practices describes how the Citigroup Retiree Medical Benefit Plan (the "Health Plan"), may use and disclose your protected health information.

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

For Answers to Your Questions and Additional Information

If you have any questions or want additional information about this notice, call the Citi Benefits Center as instructed on page 2. To exercise any of the rights described in this notice, contact the third-party administrator for the Health Plan as instructed on page 42.

The Health Plan's Responsibilities

The Health Plan is required by law to maintain the privacy of your protected health information. The HIPAA Privacy Rule defines "protected health information" to include any individually identifiable health information (1) that is created or received by a health care provider, health plan, insurance company or health care clearinghouse; (2) that relates to the past, present or future physical or mental health or condition of such individual; the provision of health care to such individual or payment for such provision of health care; and (3) that is in the possession or control of an entity covered by the HIPAA Privacy Rule (called "covered entities"), including a group health plan. The Health Plan is required to limit the use, disclosure, or request for protected health information to the extent practicable to either limited data sets or, if needed, the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

The Health Plan is obligated to provide to you a copy of this notice setting forth its legal duties and privacy practices regarding your protected health information. The Health Plan must abide by the terms of this notice.

Uses and Disclosures of Protected Health Information

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

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

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

Health care operations. The Health Plan will use or disclose your protected health information to fulfill the Health Plan's 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, the Health Plan may use or disclose your protected health information (1) to provide information about a disease management program to you; (2) to respond to a customer service inquiry from you; (3) in connection with fraud and abuse detection and compliance programs; or (4) to survey you concerning how effectively the Health Plan is providing services, among other issues.

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

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

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

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

Public health activities. The Health Plan may use or disclose your protected health information for public health activities permitted or required by law. For example, the Health 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. The Health Plan may also disclose protected health information, if directed by a public health authority, to a foreign government agency collaborating with the public health authority.

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

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

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

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

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

Organ and tissue donation. The Health Plan may disclose protected health information to organizations that handle organ, eye or tissue donation and transplantation.

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

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

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

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

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

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

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

Others involved in your health care. The Health Plan may disclose your protected health information to a friend or family member involved in your health care, unless you object or request a restriction (in accordance with the process described under "Right to request a restriction" on page 40. The Health Plan may also disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition status and location. If you are not present or able to agree to these disclosures of your protected health information, then, using professional judgment, the Health Plan may determine whether the disclosure is in your best interest.

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

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

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

Other Uses and Disclosures of Your Protected Health Information

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

Contacting You

The Health Plan (or their 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 Rule.

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

Your Rights

The following is a description of your rights regarding your protected health information. If you wish to exercise any of these rights, you must contact the third-party administrator of the Health Plan that you wish to have comply with your request using the contact information on page 42.

Right to request a restriction. You have the right to request a restriction on the protected health information that the Health Plan uses or discloses about you for payment or health care operations. You also have a right to request a limit on disclosures of your protected health information to family members or friends involved in your care or the payment for your care. You may request such a restriction using the contact information on page 42.

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

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

Right to request confidential communications. If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that the Health 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 on page 42.

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

You may request an electronic copy of your protected health information if it is maintained Your request must specify the alternative means or location for communicating with you. It must also state that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger. The Health Plan will accommodate a request for confidential communications that is reasonable and states that the disclosure of all or part of your protected health information could endanger you.

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

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

Right to request an amendment. You have the right to request an amendment of your protected health information held by the Health Plan if you believe that information is incorrect or incomplete. If you request an amendment of your protected health information, your request must be submitted in writing, using the contact information on page 42 and must set forth a reason(s) to support the proposed amendment. In certain cases, the Health Plan may deny your request for an amendment.

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

Right to request an accounting. You have the right to request an accounting of certain disclosures the Health Plan have made of your protected health information. You may request an accounting using the contact information on page 42. You can request an accounting of disclosures made up to six years prior to the date of your request, except that the Health Plan are not required to account for disclosures made prior to April 14, 2003.

You are entitled to one accounting from the Health Plan free of charge during a 12-month period. There may be a charge to cover the Health Plan's costs for any additional requests within that 12-month period. The Health Plan 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 as instructed on page 2.

Complaints

If you believe the Health Plan have violated your privacy rights or are not fulfilling their obligation under the breach notice rules, you may complain to the Health Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the Health Plan using the contact information on page 42. The Health Plan will not penalize you for filing a complaint.

Changes to This Notice

The Health Plan reserves the right to change the provisions of this notice and to make the new provisions effective for all protected health information that it maintains. If the Health 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 the Health Plan (or, if you agreed to receive revised notices electronically, at the e-mail address you provided to the Health Plan).

Effective Date

This Notice of HIPAA Privacy Practices became effective April 14, 2003 and was reviewed effective October 26, 2022.

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 Street, 15th Floor
New York, NY 10013

To exercise any of the rights described in this notice, contact the third-party administrators for the Citi Retiree Medical Benefit Plan as follows.

- ConnectOne at **1 (800) 881-3938**. From the ConnectOne main menu, choose the "benefits" option and then the "retiree health and insurance" option and speak with a Citi Benefits Center representative.
- **From outside the United States and Puerto Rico:** Call **1 (469) 220-9600** for assistance. From the ConnectOne main menu, choose the "benefits" option and then the "retiree health and insurance" option and speak with a Citi Benefits Center representative.
- **For TDD service from the United States:** Call the Telecommunications Relay Services at 711. Then call ConnectOne as instructed above.
- **For text telephone service in Puerto Rico**: Call **1 (866) 280-2050**, then call ConnectOne at **1 (800) 881-3938**, and follow the instructions above to reach a Citi Benefits Center representative.

Section 1557 of the Affordable Care Act Grievance Procedure

It is the policy of Citigroup not to discriminate on the basis of race, color, national origin, sex, age or disability. 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, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be requested from the office of 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, sex, age or disability 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.

Procedure

- 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 Global Benefits Department (or their 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 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 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 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.

The availability and use of this grievance procedure does 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, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination 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, DC 20201.

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**. Such complaints must be filed within 180 days of the date of the alleged discrimination.

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 Citi Global Benefits Department will be responsible for such arrangements.

Newborns' and Mothers' Health Protection Act

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

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

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, if a covered person is receiving benefits in connection with a mastectomy under the applicable Citi Plan, the following benefits shall also be provided to the covered person if requested by the covered person's attending doctor:

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

The same limitations (e.g., annual deductibles and coinsurance provisions) that apply to the other benefits provided under the Health Plan apply to the benefits described above.

Mental Health Parity and Addiction Equity Act of 2008

The Mental Health Parity Act of 1996 required that annual and lifetime dollar limits for mental health benefits be the same as medical and surgical benefits under the Health Plan. The Mental Health Parity and Addiction Equity Act of 2008 expands those requirements to provide that mental health and substance abuse benefits should be provided at the same level as medical and surgical benefits under the Health Plan. This means that the deductions, coinsurance and limits on days for benefits for mental health and substance abuse benefits have to be at the same level as the medical and surgical benefits.

Genetic Information Nondiscrimination Act of 2008

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

Claims and Appeals

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

Medical	
• Aetna • Anthem BlueCross BlueShield	• For Aetna plans, call **1 (800) 545-5862**; for TDD service, call **1 (800) 325-2298**. • For Anthem BlueCross BlueShield plans, call **1 (855) 593-8123**.
Prescription Drug	
CVS Caremark claim form	Visit **www.caremark.com** Call **1 (844) 214-6601**
Dental	
• MetLife Preferred Dentist Program (PDP) • MetLife Retiree Dental Insurance	• Visit **www.metlife.com/dental** • Call **1 (888) 832-2576**
• Cigna Dental HMO	There are no claim forms to file under this plan.
Vision	
Aetna Vision	Call **1 (877) 787-5354**

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

- Medical, dental and vision claims must be filed within two years of the date of service.
- Prescription drug claims must be filed within one year of the date of service.

To file a claim or appeal, you must use the designated form in accordance with Plan procedures. Claims for services received on or after January 1, 2023, must be submitted within 12 months of the date of the service. By participating in the Plans, you and your beneficiaries agree that you cannot commence a legal action against the Plans more than one year after your final appeal has been denied, unless an insurance contract made available under the Plan provides for a different limitation. No legal action can be brought to recover benefits under any of the Plans until the appeal rights described in the following sections have been exercised and the Plan benefits requested in such appeal have been denied.

Important COVID-19-Related Changes that Extend Claims and Appeals Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extended the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, the Agencies extended deadlines that might have been missed during the National Emergency, which ended on May 11, 2023. The temporary extension of the deadlines expired on July 10, 2023, 60 days after the end of the National Emergency. If your deadline to file a claim or appeal occurred during the National Emergency (March 1, 2020 – May 11, 2023) and you have exceeded the deadlines outlined in the plan documents or denial notification, you may have additional time to submit your claim or appeal. For more information, contact the Claims Administrator to obtain a claims appeal form.

Claim and Appeals for Aetna Medical Plans

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

Type of Claim	Timeline After Claim Is Filed
Post-service claims (for claims filed after the service has been received)	• Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) • Notice that more information is needed must be given within 30 days • You have 45 days to submit any additional information needed to process the claim*
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*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	• Decision made within 72 hours • Notice that more information is needed must be given within 24 hours • You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	• Decision made within 24 hours for urgent care treatment • Decision made sufficiently in advance for all other claims

* Time period allowed to make a decision is suspended pending receipt of additional information.

Claim forms explain how and when to file a claim and may be obtained from the Citi Benefits Center. Call the Citi Benefits Center as instructed on page 2.

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 and time limits for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the Plan's appeals procedure.

Appeals for Aetna Medical Plans

You will have 180 days following receipt of a claim denial to appeal the decision. You will be notified of the decision no later than 15 days (for 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 information were submitted in connection with the initial claim. You may also request that the Claims Administrator provide you, free of charge, copies of all documents, records and other information relevant to the claim.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator. For preservice and post-service claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Retiree Health Benefit Plan. The Claims Administrator's decisions are conclusive and binding. The Claims Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination whether the pending health service is necessary or appropriate is between you and your doctor.

If your claim involves urgent care, an expedited appeal may be initiated by calling Member Services at the telephone number on your ID card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you and your authorized representative and the Claims Administrator by telephone, fax or other similar method. You will be notified of the decision no later than 36 hours after the appeal is received. If you are dissatisfied with the appeal decision, you may file a second-level appeal within 60 days of receipt of the level-one appeal decision. The appeal will be handled in the same timeframe as the first-level appeal and a notice will be sent to you explaining the decision.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The 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 must exhaust the applicable level-one and level-two processes of the appeal procedure before you contact the Department of Insurance to request an investigation of a complaint or appeal, or

file a complaint of appeal with the Department of Insurance, or establish any litigation or arbitration, or establish any administrative proceeding regarding an alleged breach of the policy terms by Aetna Life Insurance Company, or establish any matter within the scope of the appeals procedure.

External Review

An “external review” is a review by independent doctor, with appropriate expertise in the area at issue, of claim denials based on lack of medical necessity or the experimental or investigational nature of a proposed service or treatment.

You may, at your option, obtain external review of a claim denial provided the following are satisfied:

- You have exhausted the Aetna appeal process for denied claims, as outlined in this “Claims and appeals for Aetna medical plans” section of this document and you have received a final denial;
- The appeal is made by the member or the member’s authorized representative;
- The final denial was based on a lack of medical necessity or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment at issue for which the member is financially responsible exceeds $500.

If you meet the eligibility requirements listed above, you will receive written notice of your right to request an external review at the time the final decision on your internal appeal has been rendered. Either you or an individual acting on your behalf will be required to submit to Aetna the External Review Request Form (except under expedited review, described below), a copy of the plan denial of coverage letter and all other information you wish to be reviewed in support of your request. A request for an external review is completely voluntary and will have no effect on your rights to any other benefits under the Citi Plan. All requests for an external review must be submitted in writing to Aetna within 60 calendar days after you receive the final decision on your internal appeal.

Aetna will contact the External Review Organization that will conduct your external review. The External Review Organization will select an independent doctor with appropriate expertise in the area at issue to perform the external review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the External Review Request Form and must follow the applicable Plan documents and criteria governing the benefits.

The External Review Organization generally will notify you of the decision within 30 calendar days of Aetna’s receipt of a properly completed External Review Request Form. The notice will state whether the prior determination was upheld or reversed and briefly explain the basis for the determination. The decision of the external reviewer will be binding on the Plan, except where Aetna or the Plan Administrator can show reviewer conflict of interest, bias or fraud. In such cases, notice will be given to you, and the matter will be promptly resubmitted for consideration by a different reviewer.

An expedited review is available when your treating doctor certifies on a separate Request for Expedited External Review Form (or by telephone with prompt written follow-up) the clinical urgency of the situation. “Clinical urgency” means that a delay (waiting the full 30-calendar-day period) in receipt of the service or treatment would jeopardize your health.

Expedited reviews will be decided within five calendar days of receipt of the request. In the case of such expedited reviews, you will initially be notified of the determination by telephone, followed immediately by a written notice delivered by expedited mail or fax.

You will be responsible for the cost of compiling and sending to Aetna the information that you wish to be reviewed by the External Review Organization. Aetna is responsible for the cost of sending this information to the External Review Organization. The professional fee for the external review will be paid by Aetna.

For an individual to act on your behalf in connection with an external review, you will need to consent to the representation by signing the appropriate line on the External Review Request Form.

You may obtain more information about the external review process by calling the toll-free Member Services telephone number on your Aetna ID card.

Claims and Appeals for Anthem BlueCross BlueShield Medical Plans

Timing of Initial Claim Approval or Denial

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

- **For claims involving urgent care**, you will be notified of the approval or denial no later than 72 hours after your claim is received. If your claim did not include enough information to determine whether it should be approved or denied, you will be notified within 24 hours after receiving your claim of the specific information that is necessary. You will have at least 48 hours to provide the specified information. You will be notified of the approval or denial no later than 48 hours after Anthem BlueCross BlueShield receives the information or 48 hours after the deadline for providing the information, if earlier. For purposes of these claims procedures, urgent care means medical care or treatment that must be provided without delay to avoid seriously jeopardizing life, health or the ability to regain maximum function, or that must, in the opinion of a doctor, be provided without delay to adequately manage severe pain.
- **For medical care requiring pre-certification approval (called a "pre-certification claim")**, you will be notified of the approval or denial of your claim no later than 15 calendar days after your claim is received. Anthem BlueCross BlueShield may extend this 15-calendar day period to 30 calendar days if it needs more time to review your claim due to matters outside of its control. If a longer period of time is required, you will be notified within the initial 15-calendar day period of the reasons for the extension and the date by which a decision will be made. You will be notified if your claim did not include enough information to reach a decision. You will have at least 45 calendar days from receipt of the notice to provide the specified information.
- For care involving an ongoing course of treatment to be provided over a period of time or through a number of treatments (called "concurrent care decisions"), you will be notified in advance of any decision by Anthem BlueCross BlueShield to reduce or terminate the course of treatment that would be covered, so that you will have enough time to appeal the decision and receive a determination before the treatment is reduced or terminated. If you wish to extend the course of treatment and the treatment involves urgent care, you will be notified within 24 hours after your claim is received, as long as you make your claim at least 24 hours before the approved course of treatment is scheduled to end.
- **For all other care (e.g., reimbursement for medical services already received)**, you will be notified of the approval or denial of your claim no later than 60 calendar days after your claim is received. If a longer period of time is required, you will be notified within the initial 60-calendar day period of the reasons for the extension and the date by which a decision will be made. You will be notified if your claim did not include enough information to make a decision. You will have at least 45 calendar days from receipt of the notice to provide the specified information.
- **For claim denial notice**, if you receive notice that your claim has been denied, either in full or in part, the claim denial notice will include:
  - The specific reasons for the denial;

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

Appeal Filing Deadlines

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

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

Approval or denial of appeal. Anthem BlueCross BlueShield will send you its decision within the following deadlines: 72 hours for urgent care claims, 30 calendar days for precertification claims and 60 calendar days for all other claims.

If your claim is based on a medical judgment, in reviewing your appeal, Anthem BlueCross BlueShield will consult with a health care professional that has appropriate training and experience in the field of medicine involved in the medical judgment and will provide you with the name of the Health care professional, upon request.

If Anthem BlueCross BlueShield denies your appeal, the denial notice will include:
- The specific reasons for the denial;
- Reference to the specific Plan provisions on which the denial is based;
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA after you have followed the Plan's claims procedures and received an adverse decision on your first

appeal (in the case of an urgent care claim) or on your second appeal (in the case of all other claims);
- If an internal rule, guideline or protocol was relied on in making the adverse determination, either a copy of the specific rule, guideline or protocol, or a statement that it will be provided on request, free of charge; and
- If the denial is based on a medical necessity exclusion, experimental treatment exclusion or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, or a statement that an explanation of the scientific or clinical judgment for the determination will be provided on request, free of charge.

Second appeal to Anthem BlueCross BlueShield. For claims other than urgent care claims, if Anthem BlueCross BlueShield denies your appeal, you have 60 calendar days from receiving the appeal denial to send a second appeal to Anthem BlueCross BlueShield. Your appeal must be in writing. Anthem BlueCross BlueShield will send you its written decision within 30 calendar days for pre-certification claims and 60 calendar days for all other claims.

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

Authorized representative. If you appeal an adverse decision to Anthem BlueCross BlueShield or the Medical Review Board, you may have an authorized person represent you (at your own expense). You have the right to examine the relevant portions of any documents that Anthem BlueCross BlueShield referred to in its 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 Anthem BlueCross BlueShield 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 Anthem BlueCross BlueShield's decision, can be sent between Anthem BlueCross BlueShield you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact Anthem BlueCross BlueShield 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 Anthem BlueCross BlueShield 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
P.O. 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.

Legal action. You must follow these claims procedures completely, which require one appeal to Anthem BlueCross BlueShield for urgent care claims and two appeals to Anthem BlueCross BlueShield for all other claims, before you can take legal action. After you receive the final decision from Anthem BlueCross BlueShield, you can take legal action.

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 52, 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 doctor 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**

Claims and Appeals for MetLife Dental Plan

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

Type of Claim	Timeline After Claim Is Filed
Post-service claims (for claims filed after the service has been received)	• Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) • Notice that more information is needed must be given within 30 days • You have 45 days to submit any additional information needed to process the claim*
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*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	• Decision made within 72 hours • Notice that more information is needed must be given within 24 hours • You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	• Decision made within 24 hours for urgent care treatment • Decision made sufficiently in advance for all other claims

* Time period allowed to make a decision is suspended pending receipt of additional information.

You have the right to request a reconsideration of the denied claim by calling or writing 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 claim paid, normal processing steps are followed. If, after the review, it is determined that the original denial stands, a denial letter is written.

Responses to an appeal are conducted by an individual of higher authority than the person who originally denied the claim. The response includes:

- An explanation of why the charges are denied in plain language; and
- Reference to the section of the 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 and post-service claim appeals, Citi has delegated to MetLife as Claims Administrator the exclusive right to interpret and administer the provisions of the Dental Benefit Plan. The Claims Administrator's decisions are conclusive and binding. The Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination whether the pending health service is necessary or appropriate is between you and your doctor.

Claims and Appeals for the Cigna Dental HMO

If you have a concern about your dental office or the Cigna Dental Plan, call **1 (800) CIGNA24** (**1 (800) 244- 6224**) and explain your concern to a Customer Service representative. You can also express your 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 get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to Cigna Dental 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 Level-One Appeal

Your level-one appeal will be considered and the resolution made by someone not involved in the initial decision or occurrence. Issues involving dental necessity or clinical appropriateness will be considered by a dental professional.

If your appeal concerns a denied preauthorization, Cigna Dental will respond with a decision 15 calendar days after your appeal is received. For appeals concerning all other coverage issues, Cigna Dental will respond with a decision within 30 calendar days after your request is received. If the review cannot be completed within 30 days, Cigna Dental will notify you on or before the 30th day of the reason for the delay. The review will be completed within 15 calendar days after that. 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 second-level review. To initiate a level-two appeal, you must submit your request in writing to Cigna Dental within one year after receipt of Cigna Dental's level-one decision.

Cigna Dental Level-Two Appeal

Second-level reviews will be conducted by Cigna Dental's Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving dental necessity or clinical appropriateness, the committee will include at least one dentist. If specialty care is in dispute, the Appeals Committee will consult with a dentist in the same or similar specialty as the care under consideration, as determined by Cigna Dental.

Cigna Dental will acknowledge your appeal in writing within five business days and schedule an Appeals Committee review. The acknowledgment will include the name, address and telephone number of the appeals coordinator. Additional information may be requested at that time. The review will be held within 30 calendar days. If the review cannot be completed within 30 calendar days, you will be notified in writing on or before the 15th calendar day, and the review will be completed no later than 45 days after receipt of your request.

You may present your claim to the Appeals Committee in person or by conference call. Please advise Cigna Dental five days in advance if you or your representative plans to be present. You will be notified in writing of the Appeals Committee's decision within five business days after the Appeals Committee's meeting. The resolution will include the specific contractual or clinical reasons for the resolution, as applicable.

Cigna Dental Expedited Appeal

You may request that the resolution of your appeal be expedited if the time frames under the process described above would seriously jeopardize your life or health or would jeopardize your ability to regain the dental function 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 Cigna Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

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

Cigna Dental Independent Review

If your appeal concerns a dental necessity issue and the Appeals Committee denies coverage and you live in a state that requires that an independent review be available, you may request that your appeal be referred to an independent review organization. To request a referral to an independent review organization, the reason for the denial must be based on a dental necessity determination by Cigna Dental. Administrative, eligibility or benefit coverage limits are not eligible for additional review under this process.

There is no charge to initiate this independent review process. However, you must provide written authorization permitting Cigna Dental to release the information to the independent review organization. The independent review organization is composed of persons who are not employed by Cigna Dental or any of its affiliates. Cigna Dental will abide by the decision of the independent review organization.

To request a referral to an independent review organization, you must notify the appeals coordinator within 60 days of receipt of your level-two decision. Cigna Dental will then forward the file to the independent review organization within 30 days. The independent review organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your dental condition, as determined by the Cigna Dental Plan's dental director, the review shall be completed within three to five days.

The independent review program is a voluntary program arranged by the Plan and is not available in all areas.

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.

Appeals for the Cigna Dental HMO Plan should be mailed to:

Attn: Dental Appeals Unit
P.O. Box 188047
Chattanooga, TN 37422-8037

Claims and Appeals for the Vision Benefit Plan

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

Type of Claim	Timeline After Claim Is Filed
Post-service claims (for claims filed after the service has been received)	• Decision is made within 30 days from receipt of the request; one 15-day extension (notice for an extension must be given before the end of the 30-day period) • If more information is needed, notice must be given within 30 days • Additional information must be submitted within 45 days to process the claim*
Preservice claims (for care or treatment requiring approval before the care or treatment is received)	• Decision is made within 15 days from the receipt of the request; one 15-day extension (notice for an extension must be given before the end of the 15-day period) • If additional information is required, notice must be given within fifteen (15) days • Additional information must be submitted with 45 days to process the claim*
Urgent care claims (for medical care or treatment where delay could jeopardize your ability to regain maximum function; cause you to suffer severe pain that cannot be adequately managed without the required medical care or treatment; or in the case of a pregnant woman, cause serious jeopardy to the health of the fetus)	• Decision made within 72 hours • Notice for additional information must be given within 24 hours • Any additional information must be submitted within 48 hours from the request to process a claim • A determination will be made within 48 hours from the receipt of all additional information needed to process the claim
Concurrent care claims (a request to extend a previously approved course of treatment)	• Decision made within 24 hours for emergency/ urgent care treatment provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. • Decision made within 15 calendar days for all other care; following a request for a concurrent care claim extension. • For concurrent care claim reduction or termination, notice of claim determination to reduce or terminate a previously approved course of treatment will be given with enough time for you to file an appeal.

* Time period allowed to make a decision is suspended pending receipt of additional information.

Complaints

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

Appeals of Adverse Benefit Determinations

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; or
- A determination that the service or supply is not medically necessary.

The 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 the receipt of notice of an adverse benefit determination to request your level one 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.

Level-One Appeal

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

- **For urgent care claims (may include concurrent care claim reduction or termination),** Aetna shall issue a decision within 36 hours of receipt of the request for an appeal.
- **For pre-service claims (may include concurrent care claim reduction or termination),** Aetna shall issue a decision within 15 calendar days of receipt of the request for an appeal.
- **For post-service claims,** Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Level-Two Appeal

If Aetna upholds an adverse benefit determination at the first-level of appeal, and the reason for the adverse determination was based on medical necessity or experimental or investigational reasons, you or your authorized representative has the right to file a level-two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a level-one appeal.

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

- **For urgent care claims (may include concurrent care claim reduction or termination),** Aetna shall issue a decision within 36 hours of receipt of the request for a level-two appeal.
- **For pre-service claims (may include concurrent care claim reduction or termination),** Aetna shall issue a decision within 15 calendar days of receipt of the request for a level-two appeal.
- **For post-service claims,** Aetna shall issue a decision within 30 calendar days of receipt of the request for a level-two appeal.

Exhaustion of Process

You must exhaust the applicable level one and level two 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; or
- 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 doctor, selected by an External Review Organization, who has expertise in the problem or question involved.

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

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

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

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

Aetna will contact the Independent Review Organization that will conduct the review of your claim. The Independent Review Organization will select a doctor 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 doctor 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 Aetna Vision Plan at **1 (877) 787-5354**.

Important Notice from Citi about Your Prescription Drug Coverage and Medicare

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

More information about Medicare and your choices is set forth below.

Creditable Coverage Disclosure Notice

For former employees enrolled in certain Citi medical plans

This notice, required by Medicare to be delivered to Medicare-eligible individuals,[3] contains information about your current prescription drug coverage with Citi and prescription drug coverage available to people with Medicare.

Keep this notice. If you enroll in Medicare prescription drug coverage, you may be asked to present this notice to prove that you had "creditable coverage" and, therefore, are not required to pay a higher premium (a penalty) 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.

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[3] Citi is required by law to distribute this notice to 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.

You may request another copy of this notice by calling ConnectOne at **1 (800) 881-3938**. From the ConnectOne main menu, choose the "pension and retiree health and welfare" option and then speak with a Citi Benefits Center representative.

Prescription Drug Coverage and Medicare

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

"Creditable Coverage"

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

Understanding the Basics

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

- You *have* prescription drug coverage under your current Citi medical plan.
- If you drop your Citi prescription drug coverage and enroll in a Medicare prescription drug plan, you may not be able to get your Citi coverage back at a later date if you so choose. You should compare your current coverage carefully — including which drugs are covered — with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.
- Your existing Citi coverage is, on average, *at least as good* as standard Medicare prescription drug coverage (this is your "creditable" coverage). As a result, you can keep your current Citi coverage and *not* pay extra if you subsequently 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 - 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 or drop your prescription drug coverage under the Health Plan, you will be eligible for a 60-day Special Enrollment Period (SEP) to enroll in a Medicare prescription drug plan because of your lost coverage.
- 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 who promptly enroll for the same coverage. You must pay this higher premium percentage for 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. If you are Medicare-eligible, you will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

Do You Qualify for Extra Help from Medicare Based on Your Income and Resources?

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, call the Social Security Administration (SSA) at **1 (800) 772-1213**; for TTY service, call **1 (800) 325-0778**.

You can obtain Medicare's income level and asset guidelines by calling **1-800-MEDICARE (1 (800) 633-4227)**. If you qualify for assistance, visit the SSA website or call the SSA to request an application.

For More Information About This Notice

Call the Citi Benefits Center through ConnectOne at **1 (800) 881-3938**. From the ConnectOne main menu, choose the "pension and retiree health and welfare" option and then speak with a Citi Benefits Center representative.

For text telephone service, call the Telecommunications Relay Service at 711. Then call ConnectOne at **1 (800)-881-3938** as instructed above.

NOTE: You will get this notice each year. You will also get it 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.

"Non-Creditable Coverage"

Certain Citigroup retiree plans do not provide prescription drug coverage. If you are eligible for such a plan, and you become eligible for Medicare in the next 12 months, you may wish to consider enrolling in Medicare Part D when you are eligible to avoid potential penalties if you believe that you might be interested in having prescription drug coverage in the future.

More information about Medicare and your choices is set forth below.

Non-Creditable Coverage Disclosure Notice

For former employees enrolled in plans without a prescription drug benefit

Citigroup has determined that prescription drug coverage provided through the Citigroup Retiree Medical Benefit Plan is "creditable" coverage under Medicare. However, you may be covered under a Citi retiree plan that does not provide prescription coverage. For purposes of Medicare coverage, no coverage would be deemed as "non-creditable" coverage. This means that, if you become eligible for Medicare in the next 12 months and you are covered under a retiree medical plan that does not offer prescription drug coverage during that period, you may pay more for Medicare Part D prescription drug coverage if you later elect it.

If you are enrolled in such a plan, you may wish to consider enrolling in Medicare Part D when you are eligible to avoid potential penalties if you believe that you might be interested in having prescription drug coverage in the future.

More information about Medicare and your choices is set forth below.

This notice, required by Medicare to be delivered to Medicare-eligible individuals,[4] contains information about your current prescription drug coverage with Citigroup and prescription drug coverage available to people with Medicare.

Keep this notice. Please read this notice carefully, and keep it where you can find it. This notice has information about your current prescription drug coverage with Citi and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan.

You may receive this notice at other times in the future, for example, before the next period in which you can enroll in Medicare prescription drug coverage and/or if there are changes to your Citi coverage You may request another copy of this notice by calling ConnectOne at **1 (800) 881-3938**. From the main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative.

Prescription Drug Coverage and Medicare

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 offer more coverage for a higher monthly premium.

"Non-Creditable Coverage"

Citi has determined that you may be covered under a medical plan that does not offer prescription drug coverage, which means that on average for all plan participants, the plan is not expected to pay as much as standard Medicare prescription drug coverage pays, and therefore, is considered

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

"non-creditable coverage." This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan than not having prescription drug coverage.

Understanding the Basics

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

Consider Joining a Medicare Prescription Drug Plan

Because you do not have prescription drug coverage and as such, it is, on average, not at least as good as standard Medicare prescription drug coverage, you may pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15 - December 7. If you do not enroll in a Medicare drug plan when you are first eligible, you may have to wait to join a Medicare prescription drug plan and may have to pay a higher premium (a penalty) if you join later.

You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. Because you do not currently have prescription drug coverage under a Citi retiree medical plan, you will not be able to take advantage of special enrollment period available to individuals who have prescription drug coverage. For example, if you had prescription drug coverage and lost that coverage, through no fault of your own, you would be eligible for a 60-day Special Enrollment Period (SEP) to enroll in a Medicare prescription drug plan because of your lost coverage. The SEP is not available to you because you do not have prescription drug coverage.

You Need to Make a Decision

You should compare the coverage and cost of the plans offering Medicare prescription drug coverage in your area. You should also know that since you do not have prescription drug coverage under the Citi retiree plan, which means you do not have creditable coverage, for purposes of Medicare prescription drug coverage, if you do not join a Medicare prescription drug plan within 63 continuous days after you are eligible for Medicare prescription drug plan coverage, you may pay a higher premium (a penalty) to enroll in a Medicare prescription drug plan later.

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

For More Information About Medicare

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

Do you qualify for "extra help" from Medicare based on your income and resources? If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov** or call **1 (800) 772-1213 (TTY 1 (800) 325-0778)**.You can find Medicare's income level and asset guidelines at **www.cms.hhs.gov/medicarereform/lir.asp** or by calling **1-800-MEDICARE (1 (800) 633-4227)**. If you qualify for assistance, visit the SSA website or call the SSA to request an application.

For More Information About This Notice

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

For text telephone service, call the National Relay Service at 711. Then call ConnectOne at **1 (800) 881-3938** as instructed above.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Citigroup changes. You may request another copy of this notice by calling ConnectOne at **1 (800) 881-3938**. From the main menu, choose the "pension and retiree health and welfare" option and then follow the prompts for a Benefits Service Center representative.

ERISA Information

As a participant in the Plans described in this SPD, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

You may examine all documents governing the Plans (including group insurance policies, where applicable) and copies of all documents filed with the U.S. Department of Labor (and available at the Public Disclosure Room of the Employee Benefits Security Administration) such as annual reports (Form 5500 Series). You can review these documents at no cost to you upon request at the location of the Plan Administrator or other specified locations.

Upon written request to the Plan Administrator, you may obtain copies of documents governing the operation of the Plans, including insurance contracts, a copy of the latest annual report (Form 5500) and the current Summary Plan Description. The Plan Administrator will mail these documents to your home free of charge. You may also receive a copy of the Plan's annual financial report. The Plan Administrator will furnish each participant with a copy of the Summary Annual Report.

If there is a loss of coverage under the Plans 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 document 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 the “Claims and Appeals” section beginning on page 44.

Under ERISA, you can take steps to enforce the rights described above. For example, if you request materials from the Plans and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them, unless the materials were not sent for reasons beyond the Plan Administrator’s control.

If your claim for benefits is denied or ignored, in full or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If you believe the fiduciaries are misusing their authority under the Plans or if you believe you are being discriminated against for asserting your rights, you may request assistance from the U.S. Department of Labor or file a suit in federal court, subject to limitations imposed by Plan rules.

The court will decide who should pay court costs and legal fees. If your suit is successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. One instance in which you may be required to pay court costs and legal fees is if the court finds your suit to be frivolous.

Answers to Your Questions

If you have questions about the Plans, contact the Plan Administrator.

If you have any questions about this document 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:

Division of Technical Assistance and Inquiries, Employee Benefits Security Administration,
U.S. Department of Labor
200 Constitution Ave. NW
Washington, DC 20210

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

Administrative Information

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

Future of the Plans and Plan Amendments

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

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

The Plan Administrator has designated other organizations or persons to act out specific fiduciary responsibilities in administering the Plan including, but not limited to, any or all of the following responsibilities:

- To administer and manage the Plans including the processing and payment of claims under the Plans and the related recordkeeping, according to the terms of an administrative services or claims administration agreement;
- To prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to 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 Plan to the extent another insurer or administrator is not empowered with such responsibility.

The delegation by the Plan Administrator may (but is not required to) be in writing. Except to the extent superseded by laws of the United States, the laws of New York will be controlling in all matters relating to the Plans.

Funding and Payment Policy

Benefits under the Health Plan, the MetLife Preferred Dentist Program (PDP), the MetLife Associates Dental Plan, the MetLife Group 901 Plan, and the MetLife Group 903 Plan may be funded from the general assets of Citigroup, a trust qualified under section 501(c)(9) of the Internal Revenue Code (the "Code"), or under insurance contracts. The Cigna DHMO and the Vision Plan is fully insured. The costs of the Health Plan, the Dental Plan and the Vision Plan are shared between Citi and Plan participants. Any refund, rebate, dividend adjustment or other similar payment under any insurance contract entered into between Citi and any insurance provider shall

be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse Citi for premiums it has paid or to reduce Plan expenses.

All Plan assets shall be used to pay benefits under the Plans or pay the reasonable expenses of Plan administration. Payments under the Plans shall be made in accordance with Plan terms, insurance policies, or administrative agreements.

Compliance with Law

The Plans shall be construed and administered in compliance with federal and state law mandates governing the Plans, including ERISA, COBRA, USERRA, HIPAA, the Code, the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act of 1996, as amended, the Women's Health and Cancer Rights Act of 1998 and the Genetic Information Nondiscrimination Act of 2008.

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. Additionally, as final guidance becomes available and applicable, Citigroup will modify this SPD accordingly and/or provide a Summary of Material Modifications.

Plan Information

Plan Sponsor	Citigroup Inc. 750 Washington Blvd., 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 80% interest is owned.
Plan Administrator	Plans Administration Committee of Citigroup Inc. 388 Greenwich Street, 15th Floor New York, NY 10013
Plan Names and Numbers	
• Medical plans including prescription drugs	Citigroup Retiree Medical Benefit Plan Plan number 550
• Dental plans	Citigroup Dental Benefit Plan Plan number 505
• Vision plan	Citigroup Vision Benefit Plan Plan number 533

Claims Administrators

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

For self-insured Choice Plan, High Deductible Plan, and Red, White, and Blue Plan	Aetna P.O. Box 981106 El Paso, TX 79998-1106 **1 (800) 545-5862** Anthem BlueCross BlueShield P.O Box 105187 Atlanta, GA 30348-5187 **1 (855) 593-8123**
For prescription drug program: Retail pharmacy Mail Order Service	 CVS Caremark PO Box 52136 Phoenix, AZ 85072 **1 (844) 214-6601** CVS Caremark PO Box 65941 San Antonio, TX 78265-9541 **1 (844) 214-6601**
For vision:	Aetna Vision P.O. Box 8504 Mason, OH 45040-7111 **1 (877) 787-5354**
For dental plans: Cigna Dental Care DHMO MetLife Preferred Dentist Program (PDP) MetLife Associates Dental Plan MetLife Group 901 Plan MetLife Group 903 Plan	 Cigna Dental/Customer Service 1571 Sawgrass Corporate Parkway Suite 140 Sunrise, FL 333 **1 (800) CIGNA24** Metropolitan Life Insurance Co. MetLife Dental Claims Unit P.O. Box 981282 El Paso, TX 79998-1282 **1 (888) 832-2576**
Agent for Service of Legal Process	General Counsel Citigroup Inc. 388 Greenwich St. New York, NY 10013 Service of legal process may also be made upon the Plan Administrator
Plan Year (For All Plans)	January 1 - December 31
Type of Administration	The plans are administered by the Plans Administration Committee of Citigroup Inc. through agreements entered into with the Claims Administrators. However, final decision on the payment of claims rests with the Claims Administrators. The Claims Administrators do not guarantee the benefits under the Plans.

Glossary

The following definitions apply to all Citi retiree health care plans, 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/surgery center. A specialized facility established, equipped, operated and staffed primarily to perform surgical procedures and that fully meets one of the following two tests:

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

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

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

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located and
- It meets all of the following requirements:
  - It is operated and equipped in accordance with any applicable state law;
  - It is equipped to perform routine diagnostic and laboratory exams such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity;
  - It has available, to handle foreseeable emergencies, trained personnel and necessary equipment including, but not limited to, oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation and blood expanders;
  - It is operated under the full-time supervision of a licensed doctor of medicine (MD), doctor of osteopathy (DO) or registered nurse (RN);

- It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications;
- It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal exam, any laboratory or diagnostic tests and a postpartum summary; and
- It is expected to discharge or transfer patients within 24 hours following delivery unless medically necessary.

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

Board and room charges. Charges made by an institution for board and room and other necessary services and supplies. They must be regularly made at a daily or weekly rate.

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.

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

Claims Administrator. Aetna, Anthem BlueCross BlueShield and CVS Caremark. The Claims Administrator does not insure the benefits described in this summary.

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

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

Companion. This is a person whose presence as a companion or caregiver is necessary to enable an NME patient:

- To receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis or
- To travel to and from the facility where treatment is given.

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

Covered Health Services. Covered health services are those health services, supplies or equipment provided to prevent, diagnose, or treat a sickness, injury, mental illness, substance abuse or symptoms. Covered health services must be provided:

- When the plan is in effect;
- Prior to the date that any of the individual termination conditions, set forth herein, occur; and
- Only when the person who receives services is a covered person and meets all eligibility requirements specified in the plan.

A covered health service must meet all of the following criteria:

- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes and is based on trials that meet the following designs:
  - Well-conducted randomized controlled trials (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.); and
  - Well-conducted cohort studies (Patients who receive study treatments are compared to a group of patients who receive standard therapy. The comparison group must be identical to the study group.).
- It is the most cost-effective method and yields a similar outcome to other available alternatives.
- It is a health service or supply that is described in this document or the accompanying booklets and which is not excluded under any exclusion section.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research based on well-randomized trials and cohort studies, as described.

Convalescent Facility. An institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  - Professional nursing care by an RN or by an LPN directed by a full-time RN; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time RN;
- Is supervised full-time by a doctor or RN;
- Keeps a complete medical record on each patient;
- Has a utilization review plan; and
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care or for the care of mental disorders.

Covered family members or covered person. The retiree and the retiree's legal spouse and/or dependent children, or qualified domestic partner, who are covered under the Plans.

Custodial care. The care (including room and board needed to provide that care) given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of custodial care are help in walking and getting out of bed, assistance in bathing, dressing and feeding or supervision over medication that normally could be self-administered.

Designated transplant facility. A facility designated by the Claims Administrator to render medically necessary covered services and supplies for qualified procedures under a Citi retiree health care plan.

Doctor. 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).

Durable medical and surgical equipment. No more than one item of equipment for the same or simliar purpose (and the accessories needed to operate it) that is:
- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or injury;
- Suited for use in the home;
- Not normally of use to persons who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Not included is equipment such as whirlpools; portable whirpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

Emergency admission: One in which the doctor admits the person to the hospital or treatment facility right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:
- Which requires confinement right away as a full time inpatient and
- For which if immediate inpatient care were not given could, as determined by the plan, reasonably be expected to result in:
  - Placing the person's health in serious jeopardy; or
  - Serious impairment to bodily function; or
  - Serious dysfunction of a body part of organ; or
  - In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency care. Medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain. The symptoms must be severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:
- The patient's health would be placed in serious jeopardy;
- Bodily function would be seriously impaired; and
- There would be serious dysfunction of a body organ or part.

Emergency care includes immediate mental health and chemical dependency treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency condition. A recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and

health, to believe that his/her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

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

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

The Claims Administrator, in their judgment, may deem an experimental, investigational or unproven service covered under a Citi retiree health care plan for treating a life-threatening sickness or condition if it is determined by the Claims Administrator that the experimental, investigational, or unproven service at the time of the determination:

- Is proved 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 a Citi retiree health care plan or the disposition of its assets, renders investment advice to a Citi retiree health care plan, or has discretionary authority or responsibility in the administration of a Citi retiree health care plan.

A fiduciary must carry out his/her duties and responsibilities for providing benefits to the retiree and his/her dependent(s) and defraying reasonable expenses of administering a Citi retiree health care plan. These are duties that must be carried out with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation, in accordance with the Citi retiree health care plan documents to the extent that they agree with ERISA.

A "named fiduciary" is the one named in the Citi retiree health care plan who can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Citi retiree health care plan. These other persons become fiduciaries themselves and are responsible for their acts under the Citi retiree health care plan. To the extent that the named fiduciary allocates its responsibility to

other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary, or continuing either the appointment of the procedures; or
- The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Fully insured plan. A group insurance plan in which an insurer pays all claims and assumes risks for an employer in exchange for payment of a regular premium.

Generic drug. Equivalent medication that contains the same active ingredient and are subject to the same rigid FDA standards for quality, strength and purity as their brand-name equivalents. Generic drugs are less expensive than brand-name drugs.

Home health care agency. An agency or organization that provides a program of home health care and meets one of the following three tests:

- It is approved under Medicare;
- It is established and operated in accordance with the applicable licensing and other laws; or
- It meets all of the following tests:
  - Its primary purpose is to provide a home health care delivery system bringing supportive services to the home;
  - It has a full-time administrator;
  - It maintains written records of services provided to the patient;
  - Its staff includes at least one registered nurse or it has nursing care by a registered nurse available; and
  - Its employees are bonded, and it maintains malpractice insurance.

Hospice. An agency that provides counseling and incidental medical services for a terminally ill individual. Room and board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a hospice;
- It is licensed in accordance with any applicable state laws; or
- It meets the following criteria:
  - It provides 24/7 service;
  - It is under the direct supervision of a duly-qualified doctor;
  - 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 the purposes of the Citi retiree health care plan.

Hospital. An institution engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and fully meets one of the following three tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations;
- It is approved by Medicare as a hospital; or
- It meets all of the following tests:

- It maintains, on the premises, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified doctors;
- It continuously provides, on the premises, 24-hour-a-day nursing service by or under the supervision of registered graduate nurses; and
- It is operated continuously with organized facilities for operative surgery on the premises.

Injury. An accidental physical injury to the body caused by unexpected external means.

Intensive care unit. A separate, clearly designated service area maintained within a hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has facilities for special nursing care not available in regular rooms and wards of the hospital, special life-saving equipment that is immediately available at all times, at least two beds for the accommodation of the critically ill and at least one RN in continuous and constant attendance 24 hours a day.

LPN. A licensed practical nurse.

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 Citi retiree health care plan in reference to benefit maximums and limitations. Lifetime is understood to mean the period of time in which you and your eligible dependent are covered under the Citi retiree health plan. Under no circumstances does lifetime mean during the lifetime of the covered person.

Maximum allowed amount. Any charge that, for services rendered by or on behalf of a network doctor, does not exceed the amount determined by the Claims Administrator in accordance with the applicable fee schedule. As to charges covered in part by Medicare, an amount that meets the maximum allowed amount as established by Medicare.

Medically necessary or medical necessity. Health care services and supplies 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 government agencies that are accepted by the Claims Administrator;
- Consistent with the diagnosis of the condition;
- Required for reasons other than the convenience of the covered person or his/her doctor;
- Must be provided by a doctor, hospital or other covered provider under the Citi retiree health care plan;
- With regard to a person who is an inpatient, the patient's illness or injury requires that the service or supply cannot be safely provided to that person on an outpatient basis;
- It must not be primarily scholastic, vocational training, educational or developmental in nature or experimental or investigational;
- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy:

- For treating a life-threatening sickness or condition;
- In a clinically controlled research setting; and
- Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

The fact that a doctor has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, mental illness or pregnancy does not mean that it is medically necessary as defined above. The definition of medically necessary used in this document relates only to coverage and differs from the way in which a doctorengaged in the practice of medicine may define medically necessary. The Plans Administration Committee has delegated the discretionary authority to determine medical necessity under the Citi retiree health care plans to the appropriate Claims Administrators.

Medicare. The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act.

Mental health and chemical dependency treatment. Treatment for both of the following:
- Any sickness identified in the current edition of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM), including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause; and
- Any sickness for which the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

All inpatient services, including room and board, given by a mental health facility or area of a hospital that provides mental health or substance abuse treatment for a sickness identified in the DSM, are considered mental health and chemical dependency treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the sickness that is identified in the DSM is considered mental health and chemical dependency treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered mental health and chemical dependency treatment.

Prescription drugs are not considered mental health and chemical dependency treatment.

Morbid obesity. A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent body mass index (BMI) tables for a person of the same height, age and mobility as the covered person.

Network pharmacy. Registered and licensed pharmacies, including mail-order pharmacies, that participate in the network.

Network provider. A provider that participates in a Citi retiree health care plan network or one of the HMOs.

National Medical Excellence Patient. This is a person who:
- Requires any of the National Medical Excellence procedure and treatment types for which the charges are a covered medical expense; and
- Contacts the Claims Administrator and is approved by the Claims Administrator as an National Medical Excellence Patient; and
- Agrees to have the procedure or treatment performed in a hospital designated by the Claims Administrator as the most appropriate facility.

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 to be non-occupational regardless of 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.

Non-preferred brand-name drug. A brand-name drug that is not a formulary drug. See the definition of preferred brand-name drug.

Non-urgent admission. One which is not an emergency admission or an urgent admission.

Nurse-midwife. A person licensed or certified to practice as a nurse-midwife and who fulfills both of these requirements:
- A person licensed by a board of nursing as an RN; and
- A person who 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:
- A person licensed by a board of nursing as an RN; and
- A person who 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 doctor 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 a Citi retiree health care plan network or an HMO.

Out-of-network pharmacy. A pharmacy other than a health plan network pharmacy.

Out-of-network provider. A provider that does not participate in a health plan network or an HMO.

Outpatient care. Treatment including services, supplies and medicine provided and used at a hospital under the direction of a doctor to a person not admitted as a registered bed patient or services rendered in a doctor's office, laboratory, or X-ray facility, an ambulatory surgical center or the patient's home.

Physical therapy. Services designed to restore an individual to a level of function present prior to an illness or accidental injury.

Plan Administrator. The Plans Administration Committee of Citigroup Inc.

Plan Sponsor. Citigroup Inc.

Plan year. The calendar year beginning on either the effective date of the plan or on the day following the end of the first plan year, which is a short plan year.

Preadmission tests. Tests performed on a covered person in a hospital before confinement as a resident inpatient provided they meet all of the following requirements:

- The tests are related to the performance of scheduled surgery;
- The tests have been ordered by a doctor after a condition requiring surgery has been diagnosed and hospital admission for surgery has been requested by the doctor 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 prescribed from a list of medications preferred for its clinical effectiveness and opportunity to help contain health care costs. Preferred drugs are part of an incentive program to help control the costs of care and are frequently called formulary drugs.

Prescription drugs. Any drugs that cannot be dispensed without a doctor's prescription. The following will be considered prescription drugs:

- Federal legend drugs, 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 doctor 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 as the coordinator of member care. The PCP is not an agent or employee of the Claims Administrator or employer.

Psychiatrist. A doctor who specializes in mental, emotional or behavioral disorders.

Psychologist. A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist; or
- A member or fellow of the American Psychological Association, if there is no government licensure or certification required.

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

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

Rehabilitation facility. A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

Retirement/retirement date. Under the terms of the Citigroup Retiree Health Plans, employees eligible for coverage under the retiree health plans are considered to have retired if they terminate employment with the company and at the time of termination have attained a minimum of age 50 with at least five years of service and age plus years of service equal at least 60. The date of termination of employment is considered the date of retirement from Citi, and the first of the month following termination of employment is considered the first day of retirement with regard to eligibility for retiree health benefits.

Room and board/semi-private rate. Room, board, general-duty nursing, intensive nursing care by whatever name called and any other services regularly furnished by the hospital as a condition of occupancy of the class of accommodations occupied but not including professional services of doctors or special nursing services rendered outside an intensive care unit by whatever name called.

RN. A registered nurse.

Self-insured or self-funded plan. A plan in which no insurance company or service plan collects premiums and assumes risk. Citi assumes the risk for all claims and pays them from its general assets. Citi has contracted with the Claims Administrators through an administrative-services-only contract for the Claims Administrators to provide all administration including claims processing associated with the Citi retiree health care plans.

Sickness. Bodily disorder or disease. The term “sickness” used in connection with newborn children will include congenital defects and birth abnormalities, including premature births.

Skilled nursing facility. A facility, if approved by Medicare as a skilled nursing facility, is covered by the Citi retiree health care plans. If not approved by Medicare, the facility may be covered if it meets the following tests:

- It is operated under the applicable licensing and other laws;
- It is under the supervision of a licensed doctor or registered nurse who is devoting full time to supervision;
- It is regularly engaged in providing room and board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient’s expense during the convalescent stage of an injury or sickness;
- It maintains a daily medical record of each patient who is under the care of a licensed doctor;
- It is authorized to administer medication to patients on the order of a licensed doctor; and
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics, drug addicts or the mentally ill.

A skilled nursing facility that is part of a hospital will be considered a skilled nursing facility for the purposes of the Citi retiree health care plans.

Terminally ill. This is a medical prognosis of six months or less to live.

Treatment center/facility. A facility that provides a program of effective mental health and chemical dependency treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law;
- It provides a program of treatment approved by a doctor and the Claims Administrator;
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient;
- It provides at least the following basic services:
  - Room and board (if this plan provides inpatient benefits at a treatment center);
  - Evaluation and diagnosis;
  - Counseling by a licensed provider; and
  - Referral and orientation to specialized community resources.

Treatment centers that qualify as a hospital are covered as a hospital and not as a treatment center.

Urgent admission. One in which the physician admits the person to the hospital due to:

- The onset of or change in a disease; or
- The diagnosis of a disease; or
- An injury caused by an accident which, 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 became apparent.

Utilization review. A review and determination as to the medical necessity of services and supplies.