



2012 Annual Benefits Enrollment



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ENROLL IN 3 EASY STEPS

You will enroll for your benefits online. Online enrollment is simple, accurate and eliminates the need to submit paper forms. There are steps you will need to complete before and after you enroll online to make sure you get the coverage you want.

1. REVIEW YOUR ENROLLMENT WORKSHEET

Your enrollment worksheet lists your benefit options, your costs, your dependents and other information, such as your Personalized Identification Number (PIN). Be sure to review the worksheet and confirm that the information is accurate. You will have the opportunity to update your beneficiary information when you enroll online. Use this worksheet to note the elections you want to make, and have it handy when you login to enroll.

2. ENROLL ONLINE

When you are ready to enroll, visit the enrollment website at www.citizensbanking.com/staff or go to CNet (intranet Homepage) > HR4U Portal > Benefits Welcome > Benefits Enrollment site (under recommended links). During annual enrollment, the website will be available 24 hours a day, seven days a week from anywhere you have Internet access. Elections entered as of 11:59 p.m., Eastern Time, on the last day of the enrollment period will be considered your benefit choices for 2012. After you enter your elections, you must click on the Finish button to submit your elections. If you do not click Finish, your elections will not be saved.

If you are a new hire, you will receive your benefits enrollment information via email that includes the login information and PIN for the online enrollment system, as well as the date by which you must enroll.

3. SAVE A CONFIRMATION STATEMENT

Once your elections have been submitted online, save a confirmation statement for your records. **This is the only confirmation statement you will receive.** Your elections are final and no changes will be permitted after the enrollment deadline unless you have a qualifying status change (see **QUALIFIED STATUS CHANGES** section for details).

Everyone must enroll for benefits. If you don't make elections during the enrollment period, you will not have healthcare benefits (Medical/Rx, Dental, and Vision) in 2012. **You will only receive default coverage as listed below.**

PLEASE NOTE: Your 2011 elections will not carry over to 2012 with the exception of your dental election which is a two year election.

WHAT HAPPENS IF YOU DON'T ENROLL (DEFAULT COVERAGE)

FULL-TIME STAFF MEMBERS

- **Medical:** No coverage
- **Dental:** Same as 2011
- **Vision:** No coverage
- **Short Term Disability (STD):** 60% of pay
- **Long Term Disability (LTD):** 50% of pay
- **Life Insurance:** Same as 2011
- **Dependent Life Insurance:** Same as 2011
- **Accidental Death & Dismemberment (AD&D) Insurance:** Same as 2011
- **Paid Time Off (PTO):** Paid Time Off
- **Purchased Paid Time Off:** None
- **Reimbursement Accounts:** None

PART-TIME STAFF MEMBERS

- **Medical:** No coverage
- **Dental:** Same as 2011
- **Vision:** No coverage
- **Voluntary Short Term Disability:** Same as 2011
- **Life Insurance:** Same as 2011
- **Dependent Life Insurance:** Same as 2011
- **Accidental Death & Dismemberment (AD&D) Insurance:** Same as 2011
- **Paid Time Off (PTO):** Paid Time Off
- **Reimbursement Accounts:** None



A GLANCE AT YOUR 2012 BENEFITS

Here is an overview of the benefit options available for 2012.

BENEFIT	FULL-TIME STAFF MEMBERS	COMMISSIONED STAFF MEMBERS	PART-TIME STAFF MEMBERS
Medical	✓	✓	✓
Dental	✓	✓	✓
Vision	✓	✓	✓
Short-Term Disability (STD)	✓	✓	✓
Long-Term Disability (LTD)	✓	✓	
Employee Life Insurance	✓	✓	✓
Dependent Life Insurance	✓	✓	✓
Accidental Death and Dismemberment (AD&D) Insurance	✓	✓	✓
Healthcare Savings Account (HSA)	✓	✓	✓
Reimbursement Account: Health Care Reimbursement Account Dependent Care Reimbursement Account Commuter Benefit Account	✓	✓	✓
Paid Time Off (PTO)	✓		✓
Voluntary Group Legal Plan	✓	✓	✓

A Summary Plan Description (SPD) for each of the plans is accessible on the [HR4U Portal](#) under the applicable benefit section (medical, dental, etc.).



You are eligible to enroll for benefits on the first of the month following 30 days from your date of hire. Full-time staff members must average a minimum of 36 hours per week and part-time staff members must average a minimum of 20 hours per week.

Your spouse or same-gender domestic partner is not required to take other medical coverage. However, if other medical coverage is available, you should compare your choices and cover your dependents under the most appropriate plan.

COVERAGE FOR YOUR DEPENDENTS

You can elect coverage for yourself and your eligible dependents. You can choose from the following levels of coverage: employee only, employee plus spouse, employee plus child or children, or family (employee plus spouse and child or children). For medical, dental and vision programs, your eligible dependents are:

- Your legal spouse or same-gender domestic partner. A “same-gender domestic partner” is defined as an unmarried partner of the same-gender with whom you have a spouse-like relationship, who is at least 18 year of age or older, with whom you share a residence or own a home, and with whom you are interdependent financially. You cannot be related by blood, and you must be able to certify your domestic partner relationship.
- An eligible dependent child of you, your spouse, or your same-gender domestic partner up to the end of the month in which they turn 26 years old - or of any age if they are mentally or physically disabled.
- An eligible dependent child includes:
 - ▶ A biological or legally adopted child,
 - ▶ A child who is placed with you for adoption,
 - ▶ A stepchild,
 - ▶ A child for who you or your spouse/same-gender domestic partner are legal guardians, or
 - ▶ A child that you are required to cover pursuant to a qualified medical child support order.

For the Dependent Life Program, your eligible dependents are:

- Your legal spouse or same-gender domestic partner. A “same-gender domestic partner” is defined as an unmarried partner of the same-gender with whom you have a spouse-like relationship, who is at least 18 year of age or older, with whom you share a residence or own a home, and with whom you are interdependent financially. You cannot be related by blood, and you must be able to certify your domestic partner relationship.
- An eligible dependent child of you, your spouse, or your same-gender domestic partner up to the end of the month in which they turn 26 years old - or of any age if they are mentally or physically disabled.
- An eligible dependent child includes:
 - ▶ A biological or legally adopted child,
 - ▶ A child who is placed with you for adoption,
 - ▶ A stepchild,
 - ▶ A child for who you or your spouse/same-gender domestic partner are legal guardians, or
 - ▶ A child that you are required to cover pursuant to a qualified medical child support order.
- The dependent child must wholly depend on you for support and maintenance.
- The dependent child cannot be married.

COMMISSIONED STAFF

Commissioned staff will be provided with the same benefits as full-time staff with the following differences.

- Life insurance with base annual wages defined as the greater of your 2010 W-2* earnings or \$50,000
- LTD/STD benefits with wages defined as \$50,000
- No paid time off

If you and your spouse or your same-gender domestic partner are both employed by Citizens Bank, you cannot duplicate coverage. Additionally, you cannot elect Spouse Life Insurance coverage.

*W-2 earnings used exclude nonqualified moving expense, nontaxable stock options, reward and recognition, special bonus for sign on or retention, stock option earnings, tuition reimbursement and/or the taxable portion of group life insurance.



PAYING FOR COVERAGE

The following table outlines how both you and the Bank contribute to the cost of your benefits.

BENEFIT	FULL-TIME STAFF MEMBERS	PART-TIME STAFF MEMBERS
Bank-Paid	Life insurance: 1 times pay AD&D Insurance: 1 times pay Short-Term Disability: 60% of pay Long-Term Disability: 50% of pay Paid Time Off (PTO)* Employee Assistance Program (EAP)	Life Insurance: 1 times pay AD&D Insurance: 1 times pay Paid Time Off (PTO) Employee Assistance Program (EAP)
Bank and Employee Share Cost	Medical Dental	Medical Dental
Employee-Paid	Vision Optional Life Insurance Optional AD&D Insurance Optional Long-Term Disability Dependent Life Insurance Reimbursement Accounts Group Legal Plan Purchased Paid Time Off (PTO)*	Vision Optional Life Insurance Optional AD&D Insurance Dependent Life Insurance Voluntary Short-Term Disability Reimbursement Accounts Group Legal Plan

*Commissioned staff do not qualify for this benefit.

For more details about your benefit options and other limitations, see the related sections in this enrollment guide. The per-pay period contributions for each option and coverage level are shown on your enrollment worksheet.

MEDICAL PLAN PREFERRED RATES

CURRENT STAFF MEMBERS

To build on our efforts to assist all of our staff members in improving their health, the Bank offers you an opportunity to reduce your medical plan contributions.

To receive Preferred Rates for 2013, you and your spouse or same-gender domestic partner must both complete the following items by September 20, 2012:

- Complete the HealthQuest Profile AND
- Visit your primary medical provider to complete a Care Plan form.

The HealthQuest Profile (HQP) is an annual online self-assessment of your health.

The Care Plan form is completed by your primary medical provider during a scheduled office visit. The form is intended to assist in setting goals for maintaining or achieving a healthy lifestyle. For example, you and your primary medical provider may establish a Care Plan for lowering your blood pressure. This may include lifestyle changes and/or the addition of a blood pressure-lowering medication.

NEW STAFF MEMBERS

If you are a new hire, you and your spouse or same-gender domestic partner will have 30 days following your benefit effective date to enroll in the **CBFit4Life** Wellness Program and complete the HealthQuest Profile (HQP). If you and your spouse or same-gender domestic partner meet this requirement, you will receive Preferred Rates on the first paycheck of the second month following your benefits effective date. If you and your spouse or same-gender domestic partner do not complete the HQP in the required timeframe, you must wait until next year to change your status, and you will not receive Preferred Rates for this year.

In order to receive Preferred Rates for 2013, you and your spouse or same-gender domestic partner must both complete the following items by September 20, 2012:

- Complete the HealthQuest Profile AND
- Visit your primary medical provider to complete a Care Plan form.



QUALIFIED STATUS CHANGES

If you experience a qualified status change during the year which permits you to enroll in our plan, you will have an opportunity to complete the program requirements in 2012 to receive Preferred Rates in 2013.

TOBACCO USE SURCHARGE

Tobacco use is the most preventable cause of chronic disease in this country. That's why the Bank charges an additional surcharge on medical plan contributions if you use tobacco products. To avoid the surcharge, you must certify that you and your spouse or same-gender domestic partner have not used tobacco products for the last six months.

If it is medically inadvisable or unreasonably difficult due to a health factor for you and your spouse or same-gender domestic partner to meet the program's requirements, the Bank provides a reasonable alternative standard for you and your spouse or same-gender domestic partner can avoid the surcharge. You and your spouse or same-gender domestic partner can still avoid the surcharge by providing proof of

TAX ADVANTAGES WHEN YOU PAY WITH BEFORE-TAX MONEY

In many cases, you can use before-tax dollars to pay for your benefits. This means the amount is deducted from your paycheck before Federal, Social Security, Medicare, State and Local taxes are calculated. The W-2 statement of wages form that you'll get at the end of the year will show the amount that's been excluded from your gross income.

NOTE: According to IRS regulations, if you elect coverage for a same-gender domestic partner, the value of the health benefits is taxable to you and subject to withholding.

2012 MEDICAL PLAN OPT OUTS

If you completed a HQP in 2012, you will have 90 days after enrollment in the medical plan on January 1, 2013 to visit your primary provider and complete a Care Plan form to qualify for Preferred Rates.

Once the Bank is notified by HealthPlus that you have completed the HQP and Care Plan you will receive Preferred Rates on the first paycheck that is administratively feasible.

enrollment in a recognized tobacco cessation program within 30 days of the end of your enrollment period.

Examples of recognized programs include:

- HealthQuest Tobacco Cessation Program – learn more at www.quitnet.com/healthplus
- American Cancer Society Quitline – learn more at www.cancer.org
- American Lung Association Freedom from Smoking® – learn more at www.lungusa.org

If you, your spouse or same-gender domestic partner use tobacco products and do not enroll in a tobacco cessation program, you must wait until next year to change your status, and you will be required to pay the surcharge for this year.



QUALIFIED STATUS CHANGES

In most cases, you cannot change your benefit elections during the plan year. However, if you experience one of the following qualified status changes, you may be permitted to change certain benefit elections:

- **Legal marital status:** events that change your legal marital status, including marriage, death of a spouse, divorce, or legal separation.
- **Number of dependents:** events that change the number of dependents in your family, including birth, adoption, placement for adoption, or death.
- **Employment status:** either you, your spouse, or dependent child starts or stops working.
- **Work schedule:** working hours for you, your spouse, or your dependent child are reduced or increased. A change in work schedule includes a switch between part-time and full-time employment or an unpaid leave of absence.
- **A dependent either satisfies or ceases to meet eligibility requirements** for dependents (end of the month of attainment of age 26).
- **A same-gender domestic partner either satisfies or ceases to meet the eligibility requirements** for same-gender domestic partners.
- **Change in your spouse's medical coverage:** a significant change in medical benefits and/or contribution requirements resulting from your spouse's employment. The event is defined as the effective date of the attainment or loss of coverage.

Qualified status changes must be approved by Human Resources. In general, changes are not permitted unless the change event affects your eligibility or a dependent's eligibility for benefits. Also, benefit changes must be directly related to the qualified status change. For example:

- If you get married, you can add your spouse to your coverage, as well as change your option.
- If your spouse loses his or her eligibility for health plan coverage, either through job loss or a reduction in hours, you can add him or her to your health plan.
- If you opted out of the Bank's medical coverage because you were covered under your spouse's plan, and your spouse then loses coverage for you due to job loss or reduction in hours, you can both enroll in the Bank's medical plan.

Remember, the elections you make now will **remain in effect until December 31, 2012**, unless you have a qualified status change. If you provide notice of your qualified status change within 30 days of the event, your election change will be retroactive to the date of the event. If you fail to notify Human Resources in a timely manner, you will need to wait until the following annual enrollment period to change your coverage.

You must report any qualified status change (with appropriate documentation) to Human Resources within 30 days of the event in order to make a change to your current plan year elections.



Medical coverage gives you financial protection against the high cost of treating a serious illness or medical condition. Each of your options also provides coverage for preventive services including annual physicals and well-child care. Please read the general plan information in this guide, including the Medical Comparison Chart, to aid you in selecting the best medical options for you and your eligible dependents.

All of your medical options are Preferred Provider Organizations (PPOs), which do not require you to use a Primary Care Physician (PCP). HealthPlus is the medical insurer for all of our medical options. Under PPOs, participating doctors and hospitals agree to accept negotiated fees as payment in full, so you won't be billed for charges that exceed the negotiated amount. Additionally, when you receive covered services from a participating provider, you save money because your share of the cost is based on the negotiated fee and the coinsurance is paid at a higher rate.

The HealthPlus network (and their partner networks) provide extensive coverage across the country. You can receive care from any provider in the following networks:

- **Michigan** – HealthPlus and Cofinity (formerly PPOM)
- **Illinois** – Health's Finest Network (HFN)
- **Ohio** – Emerald Health Network
- **Wisconsin and UP Michigan** – HealthEOS
- **All other states** – First Health Network

You can freely use any of the doctors in the network or outside of the network without referrals. You will receive a higher level of coverage when you obtain services from network providers. If you chose to receive services from a non-network provider, your benefits will be paid at the non-network level. When scheduling services with a network provider, be sure to state the network affiliation (HealthPlus, Cofinity, HFN, Emerald Health Network, HealthEOS, or First Health Network).

PPO OPTIONS

There are four PPO options available to you. Here is a summary of your medical plan options:

- The **Comprehensive Plan** has the highest per paycheck contribution but gives you the highest level of coinsurance and the lowest deductibles and copayments.
- The **Standard Plan** offers a balanced option with a moderate per paycheck contribution and a moderate level of coinsurance than the Comprehensive Plan but higher potential out-of-pocket costs throughout the year.
- The **Basic Plan** has a lower per paycheck contribution but higher out-of-pocket cost, which means you will pay more for care if you need it during the year. The Basic Plan also covers prescription drugs differently than the Comprehensive or Standard Plans – with a separate annual deductible for prescription drugs.
- The **Select^{+HSA} Plan** has the lowest per paycheck contribution but the highest out-of-pocket cost. This plan qualifies as a High Deductible Health Plan (HDHP). You may use this plan in conjunction with a Health Savings Account (HSA). **IMPORTANT!** You must satisfy the deductible before any medical or prescription drug benefits are paid. Some medications classified as preventive will be covered **before** your deductible. A list of the medications in this category can be found on the HealthPlus website at www.healthplus.org/citizens.aspx. If you cover someone in addition to yourself, you must meet the entire family deductible before benefits are paid.

You also have access to the **WebMD Coverage Advisor**, an online tool that can help you select the right medical plan by estimating your per paycheck cost and your total out-of-pocket expenses (deductible, coinsurance, and copays) under the four medical plan options. WebMD Coverage Advisor is available on the HealthPlus website at www.healthplus.org/citizens.aspx.



MEDICAL BENEFIT CHOICE (CONTINUED)

PRESCRIPTION DRUG BENEFITS

Prescription drug coverage is provided through HealthPlus with each medical plan option. Each option features a four-tier drug formulary structure:

- Generic
- Preferred Brand
- Non-Preferred Brand
- Specialty

You save the most when you choose generic drugs.

The prescription drug benefit has a “Mandatory Generic” provision. This means if there is a generic alternative available for the medication prescribed, HealthPlus will cover the cost of the generic. If you elect to receive the brand, when a generic alternative is available, you will be responsible for the difference in cost between the generic and brand, in addition to the generic copay.

If a generic is not available, you can choose a brand name drug from the formulary. Drugs on the formulary have been selected for their effectiveness, availability and cost. Brand-name drugs fall into two categories – preferred and non-preferred. You can select a medication in either category, but you pay a higher copayment if you choose a non-preferred brand.

Specialty medications are those that require special handling, administration, or monitoring, or those used to treat complex, chronic and often costly conditions. Some examples of complex conditions requiring specialty medications are:

- multiple sclerosis
- rheumatoid arthritis

If you or one of your dependents is prescribed a specialty medication, contact HealthPlus. HealthPlus will assist you or your dependents in obtaining this medication.

Some medications require prior authorization and/or step therapy and certain clinical criteria must be met before coverage is provided.

PHARMACY NETWORK

You may fill your prescriptions at any of the many in-plan network pharmacies, such as Wal-Mart, Target or CVS. If you fill your prescription at a non-network pharmacy, you are responsible for the difference between the amount the pharmacy charges and the amount HealthPlus would have paid an in-network pharmacy. This could result in significant out-of-pocket costs. Please use a network pharmacy whenever possible.

You can locate a pharmacy by contacting HealthPlus or visiting www.healthplus.org.

When filling a 90-day prescription, HealthPlus offers you two options at the same copay:

1. Retail Pharmacy - Most medications are available through this program. Please note: If your doctor is prescribing a medication for the first time, you will need to fill a 30-day prescription first to ensure that the drug and dose are right for you.
2. Mail Order - Most maintenance medications are available through the mail order program with HealthPlus' mail order vendor, Express Scripts.

REMEMBER! If you take a maintenance medication (those taken regularly over an extended period of time), you are permitted one 30-day fill at a retail pharmacy. Any future refills will need to be filled using one of the 90-day options.

For additional information on either of these programs, visit CBNet (intranet Homepage) > **HR4U Portal** >Benefits >2012 Benefits Information.

ID CARDS

You will receive **one card** for both medical and prescription drug benefits.

HEALTH SAVINGS ACCOUNT (HSA)



If you choose to enroll in the **Select^{HSA} Plan**, you are eligible to open a Health Savings Account (HSA). If you choose to open an HSA, your HSA will be serviced by HSA Bank.

An HSA is an interest bearing, tax-free account that is owned by you and can be taken with you if you leave the Bank. It allows you to save money through pre-tax payroll deductions to help you pay for your out-of-pocket medical expenses, such as the deductible and coinsurance. The money you accumulate in your HSA rolls over from year to year, and you have the opportunity to direct investment options. The HSA offers a way to begin saving for current and future medical expenses on a tax-free basis.

If you are eligible to contribute to an HSA, the IRS allows you to set aside up to \$3,100 (if you are enrolled in employee only medical coverage) or \$6,250 (if you are enrolled in employee plus spouse, employee plus child (or children) or family medical coverage).

For more information about HSAs or HSA Bank visit the HR4U Portal.

IMPORTANT! It is your responsibility to maintain your eligibility to contribute to an HSA, as well as monitor the eligibility of your HSA withdrawals. Please contact a tax professional for advice.



MEDICAL OPTIONS COMPARISON CHART

The following chart compares coverage under the four medical plan options.

PLAN FEATURE	COMPREHENSIVE PLAN		STANDARD PLAN		BASIC PLAN		SELECT ^{+HSA} PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE (includes well-baby and routine physicals)	100%	35% after deductible	100%	40% after deductible	100%	50% after deductible	100%	50% after deductible
DEDUCTIBLE								
Single	\$500	\$1,000	\$850	\$1,700	\$1,500	\$3,000	\$1,500	\$3,000
Family	\$1,000	\$2,000	\$1,700	\$3,400	\$3,000	\$6,000	\$3,000	\$6,000
DEDUCTIBLE APPLIES TO COINSURANCE	Medical Only		Medical Only		Medical Only		Medical & Prescription Drugs	
Plan Pays	85%	65%	80%	60%	80%	50%	80% after deductible	50% after deductible
You Pay	15%	35%	20%	40%	20%	50%	20% after deductible	50% after deductible
ANNUAL OUT-OF-POCKET MAXIMUM (includes deductible)								
Single	\$2,300	\$4,600	\$3,100	\$6,200	\$5,000	\$6,500	\$5,000	\$9,500
Family	\$4,600	\$9,200	\$6,200	\$12,400	\$10,000	\$13,000	\$10,000	\$19,000
OFFICE VISITS (illness/injury)	\$20 copay (\$30 copay for specialist)	35% after deductible	\$25 copay (\$35 copay for specialist)	40% after deductible	\$40 copay	50% after deductible	\$40 copay after deductible	50% after deductible
EMERGENCY ROOM SERVICES	\$100 copay	\$100 copay	\$100 copay	\$100 copay	\$150 copay	\$150 copay	20% after deductible	20% after deductible
URGENT CARE SERVICES	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$75 copay	\$75 copay	20% after deductible	20% after deductible
PRESCRIPTION DRUG DEDUCTIBLE	N/A		N/A		\$250/person per year		Must meet combined medical & prescription drug deductible (see above)	
RETAIL PRESCRIPTION DRUGS (30 day supply)								
Generic	20% coinsurance with \$5 min/\$100 max		20% coinsurance with \$5 min/\$100 max		\$10 copay after deductible		\$10 copay after deductible	
Preferred Brand	25% coinsurance with \$30 min/\$100 max		25% coinsurance with \$30 min/\$100 max		\$30 copay after deductible		\$30 copay after deductible	
Non-Preferred Brand	30% coinsurance with \$50 min/\$150 max		30% coinsurance with \$50 min/\$150 max		\$60 copay after deductible		\$60 copay after deductible	
MAIL ORDER PRESCRIPTION DRUGS (90 day supply)								
Generic	\$15 copay		\$15 copay		\$30 copay after deductible		\$30 copay after deductible	
Preferred Brand	\$90 copay		\$90 copay		\$90 copay after deductible		\$90 copay after deductible	
Non-Preferred Brand	\$150 copay		\$150 copay		\$180 copay after deductible		\$180 copay after deductible	
SPECIALTY PRESCRIPTION DRUGS (30 day supply)	40% coinsurance with \$100 min/\$300 max		40% coinsurance with \$100 min/\$300 max		40% coinsurance with \$100 min/\$300 max after deductible		\$60 copay after deductible	
LAB & PATHOLOGY TESTS	100%	35% after deductible	100%	40% after deductible	100%	50% after deductible	20% after deductible	50% after deductible
DIAGNOSTIC & THERAPEUTIC RADIOLOGICAL SERVICES	15% after deductible	35% after deductible	20% after deductible	40% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible

MEDICAL COMPARISON CHART (CONTINUED)



PLAN FEATURE	COMPREHENSIVE PLAN		STANDARD PLAN		BASIC PLAN		SELECT ^{+HSA} PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
MEDICAL EQUIPMENT AND SUPPLIES	15% after deductible	Not covered (except breast prosthesis after mastectomy)	20% after deductible	Not covered (except breast prosthesis after mastectomy)	20% after deductible	Not covered (except breast prosthesis after mastectomy)	20% after deductible	Not covered (except breast prosthesis after mastectomy)
ALLERGY TESTING	15% after deductible	35% after deductible	20% after deductible	40% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
MATERNITY								
Delivery	15% after deductible	35% after deductible	20% after deductible	40% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Pre/Post Natal Visits	Office copay applies at first visit	35% after deductible	Office copay applies at first visit	40% after deductible	Office copay applies at first visit	50% after deductible	20% after deductible	50% after deductible
MENTAL HEALTH / SUBSTANCE ABUSE TREATMENT								
Inpatient	15% after deductible	35% after deductible	20% after deductible	40% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	15% deductible does not apply)	35% (deductible does not apply)	20% deductible does not apply)	40% (deductible does not apply)	20% deductible does not apply)	50% (deductible does not apply)	20% after deductible	50% after deductible
HOME HEALTH CARE	15% after deductible	35% after deductible	20% after deductible	40% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
CHIROPRACTIC CARE	\$20 copay	\$20 copay	\$25 copay	\$25 copay	\$40 copay	\$40 copay	20% after deductible	50% after deductible
	Limited to 30 visits per year						Limited to 38 visits per year	
HOSPITALIZATION SERVICES	15% after deductible	35% after deductible	20% after deductible	40% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible

THINGS TO THINK ABOUT

Some issues to consider when choosing medical coverage:

- **Is your spouse or same-gender domestic partner eligible for medical coverage through his or her employer?** If your spouse or same-gender domestic partner has other medical coverage available, you should compare all your medical plan choices and make sure you choose to cover your dependents under the plan that offers the most appropriate level of coverage for them.
- **What kind of medical expenses do you expect for the coming year?** Reviewing your past medical expenses may help you anticipate expenses for the coming year. Try to balance the cost of coverage against the potential out-of-pocket expenses you could incur if you or a family member needs treatment. Remember - you also have access to the WebMD Coverage Advisor, an online tool that can help you select the right medical plan by estimating your per paycheck cost and your total out-of-pocket expenses under the four medical plan options. **WebMD Coverage Advisor** is available on the HealthPlus website at www.healthplus.org/citizens.aspx.
- **How does your medical choice fit with your other benefits elections?** Each time you make a benefit election, you are shaping your overall benefit package. And, keep in mind that you can pay for some medical expenses through your Health Care Reimbursement Account, as described in the **REIMBURSEMENT ACCOUNT CHOICES** section of this Guide. This may affect your choice of medical coverage.



DENTAL BENEFIT CHOICES

Dental coverage helps with the cost of routine dental care and major services for you and your family. The Bank offers you the opportunity to enroll in one of two dental benefit options: Level I and Level II. Both options provide coverage for most dental services. The Level II option has a higher annual benefit maximum, as well as richer coverage for major and orthodontic services. However, your per paycheck contribution will be higher if you enroll in the Level II option. Also, the Level II plan is an active PPO. This means your dollars go farther when you seek services from a PPO dentist.

REMEMBER! If you chose to enroll in one of our dental plans for 2011, the election you made was for two years. You must remain enrolled in your elected dental plan for 2012. You may not change plans or drop coverage until 2013.

With **Delta Dental of Michigan** you have the freedom to visit any dentist for services; however, Delta Dental offers you an opportunity to save money by using participating providers. If you select a dentist that participates with Delta Dental, that dentist has agreed to accept Delta's approved amount for services. If, on the other hand, you visit a nonparticipating provider, you may be balance billed for amounts exceeding the amount approved by Delta.

The level of participation is broken down into three categories:

DELTA PPO – If you visit a Delta PPO provider, you will receive the highest level of benefits and the deepest discounts. By seeking services at a Delta PPO provider, your out-of-pocket costs will be the lowest possible and your benefit maximum will go farther. Delta PPO providers have signed contracts with Delta Dental to provide services at a discounted, negotiated rate.

DELTA PREMIER – The Delta Premier network is a very large network of dentists. If you visit a Delta Premier provider, your out-of-pocket amount will still be reduced. Delta Premier dentists have signed contracts with Delta Dental to provide services at negotiated rates.

NONPARTICIPATING – If you choose to visit a dentist that does not participate with Delta Dental, you still have the same level of coverage; however, since these dentists have not signed contracts with Delta, you may be balance billed up to the full amount of charges.

You can locate a dentist by contacting Delta Dental at the telephone number or website listed in the Who To Contact section of this guide.

Delta Dental will not issue an ID card to you. Simply inform your dental care provider that you are a Citizens Bank staff member under the Delta Dental Plan of Michigan (regardless of the state that you receive services) and they will be able to access plan information online or by phone. If you would like an ID card, you can print one from Delta Dental's website.

THINGS TO THINK ABOUT

Some issues to consider when choosing dental coverage:

- **What are your expected dental expenses for the coming year?** Consider using the dental plan and the Health Care Reimbursement Account to help pay for high-cost dental services or amounts that exceed the lifetime orthodontia maximum.
- **Do you need coverage for your entire family?** You may select from four coverage levels – employee only, employee plus spouse, employee plus child (or children) or family. So, if your family members have dental coverage from another source, you may want to elect coverage for yourself only.
- **Are you planning to have basic or major services performed?** Consider using a Delta PPO provider if you need costly dental procedures done. Your dollar will be stretched the farthest by taking advantage of the PPO's deep discounts and getting the highest level of coverage.
- **Are you planning to enroll in a dental plan?** Remember, you are making a two-year dental election, so choose wisely.

DENTAL OPTIONS COMPARISON CHART



PLAN FEATURE	LEVEL I	LEVEL II	
ANNUAL DEDUCTIBLE			
Single	\$50	\$50	
Family	\$150	\$150	
BENEFIT MAXIMUMS			
Dental Services	\$1,000/person per year	\$1,500/person per year	
Orthodontia	\$1,500/person lifetime	\$1,500/person lifetime	
DIAGNOSTIC AND PREVENTIVE SERVICES* (Exams and cleanings)	100% Not subject to deductible	100% Not subject to deductible	
BASIC SERVICES* (Fillings, extractions, endodontics, x-rays)	80% after deductible	80% after deductible	
MAJOR SERVICES* (Bridgework and dentures)	50% after deductible	PPO 80% after deductible	Premier or non-participating 70% after deductible
ORTHODONTIC SERVICES* (Coverage for dependents only to age 19)	50% (no deductible)	60% (no deductible)	

*Based on the usual, customary, and reasonable cost of the service as determined by your plan. This is the "allowable amount".



VISION BENEFITS CHOICES

Vision coverage helps with the cost of annual eye exams and materials such as eye glass frames or contacts. You may choose from two vision coverage options available through **Vision Service Plan (VSP)**. Both options offer similar services, but Level II provides you with a higher level of coverage. Both options also give you access to VSP's network of eye care doctors (network providers).

Each time you need vision care, you decide whether to use a network provider or a non-network provider. You save money if you go through the VSP network for your services and supplies. Check with your regular eyecare provider to see if s/he is part of the VSP network. You can also locate a VSP provider by contacting VSP at the telephone number or website listed in the Who To Contact section of this guide.

If you search for a vision provider on the VSP website without logging in, you must select the VSP Signature network from the list in order to view doctors that participate in our vision plan. If your provider is not on the list and you want to continue using that provider, the plan will pay a fixed dollar amount toward your vision care.

VSP will not issue an insurance card to you. Simply inform your vision care provider that you are a Citizens Bank staff member and they will be able to access plan information online or by phone. If you would like an ID card, you can print one from VSP's website.

THINGS TO THINK ABOUT

- **What are your expected vision expenses for the coming year?** Consider using the vision plan and the Health Care Reimbursement Account to help pay for amounts that exceed the vision benefit.
- **Do you need coverage for your entire family?** You may select from four coverage levels – employee only, employee plus spouse, employee plus child (or children) or family. So, if your family members have vision coverage from another source or do not require vision coverage, you may want to elect coverage for yourself only.
- If you select HealthPlus medical coverage through the Bank, you are eligible for EyeMed Vision Care discounts at no cost to you. These discounts include substantial savings on frames, bifocals and contact lenses from any EyeMed Vision Care provider. This is an optional discount program and not a benefit under the VSP or HealthPlus insurance plans. Be sure to evaluate your potential vision-related expenses before making your selection so you have the appropriate level of vision coverage. The discounts provided through EyeMed may be adequate for your vision care needs. Visit EyeMed Vision Care at www.eyemedvisioncare.com or call 866-559-5252 (use group code: 9232810) for more information.
- Remember – when selecting a VSP provider, it is important to select one in VSP's Signature network. With a VSP Signature provider, you will receive the highest level of benefits and the least amount of out-of-pocket costs.

VISION OPTIONS COMPARISON



PLAN FEATURE	LEVEL I		LEVEL II	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
EXAMS	\$25 copay	\$40	\$5 copay	\$40
CONVENTIONAL LENSES*				
Single-vision lenses	\$25 copay then covered at 100%	\$35	\$10 copay then covered at 100%	\$35
Bifocal lenses		\$52		\$52
Trifocal lenses		\$65		\$65
LENS OPTIONS**	Lens options are available at discount pricing		Lens options are available at discount pricing	
FRAMES	\$130 retail allowance 20% off overage	\$45	\$130 retail allowance 20% off overage	\$45
CONTACT LENSES (in lieu of glasses)				
Medically necessary	Unlimited	\$210	Unlimited	\$210
Not medically necessary	\$130	\$105	\$130	\$105
LASER SURGERY	Discounted through VSP contracted centers		Discounted through VSP contracted centers	
BENEFIT FREQUENCY				
Exams, Frames, and Lenses	Once every 12 months		Once every 12 months	
Not medically necessary	Once every 12 months in lieu of lenses and frames		Once every 12 months in lieu of lenses and frames	
ADDITIONAL DISCOUNTS***	20% discount on additional pairs of glasses 15% discount on contact lens professional fees		20% discount on additional pairs of glasses 15% discount on contact lens professional fees	

*Single, bifocal and trifocal lenses in either glass or plastic are covered in full.

**Polycarbonate lens are covered in full for children.

***Discount is available for 12 months from the last eye exam and through the same VSP doctor who performed the exam.



SHORT TERM DISABILITY (STD)

FULL-TIME STAFF MEMEBERS

The Bank provides full-time staff members with the following Short-Term Disability (STD) coverage through Unum.

- 60% of your pay for up to 11 weeks.

YOUR BENEFIT

This coverage provides full-time staff members an income replacement benefit for up to 11 weeks if you have a temporary disability and are unable to work due to a non-work related injury or illness. Your disability must be approved by Unum. STD begins on the 15th calendar day of absence and provides you with 60% of your pay, up to a maximum of \$3,500 per week. Pay is defined as your base annual salary. Any other forms of compensation will not be included in determining your pay for the purpose of this benefit.

If you become disabled, you may be eligible for benefits from other sources. If this is the case, your STD benefit will be offset by the amount of these benefits, which may include:

- Any other government disability benefits, such as those provided by the Occupational Disease Act or State Compulsory Disability Law,
- Benefits from any other Bank-sponsored benefit plan,
- Benefits from no-fault motor vehicle laws, or
- Benefits from workers' compensation coverage.



PART-TIME STAFF MEMBERS

Part-time staff members are eligible to purchase the following Voluntary Short-Term Disability (VSTD) coverage through Unum.

- 60% of your pay for up to 11 weeks.

YOUR BENEFIT

This coverage provides part-time staff members an income replacement benefit for up to 11 weeks if you have a temporary disability and are unable to work due to a non-work related injury or illness. Your disability must be approved by Unum. VSTD begins on the 15th calendar day of absence and provides you with 60% of your pay, up to a maximum of \$700 per week. Pay is defined as your base annual salary. Any other forms of compensation will not be included in determining your pay for the purpose of this benefit.

If you become disabled, you may be eligible for benefits from other sources. If this is the case, your VSTD benefit will be offset by the amount of these benefits, which may include:

- Any other government disability benefits, such as those provided by the Occupational Disease Act or State Compulsory Disability Law,
- Benefits from any other Bank-sponsored benefit

plan,

- Benefits from no-fault motor vehicle laws, or
- Benefits from workers' compensation coverage.

Pre-existing condition limitations apply to the VSTD Plan. Pre-existing conditions are not covered under the plan. They are defined as follows:

- **Any condition that you received medical treatment, consultation, care or services including diagnostic measures or took prescribed drugs or medicines in the three months just prior to your effective date of coverage; and**

Any pre-existing condition will not be covered for a period of 12 months.

If you are currently enrolled in VSTD, your election will automatically rollover to 2012 unless you elect otherwise.

THINGS TO THINK ABOUT

Some issues to consider when choosing Voluntary STD coverage:

- **The Voluntary Short Term Disability plan has a pre-existing condition limitation.** Certain conditions will not be covered under the plan until you have been insured for at least 12 months.
- **The Voluntary Short Term Disability plan requires Evidence of Insurability.** If you enroll in the Voluntary Short Term Disability plan during this annual enrollment, you must complete an Evidence of Insurability form. Coverage will not go into effect until approved by Unum.



FAMILY MEDICAL LEAVE

The Bank recognizes that staff members may occasionally have personal health conditions and family health situations requiring an extended period of time away from work. The Bank's Family Medical Leave policy allows any staff member with 1,000 hours of service, and at least 12 months of employment to request a family or medical leave of absence without pay for up to 12 weeks within any rolling 12-month period. You must use any PTO time available or time in your FMLA Bank to cover any unpaid part of any family or medical leave of absence.

A family or medical leave of absence may be considered for the following reasons:

- Serious personal illness,
- The birth of a child,
- The placement of a child with a staff member for adoption or foster care, or
- The extended illness of a family member (spouse, child, parent, step-parent, parent-in-law, or same-gender domestic partner as defined under the policy).

This policy is intended to comply with the Family Medical Leave Act of 1993 as amended, as well as any Michigan, Wisconsin, Ohio, or Indiana state statutes which apply. The Health Insurance Portability and Accountability Act of 1996 as amended may also apply to certain records covered by this policy. For more information about this benefit or to receive a copy of the complete Family Medical Leave policy, visit the HR4U Portal.

If you expect to be absent from work for five consecutive days or more, you must contact Unum and complete the Leave of Absence Request form located on the HR4U Portal in accordance with Citizens' Leave of Absence policy. In addition, it is the employee's responsibility to ensure any absence from work is arranged with his/her supervisor/manager.

STEPS TO APPLY FOR A LEAVE OF ABSENCE

1. Contact your manager to inform them of your leave.
2. Complete the Leave of Absence Request Form found on the HR4U Portal. Email the completed form to the parties indicated on the form.
3. Call Unum at 877-646-6450.
 - ▶ If additional information is needed, Unum will contact you at your home telephone number.
4. Upon your return to work, you must provide a Return to Work Authorization to your manager, Human Resources, and Unum. You must call Human Resources to have your system access returned.

See **PAID TIME OFF** section of this Guide for more details.

THINGS TO THINK ABOUT

Some issues to consider when using Family Medical Leave:

- **PTO does not accrue while on Leave of Absence.**
- **Employees on Leave of Absence are not eligible for holiday pay when the holiday falls during their Leave of Absence.**

LONG-TERM DISABILITY (LTD) BENEFIT CHOICES



The Bank provides full-time staff members with Long-Term Disability (LTD) coverage through Unum. The benefit protects you and your family by continuing part of your pay when an illness or injury prevents you from working. The Bank automatically provides full-time staff members with the following LTD coverage:

- 50% of your pay (before-tax)

During enrollment, you can choose to change the tax status of this benefit to after-tax or you can upgrade your LTD coverage to 60% of your pay (before- or after-tax) by paying a contribution.

YOUR BENEFIT

Your benefit payment will begin after you have been disabled for 90 days. This benefit coordinates with the duration of benefits of our Short-Term Disability (STD) program, creating seamless income replacement for you. For the first two years of benefit payments, disability is defined as an injury or illness that keeps you from performing your regular occupation. After that, payments will continue only if you're still unable to work at any job for which you're reasonably qualified. Payments will continue until you recover, die, or reach age 65, whichever comes first.

If you become disabled, you may be eligible for benefits from other sources. If this is the case, your monthly LTD benefit will be offset by the amount of these benefits, which may include:

- Social Security disability benefits, including those payable to your dependents.
- Any other government disability benefits, such as those provided by the Occupational Disease Act or State Compulsory Disability Law,
- Benefits from any other Bank-sponsored benefit plan,
- Benefits from no-fault motor vehicle laws, or
- Benefits from workers' compensation coverage.

The maximum payment from all sources is \$15,000 a month.

BEFORE- AND AFTER-TAX BENEFITS

If you select the benefit in before-tax dollars:

- You pay for this benefit from your pay before taxes are calculated. This reduces your taxable income.
- Because you didn't pay taxes on the money, you'll have to pay taxes on any money you receive as LTD benefits. This will reduce your spendable disability income.

If you choose the benefit in after-tax dollars:

- You pay for the benefit with money that has already been taxed.
- You won't have to pay federal income taxes on your LTD benefits because you've already paid federal income taxes on your premium. If you have not previously elected to pay for your LTD premium on an after-tax basis for at least three consecutive years, you may owe taxes on a portion of the benefit you receive.

THINGS TO THINK ABOUT

Some issues to consider when choosing LTD coverage:

- **How much money would it take to keep your current lifestyle?** Would the option you choose provide the amount you need if you became disabled?
- **Will you want to increase coverage in the future?** If you enroll for the 50% option, you may increase your coverage only at the next annual enrollment period. Any increase in coverage will be subject to a pre-existing condition limitation.



EMPLOYEE LIFE INSURANCE BENEFIT CHOICES

In the event of your death, what would your family do for income? With your Bank-sponsored Life Insurance benefit through Prudential, your family or other beneficiaries may receive a payment if you die. The Bank automatically provides you with the following basic life insurance:

- One times your pay

This benefit also provides you with the following additional free services:

- FinancialPoint® Beneficiary Financial Counseling
- **EstateGuidance®** Will Preparation

You also have the opportunity to buy optional life insurance in the following amounts:

- One times your pay
- Two times your pay
- Three times your pay
- Four times your pay
- Five times your pay

The maximum amount of basic life insurance is \$400,000 or one times your pay (whichever is less). The maximum amount of optional life insurance is \$900,000 or five times your pay (whichever is less). The combined total maximum amount of life insurance coverage is \$1,300,000. At the time of hire, evidence of insurability is required if you are applying for optional coverage which exceeds \$500,000. Evidence of insurability applies to all other elected increases in coverage that are greater than 1 times pay or \$150,000.

TAXES AND YOUR LIFE INSURANCE BENEFIT

The IRS requires you to pay income tax on the value of employer-provided life insurance greater than \$50,000. For amounts greater than \$50,000, the IRS will assign a value to this coverage and add it to your paycheck as “imputed income.” This amount will be included when your taxes are calculated and will appear on your annual W-2 statement.

If you die and your beneficiaries receive a life insurance benefit from this plan, they will not owe any taxes on the amount they receive.

THINGS TO THINK ABOUT

Some issues to consider when choosing life insurance coverage:

- **How much coverage do you need?** Think about the major expenses that would have to be taken care of in the event of your death: mortgage, car payments, college tuition, etc. How much money would your family need to cover these expenses if they were suddenly faced with the loss of your income?
- **Do you need to change your current level of coverage?** During each year’s enrollment period, you must provide evidence of insurability if you elect to increase your level of optional life insurance by more than one times your pay or \$150,000 (whichever is less).
- **Are other resources available?** Do you have other savings sources that could provide income for your family? Examples include personal savings, investments and life insurance policies. How much do you want or need to supplement these sources?
- **Is your beneficiary information current?** If you’ve had a change in marital status or had a child since you first enrolled in life insurance coverage, you should check to make sure your life insurance beneficiary information is up to date. You can name or change your beneficiary online during annual enrollment or at any time throughout the year.
- **This benefit reduces at age 65 and older.** Please review the Prudential booklet for more details located on the HR4U Portal. Also, coverage effective dates and increases in coverage may be delayed if you and/or your dependents are disabled on the date coverage is scheduled to take effect.

EMPLOYEE LIFE INSURANCE BENEFIT CHOICES (CONTINUED)



Offered as part of your basic life insurance benefit, you have access to two free services. FinancialPoint® Beneficiary Financial Counseling is a free service available to life insurance beneficiaries or terminally ill staff members that are approved for the life insurance's Accelerated Benefit Option. EstateGuidance® Will Preparation allows all staff members an opportunity to create a legally binding will free of charge.

FINANCIALPOINT® BENEFICIARY FINANCIAL COUNSELING:

- Comprehensive, caring, and expert financial assistance for life insurance beneficiaries or policyholders who elect the Accelerated Benefit Option (ABO).
- Toll-free, 24/7 access through a professionally staffed phone line.
- Expert consultation with financial professionals including Certified Public Accountants and Certified Financial Planners.
- Comprehensive introduction to services, including a welcome kit.
- Financial reports developed specific to the beneficiary's life stage and financial goals.
- Objective, non-biased financial information.
- Outreach calls, follow up, and satisfaction surveys.
- Unlimited service for up to one year.
- Service delivery options via e-mail.
- Data security and confidentiality.
- Access to over 15,000 Certified Financial Planners nationwide for face-to-face counseling in major metropolitan, suburban, and rural locations if required.

ESTATEGUIDANCE® WILL PREPARATION:

- Online will preparation through an easy-to-use program.
- Allows employees to complete a legally binding will online while simultaneously talking to an attorney as they encounter questions.
- To take advantage of this free program, visit www.estateguidance.com and use the Promotional Code: EGP311.



DEPENDENT LIFE INSURANCE BENEFIT CHOICES

For the dependent life program, your eligible dependents are:

- Your legal spouse or same-gender domestic partner.

A “same-gender domestic partner” is defined as an unmarried partner of the same-gender with whom you have a spouse-like relationship, who is at least 18 year of age or older, with whom you share a residence or own a home, and with whom you are interdependent financially. You cannot be related by blood, and you must complete the domestic partner certification form.
- An eligible dependent child of you, your spouse, or your same-gender domestic partner up to the end of the month in which they turn 26 years old - or of any age if they are mentally or physically disabled.
- An eligible dependent child includes:
 - ▶ Biological or legally adopted child
 - ▶ A child who is placed with you for adoption
 - ▶ A stepchild
 - ▶ A child for who you or your spouse/same-gender domestic partner are legal guardians
 - ▶ A child that you are required to cover pursuant to a qualified medical child support order
- The dependent child must wholly depend on you for support and maintenance.
- The dependent child cannot be married.

Dependent Life Insurance provides coverage on the lives of your spouse and eligible dependent children. Benefits are paid to you if one of your insured dependents dies. You may separately elect any level of coverage for your spouse and/or child (or children) from the options listed below:

SPOUSE	CHILD (OR CHILDREN)
\$50,000	\$10,000
\$25,000	\$5,000
\$10,000	\$2,000

The amount of dependent life insurance cannot exceed 50% of your life insurance amount (basic and optional combined) under the plan. You can elect optional dependent life even if you do not elect optional employee life insurance.

You will need to provide evidence of insurability if any of the following situations apply:

- You do not enroll a dependent when first eligible, and you wish to do so at a later date.
- You increase your dependent coverage option by more than one level at a time.

THINGS TO THINK ABOUT

Some issues to consider in choosing dependent life insurance coverage:

- **If you are married, is your spouse covered by an individual life insurance policy?** If not, this coverage may provide needed protection at a reasonable cost.
- **If you have children, are they currently covered by a life insurance policy?** Some coverage may be needed to cover final medical and funeral expenses if a dependent child dies.
- **If you are married and your spouse works, does your spouse have life insurance coverage through his or her employer?** Evaluate whether this coverage is enough to replace his or her income during the period of adjustment following a death.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE BENEFIT CHOICES



Accidental Death & Dismemberment (AD&D) Insurance provides you and your family with another layer of financial protection if you die or become injured due to an accident. The Bank automatically provides you with the following AD&D insurance:

- One times your pay

You also have the opportunity to buy optional AD&D insurance in the following amounts. You may only buy additional AD&D insurance up to the amount of the employee life insurance coverage you have selected:

- One times your pay
- Two times your pay
- Three times your pay
- Four times your pay
- Five times your pay

YOUR BENEFIT

If you die accidentally, your beneficiary will receive the AD&D amount you selected, in addition to the amount you chose as your life insurance protection. This coverage also provides protection in the event of the loss of a limb and/or sight. The maximum basic AD&D benefit is \$400,000. The maximum optional AD&D benefit is \$900,000, for a combined maximum benefit is \$1,300,000.

THINGS TO THINK ABOUT

Some issues to consider in choosing AD&D insurance coverage:

- **Are you planning to start a family?** If so, you may desire additional, inexpensive protection in case of your accidental death.
- **Is your beneficiary information current?** You should check to make sure your beneficiary information is up to date. You can name or change your beneficiary online at any time.
- **This benefit reduces at age 65 and older.** Please review the Prudential booklet for more details located on the HR4U Portal.



REIMBURSEMENT ACCOUNT CHOICES

Reimbursement accounts let you set aside money from your paycheck before Federal, State, Social Security or Medicare taxes are deducted. You do not pay taxes on the money you contribute to, and receive from, any reimbursement account.

HEALTH CARE REIMBURSEMENT ACCOUNT OPTIONS

The Bank offers two types of Health Care Reimbursement Accounts. Your choice will depend on the Medical PPO option that you choose. If you choose to enroll in the Comprehensive, Standard, or Basic Plan, you are only eligible to elect the General (or Full) Purpose Health Care Reimbursement Account. If you choose to enroll in the Select^{+HSA} Plan, you are only eligible to elect the Limited Purpose Health Care Reimbursement Account.

GENERAL (OR FULL) PURPOSE HEALTHCARE REIMBURSEMENT ACCOUNT

You may set aside any dollar amount from a minimum of \$52 to a maximum of \$3,000 per year in your Health Care Reimbursement Account. You can use this money to pay for a variety of eligible expenses, such as:

- Deductibles and copays.
- Expenses not covered by our health care plan such as hearing exams, hearing aids, adult orthodontia or additional expenses for eyeglasses or contact lenses.
- Expenses in excess of your medical or dental coverage limits, such as your share of orthodontia treatment costs.
- Expenses for over-the-counter medical supplies such as adult incontinence products, pregnancy tests, contact lens solutions and supplies, diabetic testing strips and glucometers, and first aid kits.
- **REMINDER! Most Over-The-Counter drugs and medications are no longer eligible for tax-free reimbursement, unless your doctor provides you with a script for the item.**
- Dietary supplements and other items that merely promote general health, such as vitamins, are not eligible for reimbursement.

LIMITED PURPOSE HEALTH CARE REIMBURSEMENT ACCOUNT

If you enroll in the Select^{+HSA} Plan for 2012, you cannot participate in the General Purpose Health Care Reimbursement Account. The IRS does not allow it. However, you can participate in the Limited Purpose Health Care Reimbursement Account. The Limited Purpose Health Care Reimbursement Account limits the types of expenses that can be reimbursed (see chart below):

HEALTH CARE REIMBURSEMENT ACCOUNT COMPARISON

	GENERAL PURPOSE	LIMITED PURPOSE
MEDICAL PLAN ELECTION	You are eligible for this account if you enroll in the following medical options: <ul style="list-style-type: none"> • Comprehensive Plan • Standard Plan • Basic Plan 	You are eligible for this account if you enroll in the following medical options: <ul style="list-style-type: none"> • Select^{+HSA} Plan
TYPES OF EXPENSES ELIGIBLE FOR REIMBURSEMENT	<ul style="list-style-type: none"> • Medical • Prescription Drug • Dental • Vision 	<ul style="list-style-type: none"> • Dental • Vision



DEPENDENT CARE REIMBURSEMENT ACCOUNT

You may set aside any dollar amount from a minimum of \$52 to a maximum of \$5,000 per year in your Dependent Care Reimbursement Account. If you are married and file Federal income taxes separately, you may set aside up to \$2,500 per year.

This account is designed to help you pay for dependent care expenses so you (or you and your spouse) can work.

Eligible dependent care can be provided in your home or in someone else's home, or in a care facility (except a nursing home). When you submit a claim for expenses, you must show your caregiver's tax identification number. (For individuals, this usually is their Social Security number.)

Generally, your dependents include:

- Children under age 13 who qualify as dependents on your federal income tax return.
- Any dependents unable to care for themselves – for example, an incapacitated older child, spouse or an elderly parent who regularly spends at least eight hours a day in your home and otherwise qualifies as a dependent under IRS rules.

If you contribute to a Dependent Care Reimbursement Account, you must file an **IRS Form 2441** with your Federal Income Tax Return. Form 2441 is an informational form which reports the amount you pay for day care and the name of the day care facility or individual child care provider.

REIMBURSEMENT ACCOUNT HIGHLIGHTS		
YOUR OPTIONS	DEPOSITS*	COVERED EXPENSES**
HEALTH CARE REIMBURSEMENT ACCOUNT	<ul style="list-style-type: none"> • Up to \$3,000 per year (minimum annual deposit is \$52) 	<ul style="list-style-type: none"> • Deductibles • Copays • Amounts in excess of plan limits or reasonable and customary amounts <p>(For more eligible expenses, see IRS Publication 502)</p>
DEPENDENT CARE REIMBURSEMENT ACCOUNT	<ul style="list-style-type: none"> • Up to \$5,000 per year or \$2,500 if married and filing separately (minimum annual deposit is \$52) • The maximum combined election made by you and your spouse cannot exceed \$5,000 	<p>Dependent care expenses incurred so that you and your spouse can work, including:</p> <ul style="list-style-type: none"> • Day care or nursery school for children under age 13 • Care for any elderly parent, disabled spouse or other dependent <p>(For more eligible expenses, see IRS Publication 503)</p>

* You may deposit any amount within the minimum and maximum for the coming plan year.

** You can use your account for the following expenses – as long as you are not reimbursed for them by any other plan, or do not claim them as deductions or credit on your tax return.

THE REIMBURSEMENT PROCESS

ADP will process the claims for all the reimbursement accounts.

Claiming reimbursement from the Health Care and Dependent Care Reimbursement Accounts is simple:

- **Debit Card** – A debit card is issued for the Health Care Reimbursement Account. Use the card at your provider's office and the amount will automatically be deducted from your Health Care Reimbursement Account balance. Be sure to retain your receipts as they may be required to verify expenses. If seeking reimbursement for a prescribed over-the-counter medication, you must submit a paper claim; you cannot use your debit card.
 - ▶ **Keep your debit card!** Your debit card is reusable from year to year until the expiration date. Your new election will be transferred to your card.
- **Online Claim Filing** – Go to www.flexdirect.adp.com to file your claim online. Then fax or mail the documentation, receipts, or other proof of payment to ADP. This is the easiest method and it offers same-day claims processing.
- **Traditional Claims Filing** – Fill out a claim form showing the services you paid for and attach proof of payment (e.g., a paid receipt or Explanation of Benefits). Send or fax the completed form, along with the proof of payment to ADP.

You can sign up to receive your reimbursements by direct deposit through ADP. Otherwise, reimbursements will be sent to you by mail as paper checks.



REIMBURSEMENT ACCOUNT CHOICES (CONTINUED)

SPECIAL RULES

Because reimbursement accounts provide significant tax savings, the IRS imposes the following rules:

- Each account is completely separate. You may not transfer money from one account to another. For example, you may not use your Health Care Reimbursement Account to pay for dependent care expenses, or vice versa.
- If you claim an expense for reimbursement through these accounts, you may not claim the same expense as a deduction or a credit on your income tax return.
- You may receive the full year's reimbursement amount for eligible health care expenses at any time during the year.
- Dependent care reimbursement is based on the amount in your account when you submit your claim.
- Expenses for same-gender domestic partners and their children are not eligible for reimbursement from the Health Care or Dependent Care Reimbursement Accounts.
- The Health Care and Dependent Care Reimbursement Accounts give you a 90-day grace period after the end of the plan year to submit reimbursement account expenses you incurred during the prior year. So, if you incur an expense on December 31st, you have until the following March 31st to submit a reimbursement account claim.
- Any leftover money at year-end in the Health Care or Dependent Care Reimbursement Accounts cannot be returned to you; use it or lose it. This means you must plan carefully before deciding to contribute money to these accounts.

THINGS TO THINK ABOUT

Some issues to consider in choosing reimbursement account participation:

- **What kinds of health care or dependent care expenses will you have that won't be covered by benefit programs?** Think about the health care and/or dependent care expenses you've paid out of your own pocket. Contribute only the amount you'll need to cover your expenses, so that you'll use your entire contribution.
- **Should you use the Federal Tax Credit instead of the Dependent Care Reimbursement Account?** In some cases, you may save more in taxes by using the Federal Tax Credit for dependent care expenses. You may want to talk with a tax professional, especially if your tax situation is special or complex.
- **Plan for the lag time between payment and reimbursement of dependent care expenses.** Dependent Care Reimbursement Account contributions are deducted from each of your paychecks throughout the year. Contributions accumulate in your account until there is enough to cover your claim expenses. In the early part of the plan year, you may have to wait for reimbursement while your account balance accumulates.

VOLUNTARY GROUP LEGAL PLAN



The Voluntary Group Legal Plan is a valuable after-tax benefit that offers access to comprehensive legal services. The plan is administered by Hyatt Legal Plan and provides access to many different types of legal services. Hyatt Legal Plan also provides an array of fully-paid legal services when you see a plan attorney, regardless of how complex or time-consuming your case may be. There are no limits on the number of times you may use the plan, and there are no dollar limits on your use of a plan attorney for the following services:

- Unlimited phone advice and consultation
- Document preparation
- Wills
- Living trusts
- Living wills
- Sale, purchase, or refinance of primary home
- Tenancy negotiation
- Eviction defense
- Uncontested defense
- Uncontested guardianships
- Uncontested name change
- Civil litigation defense

Visit Hyatt Legal Plan at www.legalplans.com (use password: MetLaw) or call 800-821-6400 for more information.

COMMUTER BENEFIT ACCOUNT

You may set aside any dollar amount up to \$230* per month for work-related parking and/or up to \$230* per month for public transportation used for your work commute. With this account, you can have your monthly parking and/or commuting costs deducted from your paycheck on a pre-tax basis. This saves you money by reducing your taxable income and offsetting the costs of parking and/or the cost of using public transportation.

In the case of parking, the cost must be work-related and the parking lot or garage must be at or near your work location (or at or near the place from which you commute to work). The Commuter Benefit Account cannot be used for parking at or near your home.

In the case of public transportation, the covered costs must be for travel between your home and the work location.

Enrollment details and plan information can be found on the HR4U Portal. Remember - unused contributions to your Commuter Benefit Account will carry forward to the following monthly participation period, even if that period is in the following calendar year. However, if you have not had any pre-tax parking/public transportation deductions or claims for a period of six calendar months, your account balance will be forfeited. Commuter benefits are recurring elections. Any unused contributions will carry forward to the following monthly participation period next month.

COMMUTER BENEFIT ACCOUNT HIGHLIGHTS

YOUR OPTIONS	DEPOSITS	COVERED EXPENSES
COMMUTER BENEFIT ACCOUNT	<ul style="list-style-type: none"> • Up to \$230* per month for work-related parking • Up to \$230* per month for public transportation used for work commute 	<ul style="list-style-type: none"> • Parking must be work-related and be at or near your work location • Public transportation must be for travel between your home and the work location
	<p>The Commuter Benefit Account works a little differently than the other reimbursement accounts. Unlike the other accounts, you will not sign up for this account during the enrollment period. A one-time enrollment through ADP is required for this account.</p>	

*These are the 2011 benefit limits and are subject to change by the IRS.



PAID TIME OFF (PTO)

Balancing work, family, recreation and personal matters can be challenging as everyone handles these situations differently. That’s why the Bank provides you with a Paid Time Off (PTO) program that gives you the flexibility to schedule and manage your time away from work according to your individual needs. How much PTO you can accrue each year is based on your officer title and length of service with the Bank as shown in the table below:

2012 ANNUAL PTO ALLOTMENTS & BI-WEEKLY ACCRUALS

	NON-OFFICER			OFFICER/AVP		VP+
	0-6 years	7-14 years	15+ years	0-6 years	7+ years	1+ years
FULL-TIME EMPLOYEES						
Annual Allotment (Days at 8 hours)	17	22	27	22	27	27
Per Pay Period Accrual (Hours)	5.25	6.77	8.32	6.77	8.32	8.32
PART-TIME EMPLOYEES*						
PTO Accrual Allotment (Weeks)	2.0	3.0	4.0	3.0	4.0	4.0
Per Pay Period Accrual (Hours)	Average (Scheduled) Hours Per Week x Annual Allotment 26 (Pay Periods)					

HOW PTO WORKS

You accrue hours of time off in your PTO Bank on a per pay period basis based on the information recorded on the Bank’s timesheet system, which is used to track your PTO accruals, balances and usage. You can use your PTO any time during the year with management approval – even if you haven’t accrued enough time in your PTO Bank. **However, if you have used more PTO than your annual allotment allows, you will be required to reimburse the Bank for the extra time off you have taken but not accrued.** And, if you have unused time in your PTO Bank at the end of the year, you can roll up to a maximum of 120 hours of time into your FMLA Bank that can only be used for a qualified FMLA or approved medical leave of absence.

BUYING ADDITIONAL PTO

Full-time staff members can buy up to five additional PTO days in one day increments. The ability to buy additional PTO days is only available during the annual enrollment period. You cannot sell PTO days, so be sure to consider your time off needs carefully.

If you buy PTO days, the value of each day is based on your base annual salary/wages. For example, assuming you are earning \$35,000 annually, if you buy one day of PTO, you will pay approximately \$135. When taking PTO time, purchased PTO must be used first. Purchased PTO will not be carried over to your FMLA Bank.

FMLA BANK

The FMLA Bank is a bank of accumulated time that is populated with your unused Paid Time Off (PTO) from the prior calendar year. Your FMLA Bank can hold up to 120 hours and will rollover from year to year, if unused.

The time you have accumulated in your FMLA Bank can be used for a qualified FMLA or approved medical leave of absence. Examples of FMLA qualified absences include: your personal illness, birth or care of your newborn child, placement of a child for adoption or foster care, extended illness of a family member, call to active duty in the Armed Forces, or providing care for a family member injured in the Armed Forces.

Your accumulated time cannot be used as personal or sick time. If you leave the Bank, you will not be paid for accumulated time in your FMLA Bank.

Part-time employees are eligible for the FMLA Bank if they meet the FMLA and medical leave eligibility requirements. For details on FMLA eligibility and how to apply, see the **Family Medical Leave Policy (FMLA)** and the Leave of Absence (LOA) Policy located on the HR4U Portal.

If you experience a qualified FMLA leave, contact Unum at 877-646-6450 to apply and complete the Leave of Absence Request form located on the **HR4U Portal**.



BEREAVEMENT

Our bereavement policy permits staff members to take up to three days paid bereavement time in the event of the death of an immediate family member. An immediate family member is defined as a spouse/same-gender domestic partner, parent, child, sibling, grandparent or grandchild, including step relations.

Staff members may take one day of paid bereavement time in the event of the death of an in-law. An in-law is defined as a mother, father, brother, sister, daughter or son related to you by marriage. If you wish to take time off in excess of the allotted bereavement time, you may use your Paid Time Off.

THINGS TO THINK ABOUT

Some of the issues you need to consider when it comes to PTO:

- **Do you need to buy additional PTO days?** Be sure to consider your total allotment of PTO before deciding to buy additional PTO. Remember, you can only buy additional PTO days during annual enrollment.
- Should you leave the Bank, only accrued, but unused PTO is paid out. Your FMLA Bank & floating holidays are not paid out.
- PTO does not accrue when you are on Leave of Absence.



401(k) PLAN

The Bank offers you a great way to set aside dollars for your future retirement needs through our 401(k) plan, administered by Prudential. Under the plan, you can save up to 50% of your total compensation on a pre-tax basis. You are always 100% vested in your own contribution. You must be employed for three years to become fully vested in any company match contributions.

Effective January 1, 2012, the Bank will be reinstating a 401(k) company matching contribution. The Bank will match 50% of the first 2% you defer and 25% of the next 6% you defer. You must be employed for three years to become fully vested in the company matching contributions.

You are also eligible for a fully discretionary company contribution which is a percentage of your salary in any year in which you complete 1,000 hours of service and are employed on December 31. Each year, the Bank will determine whether this contribution is made and the amount of the contribution. You must work three years to become fully vested in any such discretionary company contributions.

Starting November 2, 2011, new hires are eligible to begin saving in the plan on the first day of the month following 30 days of employment. If you do not actively enroll in the plan, you will automatically be enrolled at a pre-tax contribution rate of 3%. You may change your contribution rate or elect not to participate by contacting Prudential. Otherwise, your contributions will begin on the first payroll date of the month following your eligibility date.

Effective January 1, 2012, the Bank will implement a one-time auto re-enrollment for anyone who is not currently contributing to the 401(k) plan. This re-enrollment is provided to encourage employee enrollment in the plan including participation in the company matching contribution. Staff members who do not want to participate in the plan will have the opportunity to opt out of the re-enrollment prior to January 1, 2012 by logging into their account at www.prudential.com/online/retirement. Staff members who opt out of the re-enrollment are not eligible for the company matching contribution. Upon enrollment in the plan, contributions made by staff members are eligible for company matching contributions.

Effective May 1, 2012, the auto escalation feature available under the 401(k) plan will be offered on an opt-out basis. This feature facilitates savings under the plan and aids staff members in meeting their retirement saving goals. Staff members who are contributing less than 8% will have their contribution automatically increased by 1% each May. Remember, staff members who contribute a minimum of 8% are able to take advantage of the full company matching contribution. Staff members who wish not to participate in the auto escalation will have the opportunity to opt-out prior to the May 1st effective date by logging into their account at www.prudential.com/online/retirement. Watch for communications from Prudential Retirement in early 2012 on the details of this program.

THINGS TO THINK ABOUT

Some of the things you need to consider when it comes to 401(k):

- **Am I saving enough to meet my retirement needs?** Tools are available on the [Prudential 401\(k\) website](#) to assist you with your planning.
- **Should I increase my contribution to maximize the company matching contribution?** If you are saving less than 8% , you may want to increase your contribution to take full advantage of the company matching contribution- consider the match “free money”.
- **If you do not wish to participate in the 401(k) plan including the auto escalation feature**, you must actively opt out of the January 1, re-enrollment and May auto escalation.



EMPLOYEE ASSISTANCE PROGRAM

All full- and part-time staff members have access to an Employee Assistance Program (EAP). EAP services provide you and your family with free, confidential, short-term professional assessment, diagnosis, counseling and referrals to a large network of mental health professionals. This program is administered by IMPACT. You can call an IMPACT representative 24-hours a day, 7 days a week at **800-227-6007** for assistance or visit their website at **www.impactemployeeassistance.com** (use account login: crb).

The EAP can provide easily accessible counseling for you and all members of your household. There is no cost to you or your family, unless you and your counselor decide that you would benefit from a referral for longer term counseling. The EAP is completely confidential and no one at the Bank will know if you utilize the program. The EAP can assist you in addressing issues such as:

- Relationships
- Work problems
- Family concerns
- Physical illness
- Drug and alcohol problems
- Life management
- Divorce
- Financial and legal issues
- Stress management

EMPLOYEE DISCOUNT PROGRAM

The Bank partners with Next Jump to provide all staff members with discounts for online purchases from over 20,000 merchants. The program, called CB Bonus Buyz, provides you and your family with access to private shopping events and exclusive discounts on hundreds of brand name products and services, including clothing, electronics, and special savings on theater, concert and sporting event tickets. Discounts are available to all active staff members.

ADOPTION ASSISTANCE PROGRAM

All staff members with more than six months of continuous service may be eligible for reimbursement of up to \$1,000 in expenses directly related to the adoption of a child under the age of 18 (who is not a step child).

Eligible expenses include court and legal fees, agency placement fees, medical expenses of the birth mother associated with pregnancy and delivery, and travel and lodging expenses incurred in securing adoption.

You must submit a completed **Adoption Assistance Reimbursement Form** with proof of completed legal adoption and applicable receipts to the Benefits Department for reimbursement.



WHAT HAPPENS IF YOU DON'T ENROLL (DEFAULT COVERAGE)

FULL-TIME STAFF MEMBERS

Everyone must enroll for benefits. If you don't make elections during the enrollment period, you will have no healthcare benefits (Medical/Rx, Dental*, and Vision) in 2012. You will receive default coverage as listed below.

PLEASE NOTE: Your 2011 elections will not carry over to 2012.

- **Medical:** No coverage
- **Dental:** Same as 2011
- **Vision:** No coverage
- **Short-Term Disability (STD):** 60% of pay
- **Long-Term Disability (LTD):** 50% of pay
- **Life Insurance:** Same as 2011
- **Dependent Life Insurance:** Same as 2011
- **Accidental Death & Dismemberment (AD&D) Insurance:** Same as 2011
- **Paid Time Off (PTO):** Paid Time Off
- **Purchased Paid Time Off:** None
- **Reimbursement Accounts:** None

PART-TIME STAFF MEMBERS

Everyone must enroll for benefits. If you don't make elections during the enrollment period, you will have no healthcare benefits (Medical/Rx, Dental*, and Vision) in 2012. You will receive default coverage as listed below.

PLEASE NOTE: Your 2011 elections will not carry over to 2012.

- **Medical:** No coverage
- **Dental:** Same as 2011
- **Vision:** No coverage
- **Voluntary Short-Term Disability:** Same as 2011
- **Life Insurance:** Same as 2011
- **Dependent Life Insurance:** Same as 2011
- **Accidental Death & Dismemberment (AD&D) Insurance:** Same as 2011
- **Paid Time Off (PTO):** Paid Time Off
- **Reimbursement Accounts:** None

*** REMEMBER!** If you chose to enroll in one of our dental plans for 2011, the election you made was for two years. You must remain enrolled in your elected dental plan for 2012. You may not change plans or drop coverage until 2013.



MEDICAL & PRESCRIPTION DRUG PLANS

HealthPlus:
888-212-1512
<http://www.healthplus.org/citizens.aspx>

WELLNESS PROGRAM (CBFIT4LIFE)

HealthPlus Support:
866-810-4540
Email: CBFit4Life@citizensbanking.com

DENTAL PLANS

Delta Dental of Michigan (All States):
800-482-8915
www.deltadentalmi.com

VISION PLANS

Vision Service Plan (VSP):
800-852-7600
www.vsp.com

EYEMED VISION DISCOUNT:

866-559-5252
www.eyemedvisioncare.com
Group Code: 9232810

DISABILITY

Unum:
877-646-6450
www.unum.com

HEALTH CARE AND DEPENDENT CARE

REIMBURSEMENT ACCOUNTS
ADP: 800-654-6695
www.flexdirect.adp.com

HUMAN RESOURCES

810-768-4748 (HR4U)
Email: HR4U@citizensbanking.com

401(K) PLAN

Prudential:
877-778-2100
www.prudential.com/online/retirement

VOLUNTARY GROUP LEGAL PLAN

Hyatt Legal Plan: 800-821-6400
www.leganplans.com
Password: MetLaw

EMPLOYEE ASSISTANCE PROGRAM

IMPACT: 800-227-6007
www.impactemployeeassistance.com
Account Login: crb

FAMILY MEDICAL LEAVE

Unum:
877-646-6450
www.unum.com

COMMUTER BENEFITS

ADP:
800-654-6695
www.flexdirect.adp.com

WILL PREPARATION

EstateGuidance®
www.estateguidance.com
Promotional Code: EGP311

HSA BANK

800-357-6246
www.hsabank.com
Email: askus@hsabank.com

BENEFICIARY FINANCIAL COUNSELING

FinancialPoint®: 888-327-4260

BENEFITS CONTACT INFORMATION

HEALTHPLUS 888-212-1512	EyeMed Vision Discount 866-559-5252	IMPACT (EAP) 800-227-6007
CBFit4Life Wellness Program 866-810-4540	HSA Bank 800-357-6246	Disability/ FMLA 877-646-6450
Delta Dental of Michigan (All States) 800-482-8915	ADP (REIMBURSEMENT/ COMMUTER BENEFITS) 800-654-6695	Human Resources 810-768-4748 (HR4U)
Vision Service Plan (VSP) 800-852-7600	Prudential (401(k) Plan) 877-778-2100	



IMPORTANT NOTICES

- This guide summarizes your benefits for 2012. This guide provides information about the benefits offered through the Citizens Republic Bancorp Welfare Benefit Plan (Plan Number 503). Additional details about your benefits are available in other materials provided to benefit plan participants. This guide does not provide complete details of the program. If there is any conflict between the information in this guide and the official plan documents, the official plan documents will govern. By providing information about changes taking place to the Bank's Benefit Plans, this guide meets the requirements of a Summary of Material Modifications (SMM) as required by the Employee Retirement Income Security Act (ERISA).
- This guide is not a contract for employment. While the Bank intends to continue the plan, it reserves the right to amend or terminate the plan at any time. You will be notified of any such changes.
- In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes, and the law itself as the governing documents.

AVAILABILITY OF NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Citizens Republic Bancorp Welfare Benefit Plan (Plan Number 503) maintain(s) a Notice of Privacy Practices that describe how the Plan(s) may use and disclose your protected health information and summarizes your rights with respect to that information.

A copy of the Notice of Privacy Practices is available on the HR4U Portal. If you would like a paper copy of the notice, please contact:

HR4U, mail code 001045
Citizens Bank
328 S. Saginaw St.
Flint, MI 48502
(810) 768-4748

QUALIFIED STATUS CHANGES

In most cases, you cannot change your benefit elections during the plan year. However, if you experience one of the following qualified status changes, you may be permitted to change certain benefit elections:

- **Legal marital status:** events that change your legal marital status, including marriage, death of a spouse, divorce, or legal separation.
- **Number of dependents:** events that change the number of dependents in your family, including birth, adoption, placement for adoption, or death.
- **Employment status:** either you, your spouse, or dependent child starts or stops working.
- **Work schedule:** working hours for you, your spouse, or your dependent child are reduced or increased. A change in work schedule includes a switch between part-time and full-time employment or an unpaid leave of absence.
- **A dependent either satisfies or ceases to meet eligibility requirements** for dependents (end of the month of attainment of age 26).
- **A same-gender domestic partner either satisfies or ceases to meet the eligibility requirements for same-gender domestic partners.**
- **Change in your spouse's medical coverage:** a significant change in medical benefits and/or contribution requirements resulting from your spouse's employment. The event is defined as the effective date of the attainment or loss of coverage.



Qualified status changes must be approved by Human Resources. In general, changes are not permitted unless the change event affects your eligibility or a dependent's eligibility for benefits. Also, benefit changes must be directly related to the qualified status change. For example:

- If you get married, you can add your spouse to your coverage, as well as change your option.
- If your spouse loses his or her eligibility for health plan coverage, either through job loss or a reduction in hours, you can add him or her to your health plan.
- If you opted out of the Bank's medical coverage because you were covered under your spouse's plan, and your spouse then loses coverage for you due to job loss or reduction in hours, you can both enroll in the Bank's medical plan.

Remember, the elections you make now will **REMAIN IN EFFECT UNTIL DECEMBER 31, 2012**, unless you have a qualified status change. If you provide notice of your qualified status change within 30 days of the event, your election change will be retroactive to the date of the event. If you fail to notify Human Resources in a timely manner, you will need to wait until the following annual enrollment period to change your coverage.

You must report any qualified status change (with appropriate documentation) to Human Resources within 30 days of the event in order to make a change to your current plan year elections.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) adds two new special enrollment events. You or your dependent(s) will be permitted to enroll or drop coverage in either of the following circumstances.

- You or your dependent's Medicaid or state Children's Health Insurance Program (CHIP) coverage is cancelled due to a loss of eligibility.
- You or your dependent(s) enrolls in Medicaid or the state CHIP.

NOTE: It is your responsibility to notify Human Resources within 60 days after gaining or losing coverage in Medicaid or the state CHIP.

If you need more information, the full CHIPRA notice is available on the HR4U Portal.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 NOTICE

As specified in the Women's Health and Cancer Rights Act of 1998, each medical plan sponsored by the Bank provides coverage for the following breast reconstruction procedures in connection with mastectomies:

- Reconstruction of the breast that was operated on.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Of course, coverage is provided in a manner determined in consultation with attending physicians and the patient. The deductible and copayment requirements which apply to other covered services, also apply to these post-mastectomy reconstructive and treatment services.



IMPORTANT NOTICES (CONTINUED)

IMPORTANT NOTICE FROM CITIZENS BANK ABOUT YOUR PRESCRIPTION DRUG COVERAGE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Citizens Bank 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 drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Citizens Bank has determined that the prescription drug coverage offered by the Citizens Republic Bancorp Welfare Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Citizens Bank coverage may be affected. For more information, please refer to the benefit plan's governing documents.

If you do decide to join a Medicare drug plan and drop your current Citizens Bank coverage, be aware that you and your dependents may not be able to get this coverage back. For more information, please refer to the benefit plan's governing documents.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Citizens Bank and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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



FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE...

Contact the person listed below for further information.

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 Citizens Bank changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll 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.

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the website at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 13, 2011
Name of Entity/Sender:	Citizens Bank
Contact--Position/Office:	Human Resources
Address:	328 S. Saginaw Street, Flint, MI 48502
Phone Number:	810-768-4748