

# Dental

# Contents

Citi offers two dental options to provide dental care for you and your eligible dependents. They are the:

- **MetLife Preferred Dentist Program (MetLife PDP) and**
- **CIGNA Dental HMO (dental health maintenance organization).**

You can enroll in Citi dental coverage even if you do not enroll in Citi medical coverage. You can enroll in any of the same four coverage categories available for medical coverage: Employee Only, Employee Plus Spouse/Civil Union Partner/Domestic Partner, Employee Plus Children, or Employee Plus Family. See “Coverage categories” in the *Eligibility and Participation* section.

MetLife PDP allows you to visit any dentist. However, when you visit a dentist in the Plan’s network, you will pay a discounted fee. See Your Personal Enrollment Worksheet on Your Benefits Resources™ for the cost of the options available to you.

## Quick tips

### Dental Plan differences

CIGNA Dental HMO costs less than MetLife PDP, but you must use a CIGNA Dental HMO provider to receive a benefit, except in very limited circumstances. See “CIGNA Dental HMO” beginning on page 121.

### Spending accounts

The Health Care Spending Account (HCSA) and the Limited Purpose Health Care Spending Account (LPSA) can save you money on your out-of-pocket dental expenses. Since you forfeit any money remaining in the account that you do not use by year-end, estimate conservatively.

For details, see the HCSA or the LPSA section in the *Spending Account* section.

<b>Dental options at a glance .....</b>	<b>116</b>
What Each Option Provides .....	116
<b>MetLife Preferred Dentist Program (PDP) .....</b>	<b>117</b>
How the Plan works .....	117
Covered Services .....	118
Procedures and services that are not covered .....	120
Alternate benefit provision .....	121
Predetermination of benefits .....	121
Filing a claim.....	121
<b>CIGNA Dental HMO .....</b>	<b>121</b>
CIGNA Dental HMO features.....	122
Referrals for children .....	122
How the Plan works.....	122
Patient Charge Schedule .....	123
Emergencies .....	123
Member Services .....	124
Limitations on covered services .....	124
Conversion to an individual policy .....	124
Procedures and services that are not covered .....	125
Filing claims.....	126
Extension of benefits .....	126
Disclosure Statement .....	126
<b>Claims and Appeals .....</b>	<b>126</b>
Claims and appeals for MetLife PDP .....	126
Claims and appeals for the CIGNA Dental HMO .....	127

## Dental options at a glance

### What Each Option Provides

	MetLife Preferred Dentist Program (PDP)*	CIGNA Dental HMO**
Annual deductible		
• Individual	\$50	None
• Family maximum	\$150	None
Preventive and diagnostic services	100% paid, no deductible to meet	100% paid when you use your network dentist
Basic services such as fillings, amalgams ("silver") and composite ("white"), root canals, periodontal services, extractions, oral surgery	80% after deductible	You pay a copayment when you use your network dentist
Major restorative services such as crowns, inlays/onlays, bridges, dentures	50% after deductible	You pay a copayment when you use your network dentist
Orthodontia	50% after deductible***	You pay a copayment when you use your network dentist
Lifetime orthodontia limit for children and adults	\$3,000 per person	Coverage limited to 24 months of treatment
TMJ (temporomandibular joint) treatment excluding surgery	50% after deductible if not the result of an accident (covered under orthodontia)	Not covered
Implants	Subject to "dental necessity"	Not covered
Annual maximum	\$3,000 per person	None

\* MetLife PDP providers charge negotiated fees for services. For services other than those for preventive care, you must meet the annual deductible before the Plan will pay a percentage of eligible costs. Benefit amounts for out-of-network dentists are based on reasonable and customary charges for your geographic area.

\*\* You can obtain a schedule of charges and a list of providers by calling CIGNA Dental HMO at 1-800-244-6224. Once enrolled, you can obtain a schedule of charges at [www.mycigna.com](http://www.mycigna.com).

\*\*\* Any reimbursements from Delta Dental for orthodontia treatment from 2004-2009 will be applied to the lifetime maximum of \$3,000 under the MetLife PDP.

## MetLife Preferred Dentist Program (PDP)

MetLife Preferred Dentist Program (MetLife PDP) is a preferred provider organization (PPO) consisting of a nationwide network of 126,000 dentists, including 30,000 specialists, who charge negotiated fees that are typically lower than the provider's normal fee; this reduces your out-of-pocket cost.

MetLife PDP offers:

- Total freedom of choice; you can visit any dentist at any time;
- Stringent credentialing requirements for providers;
- Personalized provider directories that you can view online or order by telephone and have faxed or mailed to you.

You can take advantage of the PDP feature, which consists of a network of dentists who accept fees that are typically 10% to 30% less than community average charges. When visiting a participating PDP dentist, you are responsible only for the difference between the Plan's benefit payment amount and the PDP fee.

To locate a participating dentist:

- Visit the MetLife website at [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits), or
- Call 1-888-832-2576 for a provider directory.

When calling to make an appointment, let the dentist know that you participate in the MetLife PDP.

### How the Plan works

MetLife PDP allows you to receive care from a MetLife preferred dentist and any other licensed dentist. At the time you need dental care, you decide whether to visit a preferred dentist or go to a dentist outside the preferred dentist program. The Plan provisions (deductibles, coinsurance, and annual and lifetime maximums) will be the same whether your dentist is a participating provider or not. However, using preferred dentists can reduce your out-of-pocket costs.

### Annual deductible and maximum

Before benefits can be paid in a calendar year, you and/or your covered dependent(s) must meet the \$50 individual or \$150 family deductible. The deductible does not apply to preventive and diagnostic services. However, the deductible does apply to basic, major, and orthodontia services.

You can meet the family deductible as follows:

- Up to three people in a family: each member must meet the individual deductible; or
- Four or more people in a family: expenses can be combined to meet the family deductible. However, no one person can apply more than the \$50 individual deductible toward the \$150 family deductible.

You and/or your covered dependent(s) have an annual maximum benefit of \$3,000 per person (excluding orthodontia). A separate lifetime maximum of \$3,000 per person applies to orthodontia treatments.

### Covered charges

After you have met the deductible, MetLife PDP reimburses covered charges for out-of-network dentists at a percentage of reasonable and customary (R&C) charges. MetLife PDP determines R&C charges based on the amounts charged for a specific service by most dentists in the same geographic area in which you receive care. For network charges, the percentage of reimbursement is based on a percentage of the reduced negotiated fees with the network dentists.

A dental charge is incurred on the date the service is performed or the supply is furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the "preparation date" is considered the date the charge is incurred. The claim will be paid in a lump sum (excluding orthodontia). For example, the preparation date is considered for:

- Root canal therapy as the date the pulp chamber was opened;
- Crowns as the date the tooth was prepared for the crown;
- Partial and complete dentures as the date the impressions were taken; and
- Fixed bridgework as the date the abutment teeth were prepared for the bridge.

Orthodontic payments are paid differently.

## Dental

### Coverage for new orthodontic work

For example, if the orthodontic expense submitted is \$5,000, the Plan will pay the 50% benefit, as follows:

Coverage for orthodontic appliance: MetLife will pay an initial appliance component (sometimes referred to as the “banding” fee), based on 20% of the submitted expense, at the 50% coinsurance level:

- $\$5,000 \times 20\% = \$1,000 \times 50\% \text{ benefit} = \$500$
- First payment will be \$500

### Coverage for monthly payments:

- $\$5,000 - \$1,000 = \$4,000$
- $\$4,000 \div 24 \text{ months} = \$167 \times 50\% \text{ benefit} = \$84$
- Monthly payment will be \$84

A monthly payment of \$84 will be made over the course of treatment, paid each treatment quarter. The first payment will be based on 20% of the expense to cover the appliance fee. The remaining expense will be spread over the expected length of treatment, in this example, 24 months or eight quarterly payments. Orthodontic benefits are subject to the calendar year deductible and the \$3,000 lifetime orthodontic maximum. In this example, assuming the annual deductible has been met, the total amount paid will be \$2,516.

### Coverage for orthodontic work in progress

The MetLife PDP plan pays 50% coinsurance, after the annual deductible is met, up to a \$3,000 lifetime orthodontia maximum. Orthodontic benefits paid since January 1, 2004, under the MetLife and Delta Dental City-sponsored Plan will count toward the lifetime orthodontia maximum across both Plans.

Assume a 24-month orthodontia treatment began in January 2009, and Delta Dental paid \$1,250 for the orthodontia treatment during 2009, and the participant transfers to the MetLife PDP plan effective January 1, 2010. MetLife will calculate the benefits payable in the following way:

\$5,000	Submitted fee
$\times 20\%$	Calculation for the appliance (braces)
\$1,000	Appliance
\$5,000	Submitted fee
$- \$1,000$	Appliance
\$4,000	is divided equally into the 24 treatment months at \$167 per month (not counting the month when the appliance fee was paid).

As of January 2010, MetLife would deduct \$1,000 for the appliance from the \$5,000 submitted fee and the \$167 monthly covered expense charges for the initial 11 months of treatment.

The employee, or the dentist if benefits have been assigned, would begin to receive \$840 per month (50% coinsurance for \$167 covered service charges) in January 2009 for the remaining 13 months of treatment or until the \$3,000 lifetime orthodontia maximum is reached. If the annual deductible has not been satisfied by another claim, it will be taken from the January payment each year.

In this example, since \$1,250 was paid by Delta Dental for service charges in 2009, MetLife would pay \$84 per month for approximately 13 months of treatment or \$1,092 toward the \$3,000 lifetime orthodontia maximum.

Treatment may continue with the 2010 provider (during the 2010 plan year) regardless of whether the provider is in the MetLife Provider Network.

### Before you receive care

Before you receive certain dental services, you are advised to discuss the treatment plan with your dentist to determine what is covered.

## Covered Services

### Preventive and diagnostic services

- Routine oral exams, maximum of two exams per calendar year;
- Routine cleanings, maximum of two cleanings per calendar year;
- Fluoride treatments through age 18, maximum of one application per calendar year;
- Space maintainers through age 18;
- Full mouth series and panoramic X-rays, once every 36 months;
- Bitewing X-rays, up to two bitewing X-rays per calendar year (up to eight films per visit);

- Sealants, permanent molars only through age 16, one application every 36 months; and
- Palliative treatments: emergency treatment only; not paid as a separate benefit from other services on the same day.

## Basic services

- Fillings (except gold fillings): includes amalgam (“silver”) and composite (“white”) fillings to restore injured or decayed teeth;
- Extractions;
- Endodontic treatment;
- Oral surgery, unless covered under your medical plan or your HMO;
- Repair prosthetics: no limit;
- Recementing (crowns, inlays, onlays, bridgework, or dentures): no limit;
- Addition of teeth to existing partial or full denture;
- Denture relining and rebasing: once every 36 months;
- Periodontal maintenance treatments, up to four per calendar year; this covers up to two regular cleanings per year paid at 100% and up to four periodontal maintenance visits per year paid at 80%. These services are combined and do not exceed four per year in total;
- Periodontal scaling and root planing: no limit (subject to consultant review);
- Bruxism appliance; and
- General anesthesia, when medically necessary, as determined by the Claims Administrator and administered in connection with a covered service.

## Major services

- Inlays, onlays, and crowns (including precision attachments for dentures; must be at least five years old and unserviceable); limited to one per tooth every five years;
- Removable dentures, initial installation, and any adjustments made within the first six months;

- Removable dentures (replacement of an existing removable denture or fixed bridgework with new denture; dentures must be at least five years old and unserviceable); limited to once every five years;
- Fixed bridgework, including inlays, onlays, and crowns used to secure a bridge (initial installation);
- Fixed bridgework, including inlays, onlays, and crowns used to secure a bridge (replacement of an existing removable denture or fixed bridgework with new fixed bridgework or addition of teeth to existing fixed bridgework; bridgework must be at least five years old and unserviceable); limited to once every five years; and
- Dental implants (subject to medical necessity and consultant review); medical necessity, as determined by the Claims Administrator, is based on the number and distribution of all missing, unreplaced teeth in the arch, as well as the overall periodontal condition of the remaining normal teeth.

## Oral cancer services

Dental coverage may be available for those participants diagnosed with oral cancer.

## Orthodontia services

- Orthodontic X-rays;
- Evaluation;
- Treatment plan and record;
- Services or supplies to prevent, diagnose, or correct a misalignment of teeth, bite, jaws, or jaw joint relationship;
- Removable and/or fixed appliance(s) insertion for interceptive treatment;
- Temporomandibular joint (TMJ) disorder appliances (for TMJ dysfunction that does not result from an accident); and
- Harmful habit appliances; includes fixed or removable appliances.

### Procedures and services that are not covered

Benefits are not provided for services and supplies not medically necessary for the diagnosis or treatment of dental illness or injury. For example, cosmetic services such as tooth whitening are elective in nature and, therefore, not covered by the Plan. Medical necessity is the treatment of dental diseases such as dental decay and periodontal (gum) diseases. Dental services must be performed by a dentist licensed to practice in the state or by a legally qualified physician. A dentist is a doctor of dental surgery or a doctor of medical dentistry.

The Plan Administrator, acting through the Claims Administrator, reserves the right to determine whether, in its judgment, a service or supply is medically necessary or payable under this Plan. The fact that a dentist has prescribed, ordered, recommended, or approved a service or supply does not, in itself, make it medically necessary.

The following exclusions apply to the MetLife PDP and are *not* covered by the Plan:

- Dental care received from a dental department maintained by an employer, mutual benefit association, or similar group;
- Treatment performed for cosmetic purposes;
- Use of nitrous oxide;
- Treatment by anyone other than a licensed dentist, except for dental prophylaxis performed by a licensed dental hygienist under the supervision of a licensed dentist;
- Services in connection with dentures, bridgework, crowns, and prosthetics if for:
  - Prosthetics started before the patient became covered;
  - Replacement within five years of a prior placement covered under this Plan;
  - Extensions of bridges or prosthetics paid for under this Plan, unless into new areas;
  - Replacement due to loss or theft;
- Teeth that are restorable by other means or for the purpose of periodontal splinting; and
- Connecting (splinting) teeth, changing or altering the way the teeth meet, restoring the bite (occlusion), or making cosmetic changes.
- Any work done or appliance used to increase the distance between nose and chin (vertical dimension);
- Facings or veneers on molar crowns or molar false teeth;
- Training or supplies used to educate people on the care of teeth;
- Charges for crowns and fillings not covered under basic services;
- Any charges incurred for services or supplies not recommended by a licensed dentist;
- Any charges incurred due to sickness or injury that is covered by a Workers' Compensation Act or other similar legislation or arising out of or in the course of any employment or occupation whatsoever for wage or profit;
- Any charges incurred while confined in a hospital owned or operated by the U.S. government or an agency thereof for treatment of a service-connected disability;
- Any charges that, in the absence of this coverage, you would not be legally required to pay;
- Any charges incurred that result directly or indirectly from war (whether declared or undeclared);
- Any charges due to injuries sustained while committing a felony, assault, or during a riot or insurrection;
- Any charges for services and supplies furnished for you or your eligible dependent(s) prior to the effective date of coverage or subsequent to the termination date of coverage;
- Any charges for services or supplies that are not generally accepted in the U.S. as being necessary and appropriate for the treatment of dental conditions including experimental care;
- Any charges for nutritional supplements and vitamins;
- Services covered by motor vehicle liability insurance;
- Services that would be provided free of charge but for coverage;

- Broken appointments;
- Charges for filing claims or charges for copies of X-rays;
- Any charges for services rendered to sound and natural teeth injured in an accident;
- Care and treatment that is in excess of the reasonable and customary charge; and
- Services that, to any extent, are payable under any medical benefits, including HMOs.

## Alternate benefit provision

Before deciding how much the Plan will pay for covered procedures, MetLife will consider any less-costly alternatives that will produce a satisfactory result based on generally accepted dental standards of care. You and your dentist may choose the more costly procedure, but you will be responsible for the difference in cost between the benefit amount and the dentist's charge.

## Predetermination of benefits

MetLife recommends that you obtain a predetermination of benefits before undergoing any procedure that will cost more than \$300. By requesting a predetermination of benefits, you will know in advance how much you will be responsible for paying. Then, you can choose whether to continue with the more expensive treatment or the alternate procedure.

If you do not request a predetermination of benefits, you may find that the Plan will pay less than you anticipated or nothing at all, depending on the procedure and treatment provided.

## Filing a claim

When you visit the dentist, you will pay the dentist directly and then submit a claim for benefits. See "Claims and appeals for MetLife PDP" on page 126.

## CIGNA Dental HMO

CIGNA Dental HMO Care operates like a health maintenance organization: Once enrolled, you must receive all services from the CIGNA Dental HMO provider you selected. Except for emergency treatment for pain, you will not be covered for any dental services you receive outside the CIGNA Dental HMO network. See the CIGNA Dental HMO Patient Charge Schedule.

As a CIGNA Dental Plan member, you may be eligible for various discounts, benefits, and other consideration for the purpose of promoting your general health and well being. Visit the CIGNA website at [www.mycigna.com](http://www.mycigna.com).

Enrollment in the CIGNA Dental HMO allows the release of the enrolled member's dental records to CIGNA Dental for administrative purposes.

The CIGNA Dental HMO has no annual individual or family deductibles and no lifetime dollar maximums. Most preventive services are 100% paid when you use a network general dentist. You pay a pre-set patient charge when you use a network general dentist for other services. See the "Patient Charge Schedule" on page 123 for more information. You can obtain a schedule of charges when you enroll in the CIGNA Dental HMO or by calling CIGNA Dental at 1-800-CIGNA24 or at [www.mycigna.com/dental](http://www.mycigna.com/dental).

## Is your dentist in the CIGNA Dental HMO network?

CIGNA Dental contracts with network dentists in most areas of the country. Network dentists provide covered services to CIGNA Dental members at independently owned network dental offices. You can request a list of network dental offices in your area by calling CIGNA Dental at 1-800-CIGNA24. You can also find a provider at the CIGNA website,

[http://cigna.benefitnation.net/cigna/\(ksmtg545tv tqiyezhahstk45\)/docdir.aspx](http://cigna.benefitnation.net/cigna/(ksmtg545tv tqiyezhahstk45)/docdir.aspx).

If you want to enroll in the CIGNA Dental HMO but have a dentist whom you want to continue using, you should verify that your dentist is in the CIGNA Dental HMO. Since this Plan has no out-of-network benefits, other than for emergency treatment for pain, you won't be reimbursed for any dental services if you continue to visit your current dentist and he or she is not in the CIGNA network.

# Dental

---

If you do not choose a primary dentist when you enroll, CIGNA Dental HMO will assign a dentist to you based on your home zip code.

CIGNA Dental HMO confirms that each dentist in its network is properly licensed, certified, and insured and complies with government health standards.

## CIGNA Dental HMO features

- A nationwide network of approximately 34,000 dentists (you must use one of these providers);
- No deductibles to meet;
- No annual or lifetime dollar maximums;
- No charge for exams, X-rays, or routine cleanings;
- Reduced prices on covered procedures when there is a charge;
- Specialist care with an approved referral at the same fees you would pay a general dentist;
- Automated Dental Office Locator for 24-hour information by telephone or fax to help you find the right dentist;
- Automatic participation in the CIGNA Healthy Rewards® program, which offers discounts on various health-related services and products; for more information, visit [www.cigna.com](http://www.cigna.com);
- Orthodontia for children and adults limited to 24 months of treatment; additional treatment is available at a prorated cost of the initial treatment;
- Coverage for general anesthesia and IV sedation *when medically necessary and performed by a network oral surgeon or periodontist for covered procedures*; general anesthesia does not include nitrous oxide; and
- One routine cleaning every six months at no charge for normal healthy teeth and gums; you may pay for additional cleanings; charges are listed on the Patient Charge Schedule.

## Referrals for children

You are not required to obtain a referral from a network general dentist for a CIGNA Dental HMO member under age 7 to be treated by a network pediatric dentist. Exceptions for coverage at the network pediatric dentist for children ages 7 and older are considered for clinical and/or medical reasons.

## How the Plan works

When you enroll in the CIGNA Dental HMO, you must select a network dental office. If your first or second choice is not available, the network dental office nearest your home will be selected for you.

You can choose a different dentist in the network for yourself and each of your dependents. When you visit a network office, you will pay the amount shown on your Patient Charge Schedule for covered services. If you undergo a procedure that is not on your Patient Charge Schedule, you will pay the dentist's usual charges. If you visit an office other than your network dental office, you will pay the dentist's usual charges, except for emergencies or as authorized by CIGNA Dental.

## Specialized care

If your network general dentist determines that you need specialized dental care, your network general dentist will begin the specialty referral process. Follow your network general dentist's instructions regarding access to specialty care. Care from a network specialist is covered when CIGNA Dental authorizes payment. Treatment by a network specialist must begin within 90 days from the date of CIGNA Dental's authorization. If you are unable to obtain treatment within the 90-day period, call Member Services to request an extension. Your coverage must be in effect when each procedure begins. A referral is not necessary when visiting an orthodontist or pediatric dentist who participate in the CIGNA Dental HMO Network. **Note:** Services performed by a Pediatric Dentist are covered until the child reaches age 7. Services performed after the child reaches age 7 are not covered.

You should verify with the network specialist that your treatment plan has been authorized for payment by CIGNA Dental before treatment begins. If you receive specialty care, and payment is not authorized by CIGNA Dental, you may be responsible for the network specialist's usual charges.

## Changing your dentist

If you decide to change your network dental office, CIGNA Dental can arrange a transfer. You and your enrolled dependents may each transfer to a different network general dentist. You should complete any dental procedure in progress before transferring to another dental office.

To arrange a transfer, call Member Services at 1-800-CIGNA24. Your transfer request will take about five days to process. Transfers generally will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new dental office until your transfer becomes effective.

There is no charge to you for the transfer. However, all patient charges that you owe to your current dental office must be paid before the transfer can be processed.

## Appointments

To make an appointment with your network general dentist, call the dental office that you have selected. When you call, your dental office will ask for your ID number and will check your eligibility.

## Broken appointments

The time your network general dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your dental office to maintain a schedule that is convenient for you and efficient for the staff. The delay in treatment resulting from a broken appointment can turn a minor problem into a complex one resulting in higher cost to you, your dentist, and CIGNA Dental.

If you or your enrolled dependent(s) breaks an appointment with fewer than 24 hours' notice to the dental office, you may be charged a broken appointment fee for each 15 minute block of time that was reserved for your care. Consult your patient charge schedule for maximum charges for broken appointments (not applicable in **Texas**).

## Patient Charge Schedule

The Patient Charge Schedule lists the benefits of the CIGNA Dental HMO including covered procedures and patient charges. Patients pay the patient charges listed only when the procedures are performed by a network dentist. Procedures performed by an out-of-network dentist are not covered, and patients will be charged the dentist's usual fee for those procedures. Procedures not listed on the patient charge schedule are not covered and are the patient's responsibility at the dentist's usual fees. You may request a patient charge schedule when you enroll in the CIGNA Dental HMO or by calling CIGNA Dental at 1-800-CIGNA24 or at [www.mycigna.com](http://www.mycigna.com) (if you are already a member).

## Emergencies

An emergency is a dental condition of recent onset and severity that would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your network general dentist if you have an emergency.

Examples of a dental emergency include:

- The loss of a large filling in a tooth or crown or a cracked tooth that resulted in significant acute pain and discomfort or
- Swelling of the mouth that is a result of an infection, normally associated with an abscess.

Examples of non-dental emergencies include:

- A slight injury that did not result in significant bleeding, severe pain or acute infection;
- A sore spot under dentures that has created a small ulcer;
- A wisdom tooth that is erupting or painful, but there is no swelling; or
- A chipped tooth that produced a sensitive spot that irritates the tongue.

Routine restorative or definitive treatment (Root Canal Therapy) is not considered emergency care and should be performed or referred by the network general dentist or network pediatric dentist.

## Away from home

If you have an emergency while you are out of your service area or unable to contact your network general dentist, you may receive emergency covered services from any general dentist. Routine restorative procedures or definitive treatment (e.g., root canal) are not considered emergency care. You should return to your network general dentist for these procedures. For emergency covered services, you will be responsible for the patient charges listed on your Patient Charge Schedule. CIGNA Dental will reimburse you the difference, if any, between the dentist's usual fee for emergency covered services and your patient charge, up to a total of \$50 per incident.

## Dental

---

- For **Arizona** residents: An emergency is a dental problem that requires immediate treatment (includes control of bleeding, acute infection, or relief of pain including local anesthesia). Reimbursement for emergencies will be made by CIGNA Dental in accordance with your plan benefits regardless of the location of the facility providing the services.
- For **Pennsylvania** residents: If any emergency arises and you are out of your service area or are unable to contact your network general dentist, CIGNA Dental covers the cost of emergency dental services so that you are not responsible for greater out-of-pocket expenses than if you were attended by your network general dentist.
- For **Texas** residents: Emergency dental services are limited to procedures administered in a dental office, dental clinic, or other comparable facility to evaluate and stabilize emergency dental conditions of recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would cause a prudent layperson with average knowledge of dentistry to believe that immediate care is needed.

To receive reimbursement, send appropriate reports and X-rays to the CIGNA Dental address listed below.

CIGNA Dental  
P.O. Box 188045  
Chattanooga, TN 37422-8045

## After hours

There is a patient charge listed on your patient charge schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable patient charges.

## Member Services

If you have any questions or concerns about the CIGNA Dental HMO, call a Member Services representative who can explain your benefits or help with matters regarding your dental office or the Plan. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, covered services, plan benefits, ID cards, location of dental offices, conversion coverage or other matters, call Member Services at 1-800-CIGNA24. The hearing impaired may contact the state TTY toll-free relay service in their local telephone directory.

## Limitations on covered services

- **Frequency:** See the Patient Charge Schedule for limitations on frequency of covered services, such as cleaning.
- **Specialty care:** Except for pediatric dentistry and endodontics, payment authorization is required for coverage of services performed by a Network Specialty Dentist.
- **Pediatric dentistry:** Coverage from a pediatric dentist ends on a covered child's seventh birthday. CIGNA Dental HMO may consider exceptions for medical reasons on an individual basis. The network general dentist will provide care after the child's seventh birthday.
- **Oral surgery:** The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is for orthodontic reasons only. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Orthodontics in progress.** If orthodontic treatment is in progress for you or your dependent at the time you enroll, call Member Services at 1-800-CIGNA24 to find out if you are entitled to any benefit under the Plan.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered under your Patient Charge Schedule.

*You will pay full cost of procedures and services that are not covered.* Visit the CIGNA website at **[www.cigna.com](http://www.cigna.com)**, or call 1-800-244-6224 for more information.

## Conversion to an individual policy

You may have the right to convert your CIGNA Dental HMO coverage into an individual policy after you terminate employment with Citi. For more information, see the Plan document on the Benefits Handbook website at **[www.benefitsbookonline.com](http://www.benefitsbookonline.com)**, available from the Citi intranet and the Internet. No password is needed. If you do not have access to the Citi intranet or the Internet, you can request a copy at no cost to you by speaking with a Citi Benefits Center representative through ConnectOne. Call 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

## Procedures and services that are not covered

Listed below are the services or expenses that are *not* covered under the CIGNA Dental HMO. These services are your responsibility and are billed by the dentist at his/her usual fee:

- Services not listed on the Patient Charge Schedule, as described later in this section;
  - Services provided by an out-of-network dentist without CIGNA Dental's prior approval (except Emergencies, as explained under "Emergencies" on page 123);
  - Services related to an injury or illness covered under Workers' Compensation, occupational disease or similar laws (For **Florida** residents, this exclusion relates to such services paid under Workers' Compensation, occupational disease or similar laws);
  - Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program other than Medicaid;
  - Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war;
  - Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule;
  - General anesthesia, sedation, and nitrous oxide unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when medically necessary and provided in conjunction with covered services performed by an oral surgeon or periodontist. (For **Maryland** residents, general anesthesia is covered when medically necessary and authorized by your physician);
  - Prescription drugs;
  - Procedures, appliances or restorations if the main purpose is to change vertical dimension (degree of separation of the jaw when teeth are in contact); to diagnose or treat abnormal conditions of the temporomandibular joint ("TMJ") unless TMJ therapy is specifically listed on your Patient Charge Schedule; or to restore teeth damaged by attrition, erosion or abrasion, and/or abfraction. (For **California** residents, the word "attrition" is modified as follows: except for medically necessary treatment where functionality of teeth has been impaired);
  - The completion of crown and bridge, dentures, or root canal treatment already in progress on the date you become covered by the Plan (For **Texas** residents, pre-existing conditions, including the completion of crown and bridge, dentures, or root canal treatment already in progress on the effective date of your coverage, are not excluded if otherwise covered under your Patient Charge Schedule);
  - Replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen, or damaged due to patient abuse, misuse, or neglect;
  - Services associated with the placement or prosthodontic restoration of a dental implant;
  - Services considered unnecessary or experimental in nature (For **Pennsylvania** residents, this exclusion applies only to services considered experimental in nature. For **California** and **Maryland** residents, this exclusion applies only to services considered unnecessary);
  - Procedures or appliances for minor tooth guidance or to control harmful habits;
  - Hospitalization, including any associated incremental charges for dental services performed in a hospital. Benefits are available for network dentist charges for covered services performed at a hospital; other associated charges are not covered and should be submitted to your medical carrier for benefit determination);
  - Services to the extent you are compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy (For **Arizona** and **Pennsylvania** residents, this exclusion does **not** apply. For **Kentucky** and **North Carolina** residents, this exclusion does **not** apply to services compensated under no-fault auto or insured motorist policies. For **Maryland** residents, this exclusion does **not** apply to services compensated under group medical plans.);
  - Crowns and bridges used solely for splinting; and
  - Resin bonded retainers and associated pontics.
- Except for the limitations listed above, pre-existing conditions are not excluded.

## Filing claims

You do not need to file any claims for benefits. However, if benefit payment is denied, you may file an appeal. See “Claims and appeals for the CIGNA Dental HMO” on page 127.

## Extension of benefits

Coverage for a dental procedure, other than for orthodontics, which was started before you dropped coverage, will be extended for 90 days after the date coverage ends unless coverage loss was due to non-payment of premiums.

**Coverage for orthodontic treatment started before you dropped coverage will be extended to the end of the quarter or for 60 days after the date coverage ends, whichever is later, unless coverage loss was due to non-payment of premiums.**

## Disclosure Statement

CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc. and its operating subsidiaries. The CIGNA Dental Care Plan is provided by CIGNA Dental Health Plan of Arizona, Inc., CIGNA Dental Health of California, Inc., CIGNA Dental Health of Colorado, Inc., CIGNA Dental Health of Delaware, Inc., CIGNA Dental Health of Florida, Inc., a prepaid limited health services organization licensed under Chapter 636, Florida Statutes, CIGNA Dental Health of Kansas, Inc. (Kansas and Nebraska), CIGNA Dental Health of Kentucky, Inc., CIGNA Dental Health of Maryland, Inc., CIGNA Dental Health of Missouri, Inc., CIGNA Dental Health of New Jersey, Inc., CIGNA Dental Health of North Carolina, Inc., CIGNA Dental Health of Ohio, Inc., CIGNA Dental Health of Pennsylvania, Inc., CIGNA Dental Health of Texas, Inc., CIGNA Dental Health of Virginia, Inc. In other states, the CIGNA Dental Care plan is underwritten by Connecticut General Life Insurance Company or CIGNA HealthCare of Connecticut, Inc. and administered by CIGNA Dental Health, Inc.

# Claims and Appeals

## Claims and appeals for MetLife PDP

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

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

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

You have the right to request a reconsideration of the denied claim by calling or writing MetLife. Any additional information that you feel would support the claim should be provided to MetLife.

If after the review it is determined that the initial denial can be reversed and claim paid, normal processing steps are followed. If after the review it is determined that the original denial stands, a denial letter is written.

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

- Explanation of why the charges are denied in plain language and
- Reference to the plan (booklet) wording which justifies the denial.

The appeal request must be submitted in writing to MetLife within 180 days of receipt of the denial letter. As part of this review, you or your legal representative has the right to review all pertinent documents and submit issues and comments in writing to a committee selected by MetLife. The committee consists of senior representatives of MetLife Dental Claim Management and a Dental Consultant.

For preservice and post-service claim appeals, Citi has delegated to MetLife as Claims Administrator the exclusive right to interpret and administer the provisions of the Dental Benefit Plan. The Claims Administrator's decisions are conclusive and binding. Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

## Claims and appeals for the CIGNA Dental HMO

If you have a concern about your dental office or the CIGNA Dental Plan, call 1-800-CIGNA24 and explain your concern to a Member Services representative. You can also express that concern to CIGNA Dental in writing. Most matters can be resolved with the initial phone call. If more time is needed to review or investigate your concern, CIGNA Dental will respond to you as soon as possible, usually by the end of the next business day but in any case within 30 days.

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

CIGNA Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to the CIGNA Dental Plan within one year from the date of the initial CIGNA Dental decision. You should state the reason why you believe your request should be approved and include any information supporting your request. If you are unable or choose not to write, you can ask Member Services to register your appeal by calling 1-800-CIGNA24.

## CIGNA Dental level one appeal

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

If your appeal concerns a denied pre-authorization, CIGNA Dental will respond with a decision 15 calendar days after your appeal is received. For appeals concerning all other coverage issues, CIGNA Dental will respond with a decision within 30 calendar days after your request is received. If we need more information to make your level-one appeal decision, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

- For New Jersey residents, CIGNA Dental will respond in writing within 15 working days;
- For Colorado residents, CIGNA Dental will respond within 20 working days; and
- For Nebraska residents, CIGNA Dental will respond within 15 working days if your complaint involves an adverse determination.

If you are not satisfied with the decision, you may request a level two appeal.

## CIGNA Dental level two appeal

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review. The Level-Two Appeals process does not apply to resolutions made solely on the basis that the Plan does not provide benefits for the service performed or requested.

The review will be completed within 30 calendar days. If we need more information to complete the appeal, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

## Dental

---

### CIGNA Dental expedited appeal

You may request that the complaint or appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the plan will respond orally with a decision within 72 hours, followed up in writing.

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

### CIGNA Dental independent review

The independent review procedure is a voluntary program arranged by the Plan and is not available in all areas. Contact CIGNA Dental at 1-800-CIGNA24 for more details.

### Appeals to the state

You have the right to contact your state's Department of Insurance or Department of Health for assistance at any time.

CIGNA Dental will not cancel or refuse to renew coverage because you or your dependent has filed a complaint or appealed a decision made by CIGNA Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.