# Dental

Citi offers two dental options to provide dental care for you and your eligible dependents (including your spouse/civil union partner/domestic partner). They are the:

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

You can enroll in Citi dental coverage even if you do not enroll in Citi medical coverage. You can enroll in any of the 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.

The 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

The Cigna Dental HMO costs less than the 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 138.

### 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.

If you choose medical coverage under the Basic or Premier High Deductible Health Plans and establish a Healthcare Savings Account (HSA), you may pay for eligible dental expenses with funds from your HSA.

For details, see the HSA section in the *Spending Account* section.

## Contents

# Dental options at a glance

| | 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 maximum allowed amount 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**.

***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)

The 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.

The MetLife PDP offers:

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

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 PDP dentist, you are responsible only for the difference between the Plan's benefit payment amount and the PDP dentist's fee.

To find out if your dentist is in the PDP network:

- Visit the MetLife website at **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

The MetLife PDP allows you to receive care from any dentist. At the time you need dental care, you decide whether to visit a PDP dentist or go to a dentist outside the PDP network. The Plan provisions (deductibles, coinsurance, and annual and lifetime maximums) will be the same whether your dentist is a PDP 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 maximum family deductible. The deductible does not apply to preventive and diagnostic services. However, the deductible does apply to basic, major, and orthodontia services.

You can meet the family deductible as follows:

- Up to three people in a family: Each member must meet the individual deductible; 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 treatment.

## Covered charges

After you have met the deductible, the MetLife PDP reimburses covered charges for out-of-network dentists at a percentage of maximum allowed amount (MAA) charges. The MetLife PDP determines MAA based on the amounts charged for a specific service by most dentists in the same geographic area. For network charges, the reimbursement is based on a percentage of the fees negotiated with the network dentists.

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

- Root canal therapy as the date the pulp chamber was opened;
- 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.

## Coverage for new orthodontic work

If the orthodontic expense submitted is $5,000, for example, 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 × 20% = $1,000 × 50% benefit = $500
- First payment will be $500

## Coverage for monthly payments:

- $5,000 - $1,000 = $4,000
- $4,000 ÷ 24 months = $167 × 50% 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 orthodontia maximum. In this example, assuming the annual deductible has been met, the total amount paid will be $2,516.

## Coverage for orthodontic work in progress

The MetLife PDP pays 50% coinsurance, after the annual deductible is met, up to a $3,000 lifetime orthodontia maximum. Orthodontia benefits paid since January 1, 2004, under the MetLife and Delta Dental Citi-sponsored Plan (as of January 1, 2010, the Delta Plan was no longer available) will count toward the lifetime orthodontia maximum across both Plans.

## 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.

# Dental

## Covered services

### Preventive and diagnostic services

- Routine oral exams, maximum of two exams per calendar year (additional medically necessary oral exams will be reviewed by MetLife Dental Consultants);
- Routine cleanings, maximum of two cleanings per calendar year;
- Fluoride treatments through age 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 interreceptive treatment;
- Temporomandibular joint (TMJ) disorder appliances (for TMJ dysfunction that does not result from an accident); and
- Harmful habit appliances; includes fixed or removable appliances.

## Procedures and services that are not covered

Benefits are not provided for services and supplies not medically necessary for the diagnosis or treatment of dental illness or injury. For example, cosmetic services such as tooth whitening are elective in nature and, therefore, not covered by the Plan. 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.

Exclusions that apply to the MetLife PDP include, but are not limited to, the following, which 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 or assault or during a riot or insurrection;
- Any charges for services and supplies furnished for you or your eligible dependent(s) prior to the effective date of coverage or subsequent to the termination date of coverage;

# Dental

- Any charges for services or supplies that are not generally accepted in the United Students 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 alternative procedure.

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

## Medical necessity

Medical necessity is the treatment of dental diseases, such as dental decay and periodontal (gum) diseases. Dental services must be performed by a dentist licensed to practice in the state or by a legally qualified physician. A dentist is a doctor of dental surgery or a doctor of medical dentistry.

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

## Filing a claim

When you visit the dentist, you will pay the dentist directly and then submit a claim for benefits. See "Claims and appeals for the MetLife PDP" on page 144.

# Cigna Dental HMO

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

As a Cigna Dental Plan member, you may be eligible for various discounts, benefits, and other considerations to promote your general health and well being. Visit the Cigna website at **www.mycigna.com**.

Enrollment in the Cigna Dental HMO allows the release of your and your covered dependents' dental records to Cigna Dental for administrative purposes.

The Cigna Dental HMO has no annual individual or family deductibles and no lifetime dollar maximums. Most preventive services are 100% paid when you use a network general dentist. You pay a patient charge when you use a network general dentist for other services. See "Patient Charge Schedule" on page 140 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 visit **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 HMO members at independently owned network dental offices. You can request a list of network dental offices in your area by calling Cigna Dental at **1-800-Cigna24**. You can also find a provider on the Cigna website at **http://cigna.benefitnation.net/cigna/(ksmtg545tvtqiyezhahstk45)/docdir.aspx.**

If you want to enroll in the Cigna Dental HMO but have a dentist whom you want to continue using, you should verify that he or she is in the Cigna Dental HMO. 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 Dental HMO network.

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

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

# Cigna Dental HMO features

- A nationwide network of approximately 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**;
- Orthodontia for children and adults limited to 24 months of treatment; additional treatment is available at a prorated cost of the initial treatment;
- Coverage for general anesthesia and IV sedation *when medically necessary and performed by a network oral surgeon or periodontist for covered procedures;* general anesthesia does not include nitrous oxide; and
- Two routine cleanings for normal healthy teeth and gums every calendar year at no charge and two additional per calendar year with a copayment; charges are listed on your Patient Charge Schedule.

# Referrals for children

You are not required to obtain a referral from a network general dentist for a Cigna Dental HMO member under age 7 to be treated by a network pediatric dentist. Exceptions for coverage at the network pediatric dentist for children 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 covered dependents. When you visit a network office, you will show your Cigna Dental HMO ID card and pay the amount shown on your Patient Charge Schedule for covered services. If you undergo a procedure that is not on your Patient Charge Schedule, you will pay the dentist's usual charges. If you visit an office other than your network dental office, you will pay the dentist's usual charges, except for emergencies or as authorized by Cigna Dental.

## Specialized care

If your network general dentist determines that you need specialized dental care, he or she will begin the specialty referral process. Follow your network general dentist's instructions regarding access to specialty care. Care from a network specialist is covered when Cigna Dental authorizes payment. Treatment by a network specialist must begin within 90 days from the date of Cigna Dental's

authorization. If you are unable to obtain treatment within the 90-day period, call Member Services to request an extension. Your coverage must be in effect when each procedure begins. A referral is not necessary when visiting an orthodontist or pediatric dentist who participates in the Cigna Dental HMO network. **Note:** Services performed by a pediatric dentist are covered until the child reaches age 7. Services performed by a pediatric dentist after the child reaches age 7 are not covered.

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

## Changing your dentist/dental office

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

To arrange a transfer, call Member Services at **1-800-Cigna24**. Your transfer request will take about five days to process. Transfers generally will be effective the first day of the month after your request is processed. Unless you have an emergency, you will be unable to schedule an appointment at the new dental office until your transfer becomes effective.

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

## Appointments

To make an appointment with your network general dentist, call the dental office that you have selected or to which you have been assigned. When you call, your dental office will ask for your ID number (which can be found on your Cigna Dental HMO ID card) and will check your eligibility.

## Broken appointments

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

Your Patient Charge Schedule lists the benefits of the Cigna Dental HMO including covered procedures and patient charges. Patients pay the patient charges listed only when the procedures are performed by a network dentist. Procedures performed by an out-of-network dentist are not covered, and patients will be charged the dentist's usual fee for those procedures. Procedures not listed on your Patient Charge Schedule are not covered and are the patient's responsibility at the dentist's usual fees. You may request your Patient Charge Schedule when you enroll in the Cigna Dental HMO or by calling Cigna Dental at **1-800-Cigna24** or visit **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 to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your network general dentist if you have an emergency.

Examples of a dental emergency include:

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

Examples of non-dental emergencies include:

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

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

## Away from home

If you have an emergency while you are out of your service area or unable to contact your network general dentist, you may receive emergency covered services from any general dentist. Routine restorative procedures or definitive 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 for the difference, if any, between the dentist's usual fee for emergency covered services and your patient charge, up to a total of $50 per incident.

- For **Arizona** residents: An emergency is a dental problem that requires immediate treatment (includes control of bleeding, acute infection, or relief of pain including local anesthesia). Reimbursement for emergencies will be made by Cigna Dental in accordance with your plan benefits regardless of the location of the facility providing the services.
- For **Pennsylvania** residents: If any emergency arises and you are out of your service area or are unable to contact your network general dentist, Cigna Dental covers the cost of emergency dental services so that you are not responsible for greater out-of-pocket expenses than if you were attended by your network general dentist.
- For **Texas** residents: Emergency dental services are limited to procedures administered in a dental office, dental clinic, or 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 following Cigna Dental address:

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

## After hours

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

# Member Services

If you have any questions or concerns about the Cigna Dental HMO, call a Member Services representative who can explain your benefits or help with matters regarding your dental office 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**. If you are hearing impaired, call the state TTY toll-free relay service in your local telephone directory.

## Limitations on covered services

- **Frequency:** See your Patient Charge Schedule for limitations on frequency of covered services, such as cleaning.
- **Specialty care:** Except for pediatric dentistry and endodontics, payment authorization from the Cigna Dental HMO is required for coverage of services performed by a network specialty dentist.
- **Pediatric dentistry:** Coverage from a pediatric dentist ends on a covered child's seventh birthday. Cigna Dental HMO may consider exceptions for medical reasons on an individual basis. The network general dentist will provide care after the child's seventh birthday.
- **Oral surgery:** The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is for orthodontic reasons only. Your Patient Charge Schedule lists any limitations on oral surgery.
- **Orthodontics in progress.** If orthodontic treatment is in progress for you or your dependent at the time you enroll, call Member Services at **1-800-Cigna24** 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**, or call **1-800-244-6224** for more information.

## Conversion to an individual policy

You may have the right to convert your Cigna Dental HMO coverage into an individual policy after you terminate employment with Citi. For more information, contact the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

## Procedures and services that are not covered

Listed below are the services or expenses that are *not* covered under the Cigna Dental HMO (this list is not exhaustive, and other exclusions may apply). These services are your responsibility and are billed by the dentist at his/her usual fee:

- Services not listed on your Patient Charge Schedule;
- Services provided by an out-of-network dentist without Cigna Dental's prior approval (except emergencies, as explained under "Emergencies" on page 140);
- 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 144.

## 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 orthodontia 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

This section describes the claims and appeals process for the MetLife PDP and the Cigna Dental HMO.

## Claims and appeals for the MetLife PDP

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

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

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

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

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

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

- An explanation in plain language of why the charges are denied in plain language and
- A reference to the wording from this Plan Document that justifies the denial.

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

For preservice and post-service claim appeals, Citi has delegated to MetLife as Claims Administrator the exclusive right to interpret and administer the provisions of the Dental Benefit Plan. The Claims Administrator's decisions are conclusive and binding. The Claims Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination 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 HMO, 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 telephone call. If more time is needed to review or investigate your concern, Cigna Dental will respond to you as soon as possible, usually by the end of the next business day but in any case within 30 days.

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

Cigna Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to the Cigna Dental HMO within one year from the date of the initial Cigna Dental decision. You should state the reason why you believe your request should be approved and include any information supporting your request. If you are unable or choose not to write, you can ask Member Services to register your appeal by calling **1-800-Cigna24**.

## Cigna Dental HMO 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 precertification, Cigna Dental will respond with a decision within 15 calendar days after your appeal is received. For appeals concerning all other coverage issues, Cigna Dental will respond with a decision within 30 calendar days after your request is received. If Cigna Dental needs more information to make your level-one appeal decision, it will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

- For **New Jersey** residents, Cigna Dental will respond in writing within 15 working days;
- For **Colorado** residents, Cigna Dental will respond within 20 working days; 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 HMO 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 Cigna Dental needs more information to complete the appeal, it will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

## Cigna Dental HMO expedited appeal

You may request that the complaint or appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life 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. Call Cigna Dental at **1-800-Cigna24** for details.

## Appeals to the state

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

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