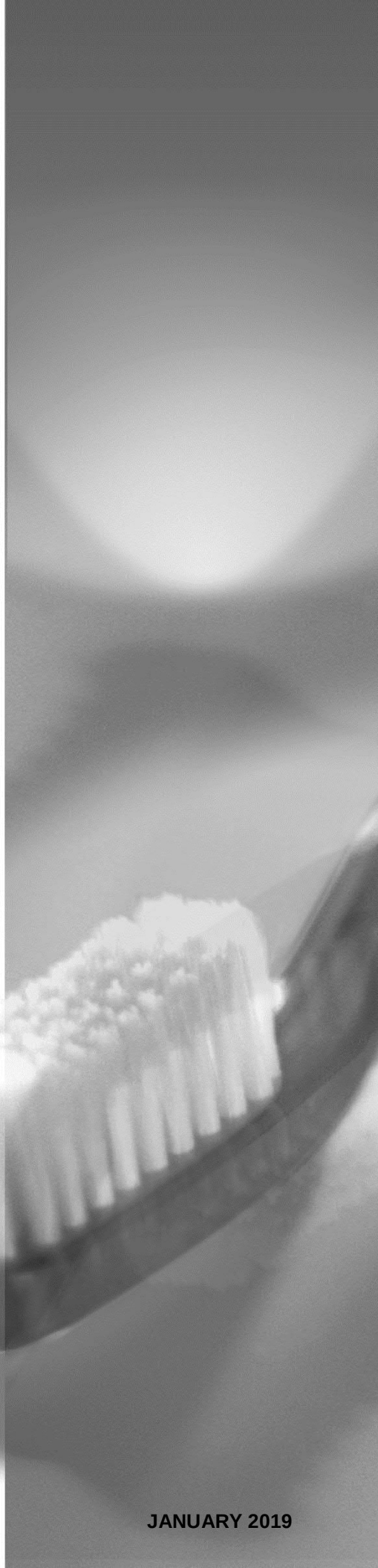
Cafeteria Dental

Table of Contents ***See Page***



THE DENTAL PLAN

TERMS

Terms that are defined in the Glossary of this SPD are bolded and capitalized when they first appear in the text; thereafter, they will be capitalized wherever they are used in the text. See the Glossary section for more information.

The Dental Plan consists of two options: Preferred Provider Organization (PPO) option and Dental Maintenance Organization (DMO) option. Employees may select coverage from one of these available options based on their home address and geographical area. Both options provide coverage for specified preventive and diagnostic services, as well as comprehensive coverage for many restorative and reconstructive services. Aetna Life Insurance Company (Aetna) is the Third Party Administrator for all dental claims. Aetna will authorize the payment of claims in accordance with the Dental Plan provisions.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Preferred Provider Organization (PPO) is a network of Dentists, both generalists and specialists, who have contracted with Aetna to provide dental services at negotiated rates. The PPO provides elements of managed Dental Care while preserving patient freedom of choice. PPO Dentists are subject to Aetna's credentialing process. To obtain a list of PPO Dentists near you, visit the Aetna website at http://www.aetna.com, or call Aetna's toll-free number (877) 238-6200. All Dental Plan provisions, rules, and exclusions, including Deductibles and Copayment factors, apply to the PPO. The group number for the Dental PPO Plan is 0727713.

How the PPO Works

Each time you seek Dental Care, you may choose to go to a PPO Dentist or an Out-of-Network Dentist. If you go to a PPO Dentist, you will receive services at Aetna's negotiated rates which are usually lower than the community average for that service. 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 "Schedule of Benefits" and "How the Dental Plan Works."

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

- go to a PPO Dentist; and
- inform the Dentist that you are a member of the PPO.

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

The Advantages of Selecting a PPO Dentist

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

- reduced Out-of-Pocket Expenses;
- freedom to choose any Dentist or specialist in the network; and
- provider credentialing and monitoring.

Aetna's negotiated fees with PPO Dentists may extend to services not covered under the Dental Plan and services received after the Dental Plan maximum has been met, where permitted by applicable state law. If you receive services from a PPO Dentist that are not covered under the Dental Plan or where the Dental Plan maximum has been met, in those states where permitted by law, you may only be responsible for the PPO Dentist fee.

If your Dentist is not a member of the PPO and is interested in joining, he/she may get more information on the PPO and an application by visiting the Aetna website at http://www.aetna.com or by calling Aetna's toll-free number (877) 238-6200.

PPO ELIGIBLE EXPENSES

When there is more than one way to provide a dental service or supply in accordance with generally accepted dental practices, the least costly way may be considered as the Eligible Expense.

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.
- Emergency palliative treatment.
- 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, 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.
- 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.

NOTE

Partial dentures will normally be replaced with partial dentures. But when only fixed bridgework will produce a professionally adequate result, then fixed bridgework will be the Eligible Expense.

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, for orthodontic treatment plans.

The Plan will not cover services for an orthodontic procedure if an active appliance for that procedure was installed before you were covered by the Dental Plan.

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;
- diagnostic procedures; or
- 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.

PPO SCHEDULE OF BENEFITS

Your costs in the PPO Dental Plan

Deductible*	
Class A—Diagnostic and Preventive Services	None
Class B—Minor Restorative Services	You pay $50 per Covered Person, up to $150 per covered family unit for in-network and out-of-network services
Class C—Major Restorative Services	You pay $50 per Covered Person, up to $150 per covered family unit for in-network and out-of-network services
Class D—Orthodontic Services	None
Class E—Temporomandibular Joint (TMJ) Syndrome Services	None

* 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. The deductible is separate for in-network and out-of-network services.

Coinsurance Level	
Class A—Diagnostic and Preventive Services	0% of Eligible Expenses.
Class B—Minor Restorative Services	20% of Eligible Expenses if services are performed by PPO Dentist. 50% of Eligible Expenses if services are performed by an Out-of-Network Dentist.
Class C—Major Restorative Services	50% of Eligible Expenses.
Class D—Orthodontic Services	50% of Eligible Expenses on a repetitive payment basis.
Class E—Temporomandibular Joint (TMJ) Syndrome Services	50% of Eligible Expenses.

Dental Maximums	
Class A—Diagnostic and Preventive Services	$2,000 maximum benefit for Classes A, B, and C Eligible Expenses combined, per Covered Person per Plan Year.
Class B—Minor Restorative Services	$2,000 maximum benefit for Classes A, B, and C Eligible Expenses combined, per Covered Person per Plan Year.
Class C—Major Restorative Services	$2,000 maximum benefit for Classes A, B, and C Eligible Expenses combined, per Covered Person per Plan Year.
Class D—Orthodontic Services	$2,000 lifetime maximum per child under age 19.
Class E—Temporomandibular Joint (TMJ) Syndrome Services	$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 Aetna 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.

No benefit will be paid for the same Eligible Expense under more than one Allstate-sponsored plan.

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 Aetna 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 Services.
- A claim submitted more than 15 months after the Expense was incurred.
- Cosmetic Procedures or 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 Aetna; 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 a Sound Natural Tooth or 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 needed to replace one or more natural teeth which were missing* before a person became a Covered Person, except for congenitally missing* teeth.
- Services for an orthodontic procedure if an active appliance for that procedure was installed before you were covered by the Plan.
- Implant-supported prosthetics to replace one or more natural teeth which were missing* before such person was covered under the Dental Plan, except for congenitally missing* natural teeth
- 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.

* The "Missing but Unreplaced Rule" (MUR) (MTE or "Missing Tooth Exclusion") applies to initial dentures, fixed/removable bridgework and implants that replace teeth missing, lost, or extracted prior to the member's effective date of coverage. The rule also applies to abutment crowns, onlays and abutment crown core buildups and post and cores that are part of a fixed bridge. This provision applies to teeth missing on the member's effective date of coverage under the Allstate plan. This rule does not apply to members who have current dental coverage under Allstate's plan offerings, and had the above treatment while covered under Allstate's plan. Check with Aetna Member Services.

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

Changes in Coverage

Rules for changing coverage in the dental plan (PPO and DMO) (i.e., as the result of a Qualified Change in Status) may be found in the Qualified Change in Status section of the Allstate Cafeteria Plan SPD. You may also make changes to your coverage during Annual Enrollment, provided you are still eligible for coverage.

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 AND APPEAL PROCEDURES

Claims

The responsibility for initial claims determinations and the full and fair review of denials (first and second level appeals and Urgent Care appeals, when applicable) pursuant to Section 503 of ERISA has been delegated to the Third Party Administrator for the Dental Plan. For additional details, please refer to the "Claim Procedures" section of the Dental Plan.

A Dental Expense claim should be submitted as soon as you or your dependents incur a dental Expense. PPO Dentists are responsible for filing in-network claims on your behalf. If you receive services from an out-of-network provider, they may submit a claim on your behalf. However, if they do not, you will be responsible for submitting the claim to Aetna.

Claim forms can be obtained from the Aetna website at http://www.aetna.com, or by calling Aetna's toll free number, (877) 238-6200. 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.

Claims mailing address:

Aetna
P.O. Box 14094
Lexington, KY 40512

Urgent Care Claims

Aetna will make notification of an **urgent care claim** determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier of the receipt of the additional information or the end of the 48-hour period given the **physician** to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Pre-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. Aetna may determine that due to matters beyond its control, an extension of this 15 calendar days claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 15 calendar days period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Post-Service Claims

Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the **post-service claim** is made. Aetna may determine that due to matters beyond its control an extension of this 30 calendar day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. If this extension is needed because Aetna needs additional information to make a claim determination, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Concurrent Care Claim Extension

Following a request for a **concurrent care claim extension**, Aetna will make notification of a claim determination for emergency or urgent care as soon as possible but not later than 24 hours, with respect to emergency or urgent care provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a concurrent care claim extension.

Concurrent Care Claim Reduction or Termination

Aetna will make notification of a claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider, you must call or write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Aetna
P.O. Box 14094
Lexington, KY 40512

Appeals

You may submit an appeal if Aetna gives notice of an adverse benefit determination. This Plan provides for two levels of appeal.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your level one appeal. Your appeal may be submitted verbally or in writing and should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

The notice of an adverse benefit determination will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna's Customer Service Unit at the toll-free phone number on your ID card.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing verbal or written consent to Aetna.

Level One Appeal

A level one appeal of an adverse benefit determination shall be provided by Aetna personnel not involved in making the adverse benefit determination.

- **Urgent Care Claims** (may include concurrent care claim reduction or termination): Aetna shall issue a decision within 36 hours of receipt of the request for an appeal.
- **Pre-Service Claims** (may include concurrent care claim reduction or termination): Aetna shall issue a decision within 15 calendar days of receipt of the request for an appeal.
- **Post-Service Claims:** Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

Level Two Appeal

If Aetna upholds an adverse benefit determination at the first level of appeal, you or your authorized representative have the right to file a level two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a level one appeal.

A level two appeal of an adverse benefit determination of an urgent care claim, a Pre-Service Claim or a Post-Service Claim shall be provided by Aetna personnel not involved in making an adverse benefit determination.

- **Urgent Care Claims** (may include concurrent care claim reduction or termination): Aetna shall issue a decision within 36 hours of receipt of the request for a level two appeal.
- **Pre-Service Claims** (may include concurrent care claim reduction or termination): Aetna shall issue a decision within 15 calendar days of receipt of the request for a level two appeal.
- **Post-Service Claims**: Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two appeal.

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

Exhaustion of Process

You must exhaust the applicable level one and level two processes of the Appeal Procedure before you establish any:

- litigation;
- arbitration; or
- administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

Appeal Definitions

Adverse Benefit Determination: A denial; reduction; termination of; or failure to provide or make payment (in whole or in part) for a service, supply or benefit.

Such adverse benefit determination may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is **experimental or investigational**; or
- A determination that the service or supply is not **medically necessary**.

Appeal: An oral or written request to Aetna to reconsider an **adverse benefit determination**.

Complaint: Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a previously approved course of treatment.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a previously approved course of treatment.

Pre-Service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- jeopardize your life;
- jeopardize your ability to regain maximum function;
- cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

The Decision of Aetna 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 not less than 60 calendar days or more than three years and 90 calendar days after the final appeal is denied by Aetna.

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.

DENTAL MAINTENANCE ORGANIZATION (DMO)

The Dental Maintenance Organization (DMO) provides services through a select group of Primary Care Dentists (PCD) who are under contract with the Dental Plan administrator to provide services at a discounted rate. You may be eligible to enroll in the DMO if there is a participating DMO dentist in your home ZIP code area. The DMO provides a broad range of dental services. Members select a participating PCD from Aetna's network to receive covered services.

PCD referrals and preauthorization are only required when specialty care is needed. No referrals are needed for orthodontia. The group number for the DMO Plan is 0727713.

The Dental DMO provides coverage when services are rendered by a PCD who must be a participating DMO dentist. There are no deductibles or dollar maximums with the Aetna Dental DMO plan option.

Please refer to the Aetna DMO booklet for detailed information regarding the plan's benefit provisions, claim procedures, and appeal process as DMO coverage can vary by state.

DMO Schedule of Benefits

Plan Design	
Annual Deductible	
Individual	None
Family	None
Services	
Preventive Services	0%
Basic Services	10%
Major Services	40%
Annual Benefit Maximum	None
Office Visit Copay	$0
Orthodontia	
Orthodontic Services	50%
Orthodontic Deductible	None
Orthodontic Lifetime Maximum	*

* 24 months of comprehensive orthodontic treatment plus 24 months of retention.

Other Services	Your Costs
Preventive	
Oral examinations*	0%
Cleanings (Adult/Child)*	0%
Fluoride*	0%
Sealants (permanent molars only)*	0%
Bitewing Images*	0%
Full Mouth Series Images*	0%
Space Maintainers	0%

Other Services	Your Costs
Basics	
Root Canal Therapy	10%
Anterior Teeth/Bicuspid Teeth	10%
Scaling and Root Planing*	10%
Gingivectomy†	10%
Amalgam (silver) Fillings	10%
Composite Fillings (anterior teeth only)	10%
➢ Stainless Steel Crowns	10%
Incision and Drainage of Abcess†	10%
Uncomplicated Extractions	10%
Surgical Removal of Erupted Tooth†	10%
Surgical Removal of Impacted Tooth (soft tissue)†	10%
Major	
Inlays‡	40%
Onlays‡	40%
Crowns‡	40%
Full and Partial Dentures	40%
Pontics	40%
Root Canal Therapy, Molar Teeth	40%
Osseous Surgery* †	40%
Surgical Removal of Impacted Tooth (partial bony/full bony)†	40%
General Anesthesia/Intravenous Sedation*	40%
Denture Repairs	40%
Crown Lengthening	40%
Crown Build-Ups	40%

Please refer to the Aetna DMO booklet for detailed information regarding the plan's benefit provisions, claim procedures, and appeal process as DMO coverage can vary by state.

* Certain services may be covered under the Medical Plan. Contact Member Services for more information.

† Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.

‡ Replacement only if the existing ones is at least five year old.

OTHER IMPORTANT INFORMATION

Changes in Coverage

Rules for changing coverage in the dental plan (PPO and DMO) (i.e., as the result of a Qualified Change in Status) may be found in the Qualified Change in Status section of the Allstate Cafeteria Plan SPD and your Aetna DMO booklet. You may also make changes to your coverage during Annual Enrollment, provided you are still eligible for coverage

Due to state law, DMO benefits for non-emergency services rendered by non-participating providers are available for contracts written in IL. The nonparticipating benefits available are subject to a $500 individual deductible and 70% coinsurance for Preventive/Diagnostic eligible procedures, 50% coinsurance for Basic and Major eligible procedures and plans with Orthodontic benefits include 50% coinsurance and $1,000 deductible.

Specialty Referrals

- Under the DMO dental plan, services performed by specialists are eligible for coverage only when prescribed by the primary care dentist and authorized by Aetna Dental. If Aetna's payment to the specialty dentist is based on a negotiated fee, then the member's copayment for the service will be based on the same negotiated fee. If Aetna's payment is on another basis, then the copayment will be based on the dentist's usual fee for the service, reviewed by Aetna for reasonableness.
- DMO members may visit an orthodontist without first obtaining a referral from their primary care dentist.

Emergency Dental Care

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week. You should contact your Primary Care Dentist to receive treatment. If you are unable to contact your PCD, contact Member Services for assistance in locating a dentist. Refer to your plan documents for details (subject to state requirements). Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

The plan pays a benefit at the network level of coverage even if the services and supplies were not provided by a network provider up to the dental emergency maximum of $75. The care provided must be a covered service or supply. You must submit a claim to Aetna describing the care given. Additional dental care to treat your dental emergency will be covered at the appropriate coinsurance level.

*Partial List of Exclusions and Limitations**

Coverage is not provided for the following:

- Services or supplies that are covered in whole or in part:
  - under any other part of this Dental Care Plan; or
  - under any other plan of group benefits provided by or through your employer.
- Services and supplies to diagnose or treat a disease or injury that is not:
  - a non-occupational disease; or
  - a non-occupational injury.
- Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
- Replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
- Plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
- Services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
- Dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion. (This item does not apply to California residents.)
- Services for (check the DMO coverage booklet):
  - an appliance or modification of one if an impression for it was made before the person became a covered person;
  - a crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; or
  - root canal therapy if the pulp chamber for it was opened before the person became a covered person.

- Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
- Services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.
- Space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Orthodontic procedure if an active appliance for that procedure was installed before coverage by the Plan.
- Orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
- General anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
- Treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
- In connection with a service given to a person age 5 or older if that person becomes a covered person other than:
  - during the first 31 days the person is eligible for this coverage, or
  - as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
    - after the end of the 12-month period starting on the date the person became a covered person; or
    - as a result of accidental injuries sustained while the person was a covered person; or
    - for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.
- Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
- A crown, cast or processed restoration unless:
  - it is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
  - the tooth is an abutment to a covered partial denture or fixed bridge.
- Pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.
- Surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.
- Services needed solely in connection with non-covered services.
- Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services. (This item does not apply to California residents.)

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

* This is a partial list of PPO exclusions and limitations; others may apply. Please check with Aetna for details, or if enrolled in the DMO, check your coverage booklet for details.

Your Dental Care Plan PPO Coverage Is Subject to the Following Rules:

Replacement Rule

The replacement of; addition to; or modification of: existing dentures; crowns; casts or processed restorations; removable denture; fixed bridgework; or other prosthetic services is covered only if one of the following terms is met:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.
- The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 7 years before its replacement.
- The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Tooth Missing But Not Replaced Rule

This item does not apply to California and Texas residents.

Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 5 years.

Alternate Treatment Rule

If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met: (a) the service must be listed on the Dental Care Schedule; (b) the service selected must be deemed by the dental profession to be an appropriate method of treatment; and (c) the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of (a) the copayment for the approved less costly service; plus (b) the difference in cost between the approved less costly service and the more costly covered service.

Finding Participating Providers

Consult Aetna Dental's online provider directory, DocFind®, for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. Not every provider listed in the directory will be accepting new patients. Although Aetna Dental has identified providers who were not accepting patients in our DMO plan as known to Aetna Dental at the time the provider directory was created, the status of a provider's practice may have changed. For the most current information, contact the selected provider or Aetna Member Services at the toll-free number, or use our Internet-based provider directory (DocFind) available at www.aetna.com.

The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.

In the event of a problem with coverage, members should contact Member Services for information on how to utilize the grievance procedure when appropriate.

All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.

In Arizona, DMO, Advantage Dental, Basic Dental and Family Preventive Dental Plans are provided or administered by Aetna Health Inc.

Please refer to the Aetna DMO booklet for detailed information regarding the plan's benefit provisions, claim procedures and appeal process as DMO coverage can vary by state. You may also contact Aetna member services.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. Aetna does not provide dental services and, therefore, cannot guarantee any results or outcomes. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.