Citigroup Dental Benefit Plan

Amended and Restated as of January 1, 2009

Citigroup Dental Benefit Plan

This plan document sets forth the terms and conditions of your benefits under the Citigroup Dental Benefit Plan (the "Plan"), as amended and restated as of January 1, 2009. Citigroup Inc. ("Citi") has entered into an arrangement with MetLife, Delta Dental and CIGNA Dental to administer the Plan. This document should be read in combination with the "About Your Health Care Benefits" document, amended and restated as of January 1, 2009, which is also a component of the Citigroup Dental Benefit Plan document.

Citi offers three dental options to provide dental care for you and your eligible dependents. The three dental options are:

- MetLife Preferred Dentist Program (MetLife PDP);
- Delta Dental; and
- CIGNA DHMO (dental health maintenance organization).

As you read the document, you will see some terms that are bold and underlined. This means that the term is a reference to another section of the document (including the About Your Health Care Benefits component).

As explained in more detail in the About Your Health Care Benefits document, Citi reserves the right to amend or terminate the Plan at any time.

This section of the document is intended to comply with the requirements of ERISA and other applicable laws and regulations. It does not create a contract or guarantee of employment between Citi and any individual.

Citigroup Dental Benefit Plan

MetLife Preferred Dentist Program

MetLife Preferred Dentist Program (MetLife PDP) is a preferred provider organization (PPO) consisting of a nationwide network of general and specialty dentists.

To locate a participating dentist:

- Visit the MetLife Web site at www.metlife.com/dental/; or
- Call 1-888-832-2576.

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

The following is a summary of features covered under MetLife PDP. Types of services and limitations are outlined in the "Covered services and limitations" section on page 4.

Type of service	Coverage*
Annual deductible	$50 per person; $150 per family
Annual maximum (excludes orthodontia)	$3,000 per person
Preventive and diagnostic services	100% of covered expenses with no deductible
Basic services	80% of covered expenses after deductible
Major services	50% of covered expenses after deductible
Orthodontia	50% of covered expenses after deductible
Lifetime orthodontia benefit (for children and adults)**	$3,000 per person

* Network percentages are based on negotiated fees with participating providers. Out-of-network percentages are based on reasonable and customary charges. For more details, see the "Covered charges" section on page 7.

** Orthodontic benefits paid since January 1, 2004, under the MetLife and Delta Dental Citi sponsored Plan will count toward the lifetime orthodontia maximum across both Plans.

Covered services and limitations

Dental services are categorized into four services — preventive and diagnostic, basic, major, and orthodontia services. Below are descriptions of covered services and limitations by category.

Preventive and diagnostic

The following is a list of covered preventive and diagnostic services and limitations:

- 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);
- X-rays: one full mouth series per 36 months and up to 2 bitewing X-rays per year (up to 8 films per visit per calendar year);
- Sealants — permanent molars only (through age 16), one application every 36 months; and
- Palliative treatments, emergency treatment only.

Basic services

The following is a list of covered basic services and limitations:

- Fillings (except gold fillings), includes silver (amalgam) and composite “white” fillings;
- Extractions;
- Endodontic treatment;
- Oral surgery, unless covered under your medical plan or your HMO/EPO;
- Repair prosthetics, no limit;
- Repair or Recementing (crowns, inlays, onlays, bridgework or dentures), 1 relining or rebasing per 36 months;
- Periodontal maintenance treatments, up to 4 per calendar year, in combination with routine cleanings;
- Periodontal scaling and root planning, no limit (subject to medical necessity and consultant review);
- Addition of teeth to existing partial or full denture; and
- General anesthesia, when medically necessary, as determined by the Claim Administrator and administered in connection with a covered service.

Major services

The following is a list of covered major services and limitations:

- Inlays, onlays, and crowns (including precision attachments for dentures), limited to one per tooth every five years; replacement if at least 5 years old and unserviceable ;
- 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 or addition of teeth to partial removable denture; dentures must be at least 5 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 initial installation 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 5 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 Claim Administrator, is based upon the number and distribution of all missing, un-replaced teeth in the arch, as well as the overall periodontal condition of the remaining teeth.

Orthodontia services

The following is a list of covered 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.

Oral cancer services

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

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.

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 × 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 8 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% co-insurance, after the annual deductible is met, up to a $3,000.00 lifetime orthodontia maximum.

Assume a 24-month orthodontia treatment began in January 2008, and Delta Dental has paid $1,250.00 for the orthodontia treatment during 2008, and the participant transfers to the MetLife PDP plan effective 01/01/2009. MetLife will calculate the benefits payable in the following way:

$5,000.00	Submitted fee
× 20%	Calculation for the appliance (braces)
$1,000.00	Appliance
$5,000.00	Submitted fee
- $1,000.00	Appliance
$4,000.00	is divided equally into the 24 treatment months at $167.00 per month (not counting the month when the appliance fee was paid).

As of January 2009, MetLife would deduct $1,000.00 for the appliance from the $5,000.00 submitted fee and the $167.00 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 $84.00 per month (50% co-insurance for $167.00 covered service charges) in January 2008 for the remaining 13 months of treatment or until the $3,000.00 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.

Since $1,250.00 was previously paid by Delta Dental for service charges in 2008 in the example above, MetLife would pay for $84.00 per month for approximately 13 months of treatment or $1,092.00 to the $3,000.00 lifetime orthodontia maximum.

Treatment may continue with the 2008 provider (during the 2009 plan year) regardless of whether or not they are 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.

Predetermination of benefits

Before starting a dental treatment for which the charge is expected to be $300 or more, you should request a predetermination of benefits using a MetLife dental claim form. Complete the employee section of the form, ask your dentist to itemize all recommended services and costs, and send the form to the Claim Administrator at the address on the form.

The Claim Administrator will notify you and your dentist of the benefits payable under the Plan. You and/or your dependent(s) and the dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed and an estimate of the dentist's fees are not submitted in advance, the Plan reserves the right to determine benefits payable by taking into account alternative procedures, services, or courses of treatment based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable, or may not be paid.

Alternative treatment

Many dental conditions can be treated in more than one way that meets generally accepted standards of dental care. MetLife PDP has an "alternate treatment" clause that governs the amount of benefits that will be paid for covered treatments.

If you choose a more expensive treatment — recommended by your dentist — than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payable will be based on the cost of the treatment that provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and you and/or your dependent(s) and the dentist decide to use a gold filling, MetLife PDP will base its reimbursement on the reasonable and customary charge for an amalgam filling. You will pay the difference in cost between the reimbursed amount and the dentist's charge.

Services 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 dental 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 Claim 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 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.

Filing claims

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" in the *About Your Health Care Benefits* document. for information about submitting claims and filing an appeal if your claim is denied.

Delta Dental

Delta Dental has two provider networks available to you through Citi: Delta Dental Premier and Delta Dental PPO.

To locate a participating dentist:

- Visit the Delta Dental Web site at
  - www.deltadentalins.com/citigroup; or
  - Call 1-877-248-4764.

When calling to make an appointment, let the dentist know that you participate in Delta Dental and ask if they are in either the Delta Dental Premier or Delta Dental PPO network.

The following is a summary of features covered under Delta Dental. Types of services and limitations are outlined in the "Covered services and limitations" on page 12.

Type of service	Coverage*
Annual deductible	$50 per person; $150 per family
Annual maximum (excludes orthodontia)	$3,000 per person
Preventive and diagnostic services	100% of covered expenses with no deductible*
Basic services	80% of covered expenses after deductible*
Major services	50% of covered expenses after deductible*
Orthodontia	50% of covered expenses after deductible*
Lifetime orthodontia benefit (for children and adults)**	$3,000 per person

* Delta Dental's participating providers agree to submit claims to Delta Dental and to accept Delta Dental's maximum plan allowances, or the dentist's actual charge, whichever is less (allowed amount) as payment in full. Participating dentists are paid directly by Delta Dental and, by agreement, can't bill you more than the applicable deductible or copayment for the service. By using a participating dentist, you limit your out-of-pocket costs. For services performed by non-participating dentists, Delta Dental sends the benefit payment directly to you. You're responsible for paying the non-participating dentist's total fee, which may include amounts, such as deductibles and copayments, in addition to your share of Delta Dental's allowance and services that aren't covered by the group dental service contract.

** Orthodontic benefits paid since January 1, 2004, under the MetLife and Delta Dental Citi sponsored Plan will count toward the lifetime orthodontia maximum across both Plans.

Covered services and limitations

Dental services are categorized into four services — preventive and diagnostic, basic, major, and orthodontia services. Below are descriptions of covered services and limitations by category.

Preventive and diagnostic

The following is a list of covered preventive and diagnostic services and limitations:

- Oral exams, maximum of two exams per calendar year;
- Routine cleanings, maximum of three cleanings per calendar year (any combination of routine or periodontal);
- Fluoride treatments (through age 17), maximum of one application per calendar year;
- Space maintainers (through age 17);
- One Full mouth x-ray every 36 months;
- Bite wing x-rays are a benefit twice per calendar year.
- Sealants — permanent molars only (through age 15), one application every 36 months; and
- Palliative treatments, emergency treatment only.

Basic services

The following is a list of covered basic services and limitations:

- Fillings (except gold fillings), Amalgam (“silver”) and Composites (“white” fillings); All other fillings will be benefited at the Amalgam amount;
- Extractions;
- Endodontic treatment;
- Oral surgery, unless covered under your medical plan or your HMO;
- Repair or recementing of crowns, inlays, onlays, bridgework or dentures – 1 denture relining or rebasing per 36 months;
- Periodontal treatment, maximum of three cleanings per calendar year (any combination of routine or periodontal);
- Injectable antibiotics; and
- General anesthesia, when medically necessary, as determined by the Plan Administrator and administered in connection with a covered service.

Major services

The following is a list of covered major services and limitations:

- Inlays, onlays, and crowns;
- 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 or addition of teeth to partial removable denture), limited to once every five years (must be at least five years old and not serviceable);
- 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), limited to once every five years (must be at least five years old and not serviceable); and
- Dental implants - surgical placement of, prefabrication, superstructure and replacement (limited to once in a lifetime for the actual implant);
- Temporomandibular joint (TMJ) disorder related services — non-surgical services and/or supplies to prevent, diagnose, or correct an abnormal functioning of the temporomandibular joint of the jaw or jaw joint relationship.

Orthodontia services

The following is a list of covered orthodontia services:

- Orthodontic x-rays;
- Evaluation;
- Treatment plan and record;
- Services or supplies to prevent, diagnose, or correct a misalignment of teeth or bite; and
- Harmful habit appliances

Oral cancer services

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

How the Plan works

Delta Dental has two provider networks available to you through Citi: Delta Dental Premier and Delta Dental PPO. Dentists in both networks agree to accept lower fees for services. The Delta Dental Premier network is larger, with more than 191,000 dental offices nationwide. You will receive a deeper discount in the smaller Delta Dental PPO network, with more than 113,000 offices.

Your total out-of-pocket payment is less if you use a Delta Dental PPO network dentist. You will pay more if you use a Delta Dental Premier dentist and even more if you use a dentist who is not in either network. You can choose any dentist at the time of service, but you will pay less out of your pocket when you use a Delta Dental participating provider.

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. A separate lifetime maximum of $3,000 per person applies to orthodontia treatments.

Covered charges

After you have met the deductible, Delta Dental reimburses covered charges for out-of-network dentists at the Delta Dental Premier Maximum Plan Allowance. For network charges, the percentage of reimbursement is based on 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.

Coverage for new orthodontic work

- After the deductible, 50% of the orthodontic benefit will be paid at the time of banding, with the remaining 50% of the orthodontic benefit paid one year after the date of banding (eligibility must continue for the second payment to be made), up to the $3,000 lifetime maximum.

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

- $5,000 (submitted amount is within MPA) x 50% copayment = $2,500
- First half benefit paid a time of banding: $2,500 / 2 = $1,250.
- Second half benefit paid 12 months after date of banding: $2,500 /2 = $1,250.

Coverage for orthodontic work in progress:

Delta Dental's liability will be calculated at 50% of Delta Dental's Allowance up to $3,000 per patient per lifetime. Benefits are based on the number of months remaining in treatment where applicable. Previous payments paid by MetLife or Delta Dental after January 1, 2004 will then be factored in to ensure that not more than the submitted fee is paid between the carriers. When present, coordination of benefits (COB) will be handled as Non-Duplication (See "Coordination of benefits" in the *About Your Health Care Benefits* document for how COB works). Examples are as follows (Non-Duplication COB not being a factor), and annual deductible previously met:

- Step 1 — $5,000 (submitted amount is within the MPA) x 50% copayment = $2,500, with a 24 month treatment plan
- Step 2 — $2,500 minus the amount previously paid by MetLife or Delta Dental under the Citi Plan = Delta Dental's payment, made in one lump sum. ($2,500 - $1,424 {previous carrier payment} = $1,076)

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.

Predetermination of benefits

Predetermination of benefits enables you and your dentist to know in advance what the Plan will pay for any service. Delta Dental recommends that your dentist submit a claim before performing services that may total more than $300.

Delta Dental will review the claim and return the predetermination voucher to your dentist (with a copy to you) that explains eligibility, scope of benefits, and the definition of a 60-day period for completion of services.

When services are completed, the voucher with the dates of service and signatures should be submitted to Delta Dental for payment. Delta Dental will pay the predetermined amount depending on your continued eligibility for coverage. The payment could be reduced if you are also eligible for coverage under another plan.

Alternative treatment

Many dental conditions can be treated in more than one way. The contract with Delta Dental has an "alternate treatment" clause that governs the amount of benefits that will be paid for covered treatments.

If you choose a more expensive treatment — recommended by your dentist — than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payable will be based on the cost of the treatment that provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and you and/or your dependent(s) and the dentist decide to use a gold filling, Delta Dental will base its reimbursement on the reasonable and customary charge for an amalgam filling. You will pay the difference in cost between the reimbursed amount and the dentist's charge.

In order to determine the amount that Delta Dental will pay, we recommend pre-determination of your dental benefits. Ask your dentist to submit a pre-determination form to Delta.

Services not covered

Benefits are not provided for services and supplies not medically necessary for the diagnosis or treatment of dental illness or injury. 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 Claim 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 Delta Dental and are *not* covered by the Plan:

- Prescription drugs, premedications, relative analgesia;
- Treatment, procedures, appliances or restorations primarily performed for cosmetic purposes;
- 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:
  - 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);
- Replacing tooth structure lost by attrition;
- Equilibration;
- Periodontal splinting;
- Procedures to correct congenital or developmental malformations except for covered dependent children or newborn children eligible at birth;
- Plaque control programs, including oral hygiene and dietary instruction, training or supplies used to educate people on the care of teeth;

- Any charges incurred for services or supplies not recommended by a licensed dentist;
- Any charges incurred due to sickness or injury that is covered by a Workers' Compensation Act or other similar legislation or 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 for 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 otherwise be provided free of charge but for coverage;
- Broken appointments;
- Charges for filing claims or charges for copies of x-rays;
- 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.

Filing claims

See "Claims and appeals for Delta Dental" in the *About Your Health Care Benefits* document. for information about submitting claims and filing an appeal if your claim is denied.

CIGNA DHMO

CIGNA DHMO is a managed dental care plan that operates like a health maintenance organization. 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 Web site, http://cigna.benefitnation.net/cigna/(ksmtg545tvtqiyezhahstk45)/docdir.aspx.

As a CIGNA Dental Plan member, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Visit the CIGNA Web site at www.cigna.com.

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

The CIGNA DHMO 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 22 for more information. You can obtain a schedule of charges when you enroll in the CIGNA DHMO or by calling CIGNA Dental at 1.800.CIGNA24 or at www.cigna.com/dental (if you are already a member).

Type of service	Coverage
Annual deductible	None
Annual maximum	None
Preventive and diagnostic services	Covered at 100%
Basic services	Based on pre-set patient charges
Major services	Based on pre-set patient charges
Orthodontia	Based on pre-set patient charges
Lifetime orthodontia benefit (for children and adults)	Coverage limited to 24 months of treatment. Atypical cases or cases longer than 24 months require additional payment by the patient.

Limitations and services not covered

Listed below are limitations and services not covered by the CIGNA DHMO:

- **Frequency**. The frequency of certain covered services, such as cleanings, is limited. The patient charge schedule lists any limitations on frequency;
- **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 for treatment by a pediatric dentist ends on an enrolled child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your network general dentist shall provide care after the child's 7th birthday;
- **Oral surgery.** The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery; and
- **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 Dental Plan.

Listed below are the services or expenses that are *not* covered under the CIGNA DHMO. 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 22;
- 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, preexisting 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, preexisting conditions are not excluded.

How the Plan works

When you enroll in CIGNA DHMO, 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 DHMO Network. Please 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 identification 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 less 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 DHMO 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 DHMO or by calling CIGNA Dental at 1.800.CIGNA24 or at 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 (NGD) or Network Pediatric Dentist (NPD).

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.

- 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 your 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 DHMO, call the Member Services Representatives. They 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 from any location at 1.800.CIGNA24. The hearing impaired may contact the state TTY toll-free relay service in their local telephone directory.

Filing claims

You do not need to file any claims for benefits. If benefit payment is denied, however, you may file an appeal. See “Claims and appeals for the CIGNA Dental Care DHMO” in the *About Your Health Care Benefits* document..

Converting coverage

If you and/or your enrolled dependents are no longer eligible for coverage through active benefits or your COBRA period has expired, you and/or your enrolled dependents may continue dental coverage by enrolling in the CIGNA Dental conversion plan. You must enroll within three months after becoming ineligible for your group’s dental plan. Premium payments and coverage will be retroactive to the date coverage under your group’s dental plan ended. You and your enrolled dependents are eligible for conversion coverage unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship;
- Fraud or misuse of dental services and/or dental offices;

- Nonpayment of premiums by the subscriber;
- Selection of alternate dental coverage by your employer; or
- Lack of network/service area.

Benefits and rates for conversion coverage and any succeeding renewals will be based on the covered services listed in the then-current standard conversion plan and may not be the same as those for Citi. Call the CIGNA Dental Health Conversion Department at 1.800.CIGNA24 to obtain current rates and make arrangements for continuing coverage.

Extension of benefits

Coverage for a dental procedure, other than 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 nonpayment 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 nonpayment of premiums.

Disclosure Statement

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