ALLSTATE CAFETERIA PLAN
SUMMARY PLAN DESCRIPTION

THE DENTAL PLAN
The Dental Plan

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THE DENTAL PLAN

The Dental Plan provides coverage for specified preventive and diagnostic services and can also ease the cost of dental treatment by providing comprehensive coverage for many restorative and reconstructive services. Metropolitan Life Insurance Company (MetLife) is the Third Party Administrator for dental claims. MetLife will authorize the payment of claims in accordance with the Dental Plan provisions, but is not an insurer of the Dental Plan.

Preferred Dentist Program (PDP)

The Preferred Dentist Program (PDP) is a network of Dentists, both generalists and specialists, who have contracted with MetLife to provide dental services at negotiated rates. The PDP provides elements of managed Dental Care while preserving patient freedom of choice. PDP Dentists are subject to MetLife’s credentialing process. All Dental Plan provisions, rules, and exclusions, including Deductibles and Copayment factors, apply to the PDP.

How the PDP Works

The PDP is simple to use. You are automatically enrolled in the PDP. There are no separate enrollment forms to complete. Each time you seek Dental Care, you may choose to go to a PDP Dentist or Out-of-Network Dentist. If you go to an Out-of-Network Dentist, you will receive services at that provider’s standard rate. Reimbursement is then made at the benefit levels described in the “Schedule of Benefits” and “How the Dental Plan Works.” If you go to a PDP Dentist, you will receive services at MetLife’s negotiated rates which are usually lower than the community average for that service. Reimbursements are then made at the benefit levels described in the “Schedule of Benefits.”

To receive benefits under the PDP when Dental Care is needed, you must:

➢ go to a PDP Dentist; and
➢ inform the Dentist that you are a member of the PDP.

There are no other procedures to follow or special claim forms to complete. PDP Dentists may file claims on your behalf.

The Advantages of Selecting a PDP Dentist

There are many benefits to participating in the PDP. They include:

➢ reduced Out-of-Pocket Expenses;
➢ freedom to choose any Dentist or specialist in the network;
➢ provider credentialing and monitoring; and
➢ reduced rates for some dental services not covered by the Dental Plan—e.g., cosmetic services and Orthodontic Services for Covered Persons age 19 and over.

If your Dentist is not a member of the PDP and is interested in joining, he/she may get more information on the PDP and an application by visiting the MetLife website at http://www.metlife.com/mybenefits or by calling MetLife’s toll free number (800) 638-8908.
ELIGIBLE EXPENSES

The Dental Plan pays benefits for five classes of covered dental services and supplies.

- **Class A—Diagnostic and Preventive Services**
- **Class B—Surgery and Minor Restorative Services**
- **Class C—Major Restorative Services**
- **Class D—Orthodontia Services**
- **Class E—Temporomandibular Joint (TMJ) Syndrome Services**

**Class A—Diagnostic and Preventive Services**

- Dental x-rays, including:
  - the x-rays needed to diagnose a specific condition;
  - full mouth (Panorex) x-rays or series—but not more than once in any 60 consecutive month period; and
  - supplementary bitewing x-rays—but not more than one series in a Plan Year.
- Oral exams—but not more than two exams in a **Plan Year**.
- Prophylaxis (scaling and cleaning of teeth)—but not more than twice in a Plan Year.
- Sealants on non-restored permanent 1st and 2nd molars and bicuspids for children up to age 19—but not more than once per tooth every 60 months.
- Space maintainers used to replace prematurely lost teeth for children under the age of 15.
- Topical application of fluoride for children under age 15—but not more than once in a Plan Year.

**Class B—Surgery and Minor Restorative Services**

Restorations of diseased teeth with amalgam, silicate, acrylic, synthetic porcelain, or composites. All restorations on one surface are considered a single restoration.

- Antibiotic injections by the attending Dentist.
- Appliance to correct bruxism—once per 24-month period.
- Endodontic treatment, including root canal therapy.
- Extractions (except when associated with Orthodontic Services), including local anesthesia and routine post-operative care.
- Fillings.
- General anesthetics when dentally necessary in connection with oral surgery, extractions or other covered dental services.
- Oral surgery, including local anesthesia and routine post-operative care, but excluding surgical biopsies.
- Periodontal maintenance following active periodontal treatment—the total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year.
- Professional consulting fees if requested by an attending Dentist—two per Plan Year. Consultations are not a covered expense when performed in conjunction with other dental procedures or when performed by the attending Dentist.

- Repair or recementing of crowns, inlays, onlays, bridgework, or dentures.

- Scaling and root planing—once per area per 24-month period.

- Treatment of periodontal and other gum and mouth tissue diseases, including periodontal surgery and grafts—once per area per 36-month period.

**Class C—Major Restorative Services**

- Implants.

- Installation of fixed bridgework, including inlays and crowns as supports.

- Installation of removable dentures, including adjustments of these dentures more than six months after they are installed.

- Rebasing of dentures—but only if they were installed more than six months earlier and if they have not been rebased during the past 36 months.

- Relining of dentures—but only if they were installed more than six months earlier and if they have not been relined during the past 36 months.

- Replacement of crowns, inlays, or onlays with new ones—but only if the existing ones:
  - cannot be made serviceable; and
  - are at least seven years old. However, if a tooth fractures underneath an existing restoration which is less than seven years old, the replacement restoration would be considered an Eligible Expense if the original restoration could not be made serviceable.
  - Replacement is limited to one in 84 consecutive months.

- Replacement of partial dentures, full removable dentures, or fixed bridgework with new ones, or teeth added to the existing dentures or bridgework—but only if:
  - the replacement or addition of teeth is needed because one or more natural teeth were extracted while covered under the Dental Plan;
  - the existing denture or bridgework cannot be made usable and is at least seven years old; or
  - the existing denture is a temporary denture that cannot be made permanent, and is replaced within 12 months by a permanent denture.
  - Replacement is limited to one in 84 consecutive months.

- Restorations of diseased teeth with inlays, onlays, fillings, or crowns—but only when these teeth cannot be restored with amalgam, silicate, acrylic, synthetic porcelain, or composites.

**Class D—Orthodontic Services**

Eligible Expense is that incurred by a child under age 19 for Orthodontic Services consisting of diagnosis, surgical therapy, and appliance therapy. This includes related oral exams, surgery, and extractions.

Limited to a lifetime maximum of $2,000 per child.
**Class E—Temporomandibular Joint Syndrome Services**

Class E Eligible Expense is that incurred for temporomandibular joint (TMJ) syndrome, which is a result of the functional disturbance of the supportive structures of the lower jaw. Eligible Expenses are limited to the necessary:

- care of acute dysfunction including limited physical therapy; or
- diagnostic procedures;
- removable TMJ orthotic appliance (a device to alter the relationship between the jaws) and or limited adjustments.

Eligible Expenses are limited to a lifetime maximum of $500.

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### SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>Deductible*</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Class A—Diagnostic and Preventive Services</td>
<td>None</td>
</tr>
<tr>
<td>Class B—Minor Restorative Services</td>
<td>You pay $50 per Covered Person, up to $150 per covered family unit.</td>
</tr>
<tr>
<td>Class C—Major Restorative Services</td>
<td>You pay $50 per Covered Person, up to $150 per covered family unit.</td>
</tr>
<tr>
<td>Class D—Orthodontic Services</td>
<td>None</td>
</tr>
<tr>
<td>Class E—Temporomandibular Joint (TMJ) Syndrome Services</td>
<td>None</td>
</tr>
</tbody>
</table>

* One $50 Deductible per Covered Person, or one $150 Deductible per covered family unit, satisfies the Deductible requirement for both Class B and Class C services.

<table>
<thead>
<tr>
<th>Coinsurance Level</th>
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</thead>
<tbody>
<tr>
<td>Class A—Diagnostic and Preventive Services</td>
<td>Dental Plan pays 100% of Eligible Expenses.</td>
</tr>
<tr>
<td>Class B—Minor Restorative Services</td>
<td>Dental Plan pays 80% of Eligible Expenses if services are performed by PDP Dentist. Dental Plan pays 50% of Eligible Expenses if services are performed by an Out-of-Network Dentist.</td>
</tr>
<tr>
<td>Class C—Major Restorative Services</td>
<td>Dental Plan pays 50% of Eligible Expenses.</td>
</tr>
<tr>
<td>Class D—Orthodontic Services</td>
<td>Dental Plan pays 50% of Eligible Expenses on a repetitive payment basis.</td>
</tr>
<tr>
<td>Class E—Temporomandibular Joint (TMJ) Syndrome Services</td>
<td>Dental Plan pays 50% of Eligible Expenses.</td>
</tr>
</tbody>
</table>
### Dental Maxims

<table>
<thead>
<tr>
<th>Class</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class A</td>
<td>Diagnostic and Preventive Services</td>
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<td>Temporomandibular Joint (TMJ) Syndrome Services</td>
</tr>
</tbody>
</table>

**Dental Plan** pays $2,000 maximum benefit for Classes A, B, and C Eligible Expenses combined, per Covered Person per Plan Year. Dental Plan pays $2,000 lifetime maximum per child under age 19. Dental Plan pays $500 lifetime maximum per Covered Person.

### HOW THE DENTAL PLAN WORKS

#### Deductible

The Deductible is shown in the “Schedule of Benefits” and refers to the amount of Eligible Expense a Covered Person must pay Out-of-Pocket before receiving reimbursement. Only Eligible Expenses that would otherwise be covered by the Dental Benefit may be used to compute the Deductible.

#### Dental Benefit

This benefit is paid for Eligible Expenses incurred for covered dental services and supplies. The Dental Benefit for each Plan Year is:

- the Eligible Expense up to the **Reasonable and Customary Charge**;
- less any applicable Deductible; and
- multiplied by the **Coinsurance Level** shown in the “Schedule of Benefits.”

In no event may the Dental Benefit exceed the dental maximum shown in the “Schedule of Benefits.” Before paying Dental Benefits, x-rays and other materials used to determine benefits payable may be requested by MetLife or the Plan Administrator. If these items are not furnished, payment will be made only for those Dental Benefits that are confirmed by the information on hand.

#### Pre-Treatment Estimate

The use of a **Pre-Treatment Estimate** is recommended to help reduce misunderstandings about your Dental Benefits if the charges are expected to be more than $300 and are not for emergency services. Your Dentist should submit a Pre-Treatment Estimate before providing services by filling out the appropriate section of the dental claim form. Then you or your Dentist must forward the form to the address noted in the instructions. The Pre-Treatment Estimate will be reviewed by MetLife and returned to the Dentist and you, showing all benefits that will be payable. When there is more than one way to provide a dental service or supply in accordance with generally accepted dental practice, the least costly way will be considered as the Eligible Expense.
**Date Expenses Are Incurred**

Under the Dental Plan, certain Expenses will not be deemed to be incurred on the date the service or supply is furnished, but rather as indicated below:

- For a crown, bridge, or inlay or onlay restoration—on the date the teeth are prepared.
- For a non-orthodontic appliance or its modification—on the date the master impression is made.
- For root canal therapy—on the date that the canal or canals are fully prepared for filling.
- For Orthodontic Services—on the date the bands are placed on the Covered Person’s teeth.

**EXCLUSIONS**

No Dental Benefit will be paid for an Expense incurred for or in connection with:

- Charges for any duplicate devices or appliances, including prosthetics.
- Charges for completion of claim forms or failure to keep a dental appointment.
- Charges for infection control.
- Charges for oral hygiene instruction, a plaque control program or dietary instruction.
- Charges for overdentures.
- Charges for replacing a lost, missing, or stolen device or appliance, including prosthetics.
- Charges for services which are experimental.
- A claim submitted more than 15 months after the Expense was incurred.
- Cosmetic services. The following services are always considered cosmetic:
  - veneers, facings, or similar properties of crowns or pontics placed on or replacing teeth in back of the second bicuspid; and
  - personalization or characterization of dentures; and
  - internal or external bleaching.
- Dental Care for a congenital or developmental malformation, unless the service is an Orthodontic Service.
- A dental service not furnished by a Dentist.
- Dental services or supplies:
  - to the extent that they are in excess of the Reasonable and Customary Charges;
  - that are not dentally necessary or customary according to generally accepted dental standards as determined by MetLife; or
  - that are not recommended or approved by a legally licensed Dentist or eligible provider under this Plan.
Except as otherwise specifically covered under the Dental Plan, appliances, restorations, or procedures for:
- altering vertical dimension;
- restoring or maintaining occlusion;
- splinting; or
- replacing tooth structure lost from abrasion or attrition.

Expenses covered under any Workers’ Compensation or Occupational Disease Law.

Gingival curettage.

An Injury to sound, natural teeth from an external force.

Military service for any country or organization, including service with military forces as a civilian whose duties do not include combat.

Prescription drugs.

Services of a Dentist employed by any government, unless a charge:
- must be paid by the Covered Person; or
- was incurred in a Veterans Health Administration hospital for non-service connected disability.

Services or supplies from a government-owned or operated hospital, unless a charge:
- must be paid by the Covered Person;
- was incurred while the Covered Person was confined in a military hospital; or
- was incurred in a Veterans Health Administration hospital for a non-service connected disability.

Surgical biopsies of tissue found in the mouth.

War or act of war, or rebellion.

EXTENSION OF BENEFITS

After coverage ends, the Dental Plan may pay a Dental Benefit:

For appliances and their modifications if:
- the Dentist took the master impression while the Covered Person was covered under the Dental Plan;
- the appliance was delivered or installed within 60 days after the coverage ended; and
- the appliance is not related to an Orthodontic Service.

For crowns, bridges, inlays, onlays, or cast restorations if:
- the teeth were prepared while the Covered Person was covered under the Dental Plan; and
- installation was within 60 days after the coverage ended.

For root canal therapy if:
- the canal or canals were fully prepared for filling while the Covered Person was covered under the Dental Plan; and
- therapy was completed within 60 days after the coverage ended.
OTHER PLAN PROVISIONS

Assignment of Benefits

The benefits provided under the Dental Plan are assignable.

Payment of Benefits

Subject to the Coordination of Benefits provision, as described in the General Provisions section, all benefits are payable immediately to the assignee, if any. Otherwise benefits are payable immediately to you or to an Alternate Recipient, or the Alternate Recipient’s custodial parent or legal guardian, pursuant to a Qualified Medical Child Support Order. If benefits are payable after your death, the Dental Plan has the option to pay benefits to your estate or to any of the following of your surviving relatives: spouse, child(ren), parent(s), brother(s) and/or sister(s).

Payment of benefits will also be made in accordance with any assignment of rights made by or on behalf of a participant or beneficiary as required by a state’s Medicaid program. Determination and payment of benefits under the Dental Plan will not take into account that a Dental Plan participant is eligible for or covered by Medicaid. Payment of benefits will be made in accordance with any state law which provides that the state has acquired the rights of the participant or beneficiary with respect to items or service the Dental Plan has a legal obligation to pay, but only to the extent the state has made payment for the benefits under the Medicaid program.

CLAIM PROCEDURES

How to File a Claim

A Dental Expense claim form should be completed as soon as you or your dependents incur a dental Expense. PDP Dentists will file claims on your behalf.

Claims forms can be obtained from the MetLife website at http://www.metlife.com/mybenefits, or by calling MetLife’s toll free number, (800) 638-8908. You and your Dentist must complete the form and return it to the address indicated in the instructions on the form. You should submit the claim within 90 calendar days of the date the Expense was incurred, or be prepared to show that you submitted the claim as soon as reasonably possible. However, claims submitted more than 15 months after the Expense was incurred will not be accepted.
Initial Benefit Determination

Post-Service Claims
Post-service claims are those claims that are filed for payment of benefits after Dental Care has been received. If your post-service claim is denied, you will receive a written notice from MetLife within 30 calendar days of receipt of the claim, as long as all needed information was provided with the claim. MetLife will notify you within this 30-calendar-day time period if additional information is needed to process the claim, and may request a one-time extension no longer than 15 calendar days. Your claim will be pended until all information is received.

Once notified of the extension you then have 45 calendar days to provide the needed information. If all of the needed information is received within the 45-calendar-day timeframe, MetLife will notify you of the determination within 15 calendar days after the information is received. If you do not provide the needed information within the 45-calendar-day period, your claim will be denied.

Appeal of Initial Benefit Determination
If you disagree with an initial benefit determination made by MetLife, you may request an appeal and have MetLife reconsider the decision. You have the right to:

- Submit a written request to MetLife for review of the claim no later than 180 calendar days after receipt of a denial determination;
- Review pertinent Plan documents; and
- Submit additional material or information in writing to MetLife.

Send your initial benefit determination appeal to:

MetLife Dental Claims
P.O. Box 14589
Lexington, KY 40512

Manner and Content of Initial Benefit Appeal
A qualified individual who was not involved in the decision being appealed will be appointed to render a decision. If your appeal is related to clinical matters, the review will be conducted in consultation with a health care professional in the field who was not involved in the initial benefit determination. MetLife may consult with medical experts as part of the appeal resolution process.

For post-service claim reviews you will be notified of the decision no later than 30 calendar days after MetLife received the written request for the review.

For urgent care claim reviews you will be notified of the decision no later than 72 hours after MetLife received the written request for review.

Notification may be written or electronic and will set forth the following:

- Specific reasons for the determination;
- Specific references to the Plan provisions on which the determination is based;
- Specific internal rule, guideline or protocol relied upon in making the determination;
A description of any additional material or information that you must provide in order to support the determination and an explanation of why such material or information is necessary; and, if applicable,

- A description of the expedited review process applicable to urgent care claims, which can be made orally, provided a written or electronic notification is furnished no later than three calendar days thereafter.

**Appeal of First Level Claim Determinations**

If you disagree with a claim determination made by MetLife, you may request a second level appeal and have MetLife reconsider the decision. You have the right to:

- Submit a written request to the MetLife for review of the claim no later than 90 calendar days after receipt of a denial determination;
- Review pertinent Plan documents; and
- Submit additional material or information in writing to MetLife.

Send your written request to MetLife as follows:

MetLife Dental Claims
P.O. Box 14589
Lexington, KY 40512

For post-service claim reviews you will be notified of the decision no later than 30 calendar days after the MetLife received the written request for the review.

For urgent care claim reviews, the Plan Administrator has delegated to MetLife the exclusive right to interpret and administer provisions of the Plan. MetLife’s decisions are conclusive and binding.

The written decision will include, in addition to other information required by applicable law:

- The specific reasons for the determination;
- Specific references to the Plan provisions on which the determination is based;
- Specific internal rule, guideline or protocol relied upon in making the determination; and
- A statement that you are entitled to receive, upon request and free of charge, copies of all documents, records and other information related to your claim for benefits.

The decision of MetLife is final.

**Time Limits on Starting Lawsuits or Other Legal Action**

No claimant (including Plan participants and their beneficiaries) or claimant’s representative may file or commence any lawsuit or legal action (under § 502 of ERISA or otherwise) to obtain any Dental Plan benefits under the Allstate Cafeteria Plan, without first having complied with and exhausted all levels of appeal required by the Dental Plan, and in any event no more than 90 calendar days after the second (final) appeal is denied by MetLife.

Failure to follow the claim procedures of the Dental Plan, including timeframes and exhaustion of administrative remedies, shall result in a loss of benefits, if otherwise available.