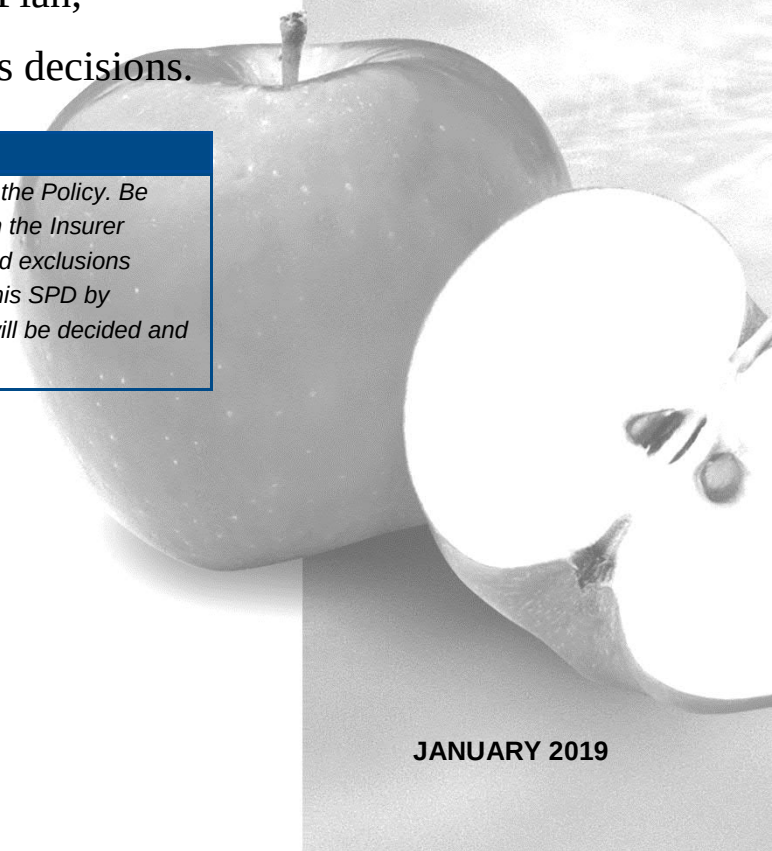
Group Accident Insurance Plan

This Summary Plan Description (SPD) represents a general summary of the features of the Allstate Group Accident Plan (the "Plan"). The Plan is insured under Group Accident Insurance Policy No. G0686 (the "Policy"), issued by American Heritage Life Insurance Company (the "Insurer"), which is a subsidiary of American Heritage Life Investment Corporation, which is a subsidiary of The Allstate Corporation. The Insurer provides administrative services on behalf of the Plan, including claims for benefits and appeals decisions.



NOTE

Because the Plan is insured, details of the Plan are governed by the Policy. Be sure to read your certificate of insurance ("the Certificate"), which the Insurer issues to each covered Plan participant. All terms, conditions, and exclusions found in the Policy and Certificate are hereby incorporated into this SPD by reference. Any discrepancies between the Policy and this SPD will be decided and resolved by the Plan Administrator, at his or her discretion.

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FACTS ABOUT THE PLAN

TERMS

Terms that are defined in the Plan Definitions *section 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* Plan Definitions *section for the definitions and/or more information about these terms.*

Summary Plan Description

The purpose of this Summary Plan Description is to explain the features of the Plan as clearly as possible. The Summary Plan Description should not be relied upon other than as a general summary of the features of the Plan. Your rights are governed by the terms of the Policy itself. You should refer to the Policy for complete information for any rights and obligations you have under the Plan. In the event of any difference between the terms of this Summary Plan Description and the Policy, the terms of the Policy shall control. Also, any questions concerning the Plan shall be determined in accordance with the terms of the Policy and not this Summary Plan Description. A copy of the Policy is available from the Plan Administrator's office.

Plan Name

The official name of the Plan is the Group Accident Insurance Plan, but it is frequently referred to as the "Plan" (within this SPD).

Plan Year

The Plan Year is the 12-month period beginning on January 1 and ending on the following December 31. The Plan maintains its financial records on the basis of a fiscal year that ends each December 31. The financial reports for the fiscal year are included in the Plan's annual report that is filed with the federal government.

Plan Administration

The Plan is sponsored by Allstate Insurance Company (Allstate) and administered by a Plan Administrator appointed by Allstate. The Plan Administrator shall have all of the duties and responsibilities imposed upon a Plan Administrator by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan Administrator has the discretionary authority to determine all questions arising under the Plan, including the power to determine the rights and eligibility of participants or any other persons, to make factual determinations, to construe and interpret the terms of the Plan, and to remedy ambiguities, inconsistencies, or omissions. Benefits under this Plan will be paid only if the Plan Administrator decides in his or her discretion that the applicant is entitled to them. Any construction, interpretation, or decision made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the construction, interpretation, or decision was arbitrary and capricious. The Plan Administrator shall have the authority to adopt procedures in order to administer the Plan.

The Plan Administrator may delegate to other persons responsibilities for performing certain duties under the Plan and may seek such expert advice as the Plan Administrator deems reasonably necessary. Because benefits under the Plan are insured, the Plan Administrator has delegated most of the powers, duties, and responsibilities described above, as well as the responsibility for claims review and the full and fair review of claim appeals pursuant to Section 503 of ERISA, to the Insurer. However, the Plan Administrator continues to have the sole and absolute discretion to determine eligibility under the Plan.

The address for the Plan Administrator and Agent for Service of Legal Process is:

Plan Administrator, Group Accident Insurance Plan
Allstate Insurance Company
2775 Sanders Road, F5
Northbrook, IL 60062-6127
(847) 402-8827

The decisions of the Plan Administrator and his or her authorized delegates will be final and binding.

Plan Financing

You pay the full cost of coverage under the Plan. Your premium contributions are made with after-tax dollars. You will pay the cost of coverage reflected on the *Your Benefits Resources*™ website, which may differ from the cost that appears in the Policy/Certificate issued by the Insurer. The difference in cost is due to the inclusion of certain expenses related to benefits administration.

Your Benefit Resources™ is a trademark of Hewitt Associates LLC.

Plan Identification

Employer Identification Number:

36-0719665

Plan Number:

554

Type of Plan

Employee welfare benefit plan providing group accident insurance coverage.

Participating Allstate Companies

- Allstate New Jersey Insurance Company
- Answer Financial, Inc. (AFI)
- Esurance Insurance Services Inc.

Plan Amendment and Termination

Allstate reserves the rights to modify, amend, suspend, or terminate the Plan and/or benefits offered under the Plan at any time, retroactively or otherwise, or to change the contribution amount required from Plan participants, by resolution of the Board of Directors of Allstate or a person duly delegated by the Board to take such action.

Clerical Errors

A clerical error by Allstate, the Plan Administrator, or the Insurer will neither void coverage which should be in force, nor will it continue coverage which should have ended. When an error is found, the Insurer and/or Plan Administrator reserves the right to determine whether a correction to contributions and/or benefits will be made.

No Employment or Vesting Rights

Participation in the Plan does not guarantee employment with Allstate or any other **Employer**, nor does it interfere with your Employer's right to discharge or terminate your employment at any time.

The Plan's participants and beneficiaries do not have a vested right in any of the Plan's benefits.

ELIGIBILITY AND EFFECTIVE DATES OF COVERAGE

Employee Coverage

You are eligible to enroll in the Plan if you are an **Employee**.

Dependent Coverage

Those eligible for dependent coverage are:

- **Your legal spouse.** For purposes of the Plan, "spouse" means a person to whom you are legally married.
- **Your civil union partner.** For purposes of the Plan, "civil union partner" means a same-sex or opposite-sex couple that has all the rights and obligations of marriage. A civil union relationship that was entered into outside of Illinois, which is valid under the laws of that jurisdiction in which the civil union relationship was created, is considered a civil union relationship in Illinois.
- **Your domestic partner.** For purposes of the Plan, "domestic partner" means your same-sex or opposite-sex partner who is eligible for coverage provided that:
  - both you and your same-sex or opposite-sex partner must be considered as domestic partners according to the law of your state of residence; or
  - if your state of residence has no domestic partnership law, the Employee and the domestic partner must:
    - have formalized their relationship pursuant to the applicable provisions of state or foreign law, or be in an exclusive committed relationship and intend that the relationship continue indefinitely;
    - share and maintain the same primary residence and be responsible for the other's welfare and financial obligations for at least 12 months prior to the effective date of coverage, and continue to do so;
    - be at least 18 years old and legally capable to enter into a contract;
    - not be married to, legally separated from, or in another domestic partner/civil union relationship with anyone else;
    - not be related by blood more closely than is permissible for marriage in the state of residence;
    - notify the Employer within 31 calendar days if the domestic partnership/civil union changes in such a manner that the domestic partner is no longer eligible for benefits; and
    - upon request by the Plan Administrator, submit proof satisfactory to the Plan Administrator that supports the nature of the domestic partner's eligibility for coverage.
- **Your children and your spouse's, civil union partner's, or domestic partner's children** who:
  - are under age 26; or
  - are incapable of self-sustaining employment by reason of a handicapped condition; became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and are chiefly dependent upon you for support and maintenance. Coverage for such an incapacitated dependent child is provided regardless of the age of the child as long as your coverage remains in force and the child remains in such condition; or

- are under 30 years of age and a military veteran who is an Illinois resident, not married, has served in the active or reserve components of the U.S. Armed Forces and has received a release or discharge other than a dishonorable discharge. To be eligible, veterans must:
  - have served in the active or reserve components of the U.S. Armed Forces, including the National Guard;
  - have received a release or discharge other than a dishonorable discharge; and
  - submit a proof of service using a DD2-14 (member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty." For information on how to obtain a copy of this form, contact the Illinois Department of Veterans' Affairs at 1-800-437-9824 or the U.S. Department of Veterans' Affairs at 1-800-827-1000.

➢ The term "child" means:

- your or your spouse's, civil union partner's, or domestic partner's natural or adopted son or daughter, stepson or stepdaughter; or
- a foster child who is placed with you or your spouse, civil union partner, or domestic partner by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

Proof of Eligibility

When you enroll yourself or a dependent, you are certifying that you have read and understand the eligibility provisions and that you and/or your dependents satisfy these requirements. The Plan Administrator may request documentation confirming an individual's eligibility at any time. Misrepresentation of eligibility may result in disciplinary action, including termination of employment.

Effective Dates of Coverage

Your coverage begins on the date you first become eligible for Employee coverage, if you have enrolled within 31 calendar days of your date of initial eligibility. These 31 days include the first day of eligibility.

You must be **Actively Employed** in order for coverage to be effective. This applies to your initial coverage, as well as any increase or addition to coverage that occurs after your initial coverage is effective.

Dependent coverage becomes available at the same time you become eligible for Employee coverage. If you have no dependents to enroll at that time, dependent coverage is available as provided in the section entitled "Availability of Coverage Outside the Initial 31-Day Eligibility Period."

Availability of Coverage Outside the Initial 31-Day Eligibility Period

If you or your eligible dependents do not enroll within the initial 31-day **Eligibility Period**, then you may be able to change most benefit choices during the **Annual Enrollment Period**. This includes the opportunity to enroll for coverage during the Annual Enrollment Period, with new coverage effective the following January 1.

You can also make certain benefit changes during the year if you experience a Qualified Change in Status. Changes made as a result of a Qualified Change in Status are generally effective on the date of your Qualified Change in Status.

To make a Qualified Change in Status during the Plan Year, you must make your election no later than 31 days from the date of your status change. If you are outside the 31 days allowed for making your change, call the Allstate Benefits Center immediately.

Annual Benefits Enrollment

If you did not elect coverage under the Plan upon your initial eligibility, you may apply for coverage for yourself as well as for your spouse/civil union partner/domestic partner and/or dependent child(ren).

You may increase your coverage option from Low to High. You may also decrease coverage from High to Low.

Qualified Changes in Status

Under Plan rules, you can make certain changes during the Plan Year if you notify the Allstate Benefits Center and make the allowable change on the Your Benefit Resources™ website at http://resources.hewitt.com/allstate within 31 days of a Qualified Change in Status. It is your responsibility to make these changes.

Event	Changes Allowed
Marriage or commencement of domestic partnership	➢ You may add, drop, or decrease coverage. ➢ You may not increase to High option if currently enrolled in Low option.
Divorce, legal separation, annulment or termination of dependent partnership	➢ You may add, drop, or decrease coverage. ➢ You may not increase to High option if currently enrolled in Low option.
Birth, adoption or placement for adoption	➢ You may add, drop, or decrease coverage. ➢ You may not increase to High option if currently enrolled in Low option.
Death of a spouse, civil union partner or domestic partner	➢ You may add, drop, or decrease coverage. Coverage will end for deceased spouse/civil union partner/domestic partner.
Death of a dependent child	➢ You may add, drop, or decrease coverage. Coverage will end for deceased dependent child. ➢ You may not increase to High option if currently enrolled in Low option.
Dependent child ceases to satisfy eligibility requirements	➢ Coverage will drop for ineligible dependents. ➢ No other changes allowed.
Dependent child satisfies eligibility requirements	➢ You may add, drop, or decrease coverage. ➢ You may not increase to High option if currently enrolled in Low option.
Loss of spouse's, civil union partner's or domestic partner's employment or decrease in hours that includes loss of coverage	➢ You may add, drop, or decrease coverage. ➢ You may not increase to High option if currently enrolled in Low option.
Commencement of spouse's, civil union partner's or domestic partner's employment or increase in hours that includes gain of coverage	➢ You may drop coverage. ➢ No other changes allowed.
Spouse's/civil union partner's/domestic partner's plan year (not annual enrollment period) does not correspond with Employee's plan year	➢ Automatically continues. No change allowed.
Change in work assignment which results in a change in eligibility	➢ You may add coverage.
Change in residence that results in a change of the participant's currently enrolled medical option	➢ Automatically continues. No change allowed.
Other non-Allstate medical coverage is lost	➢ Automatically continues. No change allowed.
Employee and/or dependents gain eligibility for Medicaid coverage	➢ Automatically continues. No change allowed.
Change in employment status	➢ See chart below.

Employment Status Change

Status Change	Changes Allowed
Termination	➢ Coverage ends on the last day of the period for which any required premiums are paid. Terminated Employee may continue coverage via Continuation of Insurance Coverage provision.
Death of Employee	➢ Coverage ends on the last day of the period for which any required premiums are paid. Dependents may continue coverage via Continuation of Insurance Coverage provision.
Retirement	➢ See Termination.
Short Term Disability (with pay)	➢ Coverage continues as an active employee as long as premiums are paid. No change allowed.
Long Term Disability (actually on unpaid Leave of Absence with an LTD and Life Premium Waiver indicator)	➢ Automatically continues as long as premiums are paid. No change allowed.
Terminated Totally Disabled	➢ Coverage ends on the last day of the period for which any required premiums are paid. Terminated employee may continue coverage via Continuation of Insurance Coverage provision.
Family Leave of Absence (LOA)	➢ Automatically continues as long as premiums are paid. No change allowed.
Illness LOA	➢ Automatically continues as long as premiums are paid. No change allowed.
Personal LOA	➢ Automatically continues as long as premiums are paid. No change allowed.
Military LOA	➢ Automatically continues as long as premiums are paid. No change allowed.

Note: For all leave types, if coverage was canceled due to non-payment, the change must be made within 31 days of returning to work.

BENEFIT INFORMATION

The Group Accident Insurance Plan pays the following benefits for a loss if, while coverage is in force, a covered person sustains an injury as a result of an accident. The injury must be diagnosed by a physician and the services described below must be provided or received within 180 days of the covered accident, unless otherwise stated. Any loss not stated in this Benefit Information section is not covered. Treatment must be received in the United States or its territories.

Schedule of Benefits

Subject to all other terms, conditions and exclusions of the Plan, including those found in the Policy, each Plan participant has a choice of either the Low Option or High Option Plan as listed below.

	Low Option Plan	High Option Plan
Base Accident Benefit		
➢ Initial Hospital Confinement	$500	$1,500
➢ Daily Hospital Confinement	$100	$300
➢ Intensive Care	$200	$600
Accident Treatment & Urgent Care Benefit		
➢ Ground Ambulance	$100	$300
➢ Air Ambulance	$300	$900
Accident Physicians Treatment	$50.00	$150.00
X-ray	$100	$300
Urgent Care	$50.00	$150.00

	Low Option Plan	High Option Plan
Benefit Enhancement		
Accident Follow-Up Treatment	$50.00	$50.00
Lacerations	$50.00	$50.00
Burns < 15% of body	$100	$100
> 15% of body	$500	$500
Skin Graft (% of Burns Benefit)	50% of burn benefit	50% of burn benefit
Brain Injury Diagnosis	$300	$300
Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI) Benefit	$50.00	$50.00
Paralysis Benefit Paraplegia	$7,500	$7,500
Quadriplegia	$15,000	$15,000
Coma with Respiratory Assistance	$10,000	$10,000
Open Abdominal or Thoracic Surgery	$1,000	$1,000
Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery Benefit		
With Repair	$500	$500
Without Repair	$150.00	$150.00
Ruptured Disc Surgery	$500	$500
Eye Surgery	$100	$100
General Anesthesia	$100	$100
Blood and Plasma	$300	$300
Appliance	$125.00	$125.00
Medical Supplies	$5.00	$5.00
Medicine	$5.00	$5.00
Prosthesis One device	$500	$500
Two or more	$1,000	$1,000
Physical, Occupational, or Speech Therapy	$30.00	$30.00
Rehabilitation Unit	$100	$100
Non-Local Transportation	$250.00	$250.00
Family Member Lodging	$100	$100
Post-Accident Transportation	$200	$200
Broken Tooth	$100	$100
Residence/Vehicle Modification	$500	$500
Pain Management (Epidural Injection)	$50	$50
Miscellaneous Outpatient Surgery	$100	$100
Dislocation/Fracture Benefit		
Dislocation/Fracture	Up to $2,000	Up to $6,000
Emergency Room Services Benefit		
Emergency Room Services	$50	$150

Base Accident Benefit Description

Initial Hospital Confinement: the Policy pays this benefit the first time a covered person is confined in a hospital after that person's effective date of coverage. This benefit is payable only once per covered person, per calendar year.

Daily Hospital Confinement: the Policy pays this benefit for each day a covered person is confined in a hospital up to a maximum of 365 days for any 1 accident, starting with the first full day of confinement. This maximum number of days may be used over a 2-year period following the date of the accident.

Intensive Care: the Policy pays this benefit for each day a covered person is confined in a hospital intensive care unit, up to 90 days for each period of continuous confinement, starting with the first full day of confinement.

Accident Treatment and Urgent Care Benefit Description

Ground Ambulance: the Policy pays this benefit if a covered person requires ground ambulance service for the transfer to or from a hospital. This benefit is payable only once per covered person, per accident.

Air Ambulance: the Policy pays this benefit if a covered person requires air ambulance service for the transfer to or from a hospital. This benefit is payable only once per covered person, per accident.

Accident Physician's Treatment: the Policy pays this benefit if a covered person receives treatment by a physician. This benefit is payable only once per covered person, per accident.

X-ray: the Policy pays this benefit if a covered person receives x-rays. This benefit is payable only once per covered person, per accident.

Urgent Care: the Policy pays this benefit if a covered person receives services at an urgent care facility. This benefit is payable only once per covered person, per accident.

Benefit Enhancement Description

Accident Follow-Up Treatment: the Policy pays this benefit for each day a covered person receives follow-up treatment. The Policy pays for 1 follow-up treatment per day for up to a maximum of 2 treatments per covered person, per accident. Treatments must be administered by a physician in a physician's office or in a hospital on an outpatient basis and must be for injuries sustained in an accident. This benefit is not payable for the same visit for which the Physical, Occupational or Speech Therapy benefit is paid.

Lacerations: the Policy pays this benefit if a covered person receives treatment for 1 or more lacerations (cuts). This benefit is payable only once per covered person, per accident.

Burns: the Policy pays this benefit if a covered person receives treatment for 1 or more burns, other than sun burns. This benefit is payable only once per covered person, per accident.

Skin Graft: the Policy pays this benefit if a covered person receives a skin graft for a burn for which a benefit is paid under the Burns benefit. This benefit is payable only once per covered person, per accident.

Brain Injury Diagnosis: the Policy pays this benefit upon the first diagnosis of 1 of the following traumatic brain injuries by a covered person: concussion, cerebral laceration, cerebral contusion, or intracranial hemorrhage. The covered traumatic brain injury must be diagnosed by computed tomography (CT) scan, magnetic resonance imaging (MRI), electroencephalogram (EEG), positron emission tomography (PET) scan, or X-ray. This benefit is payable only once per covered person, per accident.

Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI): the Policy pays this benefit if a covered person receives a CT scan or MRI. The covered person must be first treated by a physician within 30 days after the accident. This benefit is payable only once per covered person, per accident, and is limited to once per calendar year.

Paralysis: the Policy pays this benefit if a covered person receives a spinal cord injury resulting in the complete and permanent loss of use of 2 or more limbs as a result of an injury. Paralysis must be confirmed by the attending physician after the accident and have a duration of at least 90 consecutive days. This benefit is payable only once per covered person.

Coma with Respiratory Assistance: the Policy pays this benefit if a covered person is in a coma. This benefit is payable only once per covered person, per accident.

Open Abdominal or Thoracic Surgery: the Policy pays this benefit if a covered person undergoes open abdominal or thoracic surgery for internal injuries. The surgical procedure must be performed by a physician. This benefit is payable even if no surgical repair is required. This benefit is payable only once per covered person, per accident. If 2 or more surgical procedures are performed through the same incision or entry point, they are considered 1 operation.

Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery: the Policy pays this benefit if a covered person undergoes a surgical procedure to repair an injury to a tendon, ligament, rotator cuff or knee cartilage. The injured site must be torn, ruptured, or severed and the surgical procedure must be performed by a physician. This benefit is payable only once per covered person, per accident.

If exploratory surgery using arthroscopy is performed and no surgical repair is required then the Policy will pay the Without Repair amount. If 2 or more surgical procedures are performed through the same incision or entry point, they are considered 1 operation and the Policy will pay the amount for the procedure with the largest dollar amount benefit.

Ruptured Disc Surgery: the Policy pays this benefit if a covered person undergoes a surgical procedure to repair a ruptured disc of the spine. The ruptured disc must be diagnosed and the surgical procedure must be performed by a physician. This benefit is payable only once per covered person, per accident. If 2 or more surgical procedures are performed through the same incision or entry point, they are considered 1 operation.

Eye Surgery: the Policy pays this benefit for surgery or removal of a foreign object from the eye of a covered person. The procedure must be performed by a physician. An examination with or without anesthesia is not considered surgery. This benefit is payable only once per covered person, per accident.

General Anesthesia: the Policy pays this benefit if a covered person received general anesthesia administered by a nurse anesthetist or physician for surgery required to treat an injury provided a benefit is paid for surgery under one of the Surgery benefits. This benefit is payable only once per covered person, per accident.

Blood and Plasma: the Policy pays this benefit if a covered person receives a blood or plasma transfusion. This benefit is payable only once per covered person, per accident.

Appliance: the Policy pays this benefit if a covered person receives 1 of the following medical appliances prescribed by a physician as an aid in personal locomotion or mobility: wheelchair, crutches, or walker. This benefit is payable only once per covered person, per accident.

Medical Supplies: the Policy pays this benefit for over-the-counter medical supplies purchased for a covered person. This benefit is payable only once per covered person, per accident.

Medicine: the Policy pays this benefit for prescription or over-the-counter medicine purchased for a covered person. This benefit is payable only once per covered person, per accident.

Prosthesis: the Policy pays this benefit for a prosthetic arm, leg, hand, foot or eye prescribed by a physician to replace an arm, leg, hand, foot or eye that a covered person loses as a direct result of an accident. This benefit is payable only once per covered person, per accident.

Physical, Occupational or Speech Therapy: the Policy pays this benefit for physical, occupational or speech therapy treatment received by a covered person when prescribed by a physician for an injury. This includes chiropractic treatment. The Policy pays for 1 physical, occupational or speech therapy treatment per day for up to a maximum of 6 treatments per covered person, per accident. Physical, occupational or speech therapy must be for injuries sustained in an accident. This benefit is not payable for the same visit for which the Accident Follow-Up Treatment benefit is paid.

Rehabilitation Unit: the Policy pays this benefit if a covered person is confined to a rehabilitation unit as a result of an injury, provided that the covered person has been hospital confined immediately prior to being transferred to the rehabilitation unit. This benefit is paid for each day a room charge is incurred, up to 30 days for each covered person per continuous period of rehabilitation unit confinement, for a maximum of 60 days per calendar year. This benefit is not payable for days on which the Daily Hospital Confinement benefit in the certificate is paid.

Non-local Transportation: the Policy pays this benefit per trip for non-local treatment of a covered person by a physician when the same or similar treatment cannot be obtained locally. “Non-local” means a one-way trip of 50 miles or more from the covered person’s home to the nearest treatment facility. This benefit is payable up to 3 times per covered person, per accident. Transportation by ground or air ambulance is not covered under this benefit.

Family Member Lodging: the Policy pays this benefit per day for the lodging of 1 adult family member of the covered person's family to be with the covered person when a covered person is confined in a hospital. This benefit is payable for up to 30 days for each accident. This benefit is not payable if the family member lives within 50 miles one-way of the hospital.

Post-Accident Transportation: the Policy pays this benefit if a covered person is hospital confined for at least 3 consecutive days due to an injury resulting from an accident which occurs more than 250 miles from his or her place of residence and the covered person is brought home by a common carrier. Travel to the place of residence must take place within 48 hours following discharge from the hospital. This benefit is payable for the injured covered person only, and only if the Daily Hospital Confinement benefit in the certificate is paid. This benefit is payable only once per covered person, per calendar year.

Broken Tooth: the Policy pays this benefit if a covered person sustains a broken tooth that is repaired by a dental crown or filling, or is extracted. This benefit is payable for 1 crown, 1 filling or 1 extraction per covered person, per accident, regardless of the number of teeth involved. This benefit is only payable for injury to a sound, natural tooth. This benefit is not payable for injury caused by biting or chewing.

Residence/Vehicle Modification: the Policy pays this benefit if a covered person requires a permanent structural modification to the covered person's primary residence or vehicle. The modification must be certified by a physician as necessary to help enable the covered person to live in his or her primary residence or travel in his or her primary vehicle, due to the injury. The modification must occur within 365 days after the accident. This benefit is payable only once per covered person, per accident.

Pain Management (Epidural Injection): the Policy pays this benefit if a covered person receives an epidural injection in the spine to manage pain. This benefit is payable only once per covered person, per accident. An epidural injection must be for injuries sustained in an accident.

Miscellaneous Outpatient Surgery: the Policy pays this benefit if a covered person undergoes surgery on an outpatient basis. The surgical procedure must be performed by a physician. This benefit is payable only once per covered person, per accident. This benefit is not payable if the Open Abdominal or Thoracic Surgery, Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery, Ruptured Disc Surgery or Eye Surgery benefit is paid.

Dislocation/Fracture Benefit Description

Dislocation or Fracture: the Policy pays this benefit for a dislocation or fracture listed in the Policy. If more than 1 dislocation or fracture is sustained in any 1 injury, the total amount the Policy will pay for the multiple dislocations or fractures will not exceed the scheduled maximum benefit amount.

Emergency Room Services Benefit Description

Emergency Room Services: the Policy pays this benefit if a covered person, as a result of an injury, receives emergency room services. This benefit is payable only once per covered person, per accident.

Exclusions and Limitations

The Policy does not pay any benefits for any loss that is caused by or results from:

- injury incurred prior to the covered person's effective date of coverage subject to the INCONTESTABILITY provision; or
- any act of war whether or not declared, participation in a riot, insurrection or rebellion; or
- any bacterial infection (except infections which result from an accidental injury or infection which results from an accidental or involuntary or an unintentional ingestion of contaminated substance); or
- participation in any form of aeronautics except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
- engaging in an illegal occupation or committing or attempting to commit an assault or felony; or
- driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway; or

- all types of hernia, including complications due to hernia (except for hernia caused by an accident); or
- any injury sustained while the covered person is under the influence of alcohol or any drug, unless administered and taken as prescribed by a physician.

Any injury incurred while a covered person is an active member of the Military, Naval, or Air Forces of any country or combination of countries is not covered. Upon notice and proof of service in such forces, we will return the pro-rata portion of the premium paid for any period of such service.

CLAIMS PROCEDURES

How to File a Claim

You are encouraged to notify the Insurer of a claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim must be given to the Insurer within 20 days after the loss or commencement of any benefit covered by the Policy, or as soon as reasonably possible. Notice given to the Insurer by, or on behalf of, you or the beneficiary at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687, or to any authorized agent of the Insurer, with your name and certificate number, is notice to the Insurer.

The claim form can be requested from the Insurer by calling (888) 643-8319. If the claim form is not received within 15 days of the request, proof of the claim may be sent to the Insurer without waiting for the form.

The covered person must complete all applicable sections of the claim form and then give it to the attending physician. The physician should complete his or her section of the form and send it directly to the Insurer.

Written Proof of Claim

Proof must be given to the Insurer within 90 days after each loss. If it is not possible to give the Insurer proof in the time required, the Insurer will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to the Insurer no later than 1 year from the time specified unless you are legally incapacitated.

Claims Decisions

Within 30 calendar days after receiving a claim for benefits, the Insurer will:

- Either approve or deny the claim completely or partially; and
- Notify you or your representative of approval or denial of the claim

The Insurer has the right, at its own expense, to have any covered person examined by a physician of its choosing, as often as may be reasonably required while a claim is pending. The Insurer may have an autopsy performed during the period of incontestability, where it is not forbidden by law.

If Your Claim is Approved

After receiving written proof of claim, the Insurer will pay all benefits then due under this Plan. The Insurer will make payments to you unless such payments are assigned. All benefits will be paid within 30 calendar days of receiving written proof of claim or be subject to the interest rate of 9 percent per annum from the 30th calendar day of receipt of proof of claim to the date of payment. Interest totaling less than one dollar will not be paid. Notice will be provided by the Insurer to you or your assignee if there is insufficient documentation to process the proof of loss within 30 calendar days after receipt of claim. Any interest payments will be made within 30 calendar days after the payment.

Any amounts unpaid at your death may, at the Insurer's option, be paid either to the named beneficiary or to your estate. If benefits are payable to your estate or a beneficiary who cannot execute a valid release, the Insurer can pay benefits up to $1,000 to someone related to you or your beneficiary by blood or marriage whom the Insurer considers to be entitled to the benefits. The Insurer will be discharged to the extent of any such payment made in good faith.

If Your Claim is Denied

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

- Specific reasons for the decision;
- Specific references to the Plan provisions on which the decision is based;
- A description of any additional material or information required from you and an explanation of why such material is required; and
- A description of the review procedures and time limits applicable to such procedures.

Appealing Denial of Claims

On any wholly or partially denied claim, you or your representative may file an appeal with the Insurer for a full and fair review. You may:

- Request a review upon written application within 60 calendar days of the claim denial;
- Request, free of charge, copies of all documents, records and other information relevant to your claim; and
- Submit written comments, documents, records and other information related to your claim.

Send your appeal to the following address:

Allstate Benefits
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

The Insurer will notify you or your representative of its decision no more than 60 calendar days after your appeal is received. However, the time period may be extended for one 60-calendar-day period provided that, prior to the extension, the Insurer notifies you or your representative in writing that an extension is necessary due to special circumstances beyond its control, identifies those circumstances, and gives the date by which it expects to render a decision.

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

- Specific reasons for the decision;
- Specific references to the Plan provisions on which the decision is based; and
- A statement that you or your representative may request, free of charge, copies of all documents, records and other information relevant to your claim.

Decisions of the Insurer are final.

Incontestability

After two years from the effective date of the Policy, no misstatement of the **Policyholder**, made in any applications, can be used to void the Policy. After two years from the effective date of coverage, no misstatement of an Insured, made in writing, can be used to void coverage or deny a claim. After two years, no claim shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of the Policy.

Time Limits on Legal Actions

No claimant (including Plan participants and their beneficiaries) or claimant's representative may file or commence any lawsuit or legal action to obtain benefits under the Plan:

- for at least 60 days after proof of loss has been furnished; or
- after the expiration of 3 years from the time proof of loss is required to have been furnished.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. As an employee welfare benefit plan under ERISA, the Plan is subject to the HIPAA privacy rules. Pursuant to the HIPAA privacy rules, the Plan will not use or disclose your protected health information without your authorization, except for purposes or treatment, payment, health care options, Plan administration or as required or permitted by law. A description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the Plan's Notice of Privacy Practices, which can be accessed on the Allstate Intranet, or by contacting the office of the Plan Administrator.

TERMINATION OF COVERAGE

Your coverage under the Policy ends on the earliest of:

- the date the Policy is canceled;
- the last day of the period for which you made any required premium payments were made;
- the last day you are actively employed with your employer, except as provided under the TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE provision;
- the date you are no longer in an eligible class;
- the date your class is no longer eligible; or
- upon the Insurer's discovery of fraud or material misrepresentation in the presentation of a claim under the Policy.

The Policy will provide coverage for a **Payable Claim** that occurs while a covered person is covered under the Policy.

If your spouse or civil union partner is a covered person, your spouse's or civil union partner's coverage ends upon valid decree of divorce or your death.

If your domestic partner is a covered person, your domestic partner's coverage ends upon termination of the domestic partnership or your death.

Coverage for a dependent child ends on the certificate anniversary next following the date the child is no longer eligible. This is the earlier of when the child: (a) reaches age 26; or (b) 30 as described in "Dependent Coverage" on page 116. Coverage does not terminate on an unmarried child who:

- is incapable of self-sustaining employment by reason of a handicapped condition; and
- became so handicapped prior to the attainment of the limiting age of eligibility under the Policy; and
- is dependent upon you for lifetime care and supervision or other Care Providers, as defined.

This coverage continues as long your coverage remains in force and the dependent remains in such condition. Inquiry of the handicap and dependency of the child will be the Insurer's responsibility. At the time of inquiry, you will have 31 days to provide proof of the handicap and dependency of the child.

If premiums are accepted for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if you have children or family coverage in force and there are other eligible dependents still insured under the Policy.

CONTINUATION OF INSURANCE COVERAGE

This section of the SPD contains important information about Continuation of Insurance Coverage, hereafter referred to as Continuation Coverage. This section generally explains Continuation Coverage, when it may become available to you, your spouse, civil union partner, or domestic partner and children, and what needs to be done to protect the right to receive it.

What is Continuation Coverage?

Continuation Coverage is a continuation of group accident coverage under the Plan if a covered person suffers the loss of group accident coverage due to one of the following "qualifying events":

- Termination of your employment; or your eligibility due to reduction in hours; or the date you are no longer in an eligible class; or the date your class is no longer eligible. Insurance may be continued for any covered person.
- Your death. Insurance may be continued for any covered person.
- Divorce or legal separation. Insurance may be continued for any covered person whose insurance would otherwise end.
- Your becoming eligible for Medicare. Insurance may be continued for any covered person who is not entitled to Medicare.
- A child ceasing to be an eligible dependent as defined in the group policy. Insurance may continue for that child.
- The policyholder filing a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing of the bankruptcy.
- Termination of the group policy. (Benefits will be determined as if the group policy had remained in full force and effect.)
- Strike, layoff, leave of absence for personal reasons (not Family or Medical Leave Act (FMLA)). Insurance may be continued for any covered person.
- Military Service. Your leave of absence due to military service. Insurance may be continued for any covered person, except for the person who is in active military service.

The coverage being continued is subject to all terms and provisions of the group policy that do not conflict with this section. The coverage will be the same as that provided under the group policy for other persons in the same insurance class in which such person would have been if the loss of coverage had not occurred. The coverage will be subject to any changes to the group policy affecting the benefits of such class. The coverage will be effective on the day after the insurance under the group policy terminates.

Who is Eligible for Continuation Coverage?

To be eligible for Continuation Coverage, a person must be insured under the group policy on the day before the event that caused loss of coverage. In the case of bankruptcy, the person must also be: (a) an employee or member who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

Continuation Coverage is not available for any person if coverage under the group policy terminated due to your failure to make required premium payments.

Continuation Coverage is not available to any person who is on FMLA. Continuation Coverage is also not available if a person fails to pay premium while on FMLA.

A person will not be denied Continuation Coverage solely because he or she is covered under another group accident plan like this one, or eligible for Medicare on the date of the event that caused loss of coverage.

The Continuation Coverage may include any eligible dependents who were covered under the group policy.

You Must Give Notice of Some Qualifying Events

You or other qualifying dependents have the responsibility to inform the Insurer of: (a) divorce; (b) legal separation; or (c) a child losing eligibility under the policy. This notice must be made within 60 days of these events. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

The policyholder has the responsibility of notifying the Insurer of: (a) your death, termination of employment, or reduction in hours; or (b) the policyholder's bankruptcy. This notice must be made within 30 days of the event.

The Insurer will notify the qualifying person of the right to continue coverage within 14 days of the notice described above.

How Much Does Continuation Coverage Cost?

The qualifying person will be required to pay a premium for the Continuation Coverage to the Insurer.

Premiums are due and payable in advance to the Insurer at its home office. Premium due dates are the first day of each calendar month. The premium rate for the first 36 months of Continuation Coverage will not exceed 102% of the rate in effect under the group policy covering a similarly situated class of employees who have not elected Continuation Coverage. After the first 36 months, the premium rate may change for the class of persons covered under Continuation Coverage. Notice will be given at least 31 days before any change is to take effect.

Grace Period for Monthly Payments

Although monthly payments are due on the due date, you'll be given a Grace Period of 31 days after the first day of the coverage period to make each monthly payment. Your coverage will continue for each coverage period as long as payment is made before the end of the Grace Period for that payment. However, please be aware that claims incurred during the Grace Period may be denied and may need to be resubmitted.

If you fail to make a monthly payment before the end of the Grace Period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Events that End Continued Coverage

Insurance under Continuation Coverage will automatically end on the earliest of the following dates:

- The date the person again becomes eligible for insurance under the group policy.
- The last day for which premiums have been paid, if you fail to pay premiums when due, subject to the Grace Period.
- With respect to insurance for dependents:
  - the date your insurance terminates; or
  - the date the dependent ceases to be an eligible dependent under the group policy.

A dependent child whose Continuation Coverage terminates when he or she reaches the age limit may apply for Continuation Coverage in his or her own name, if he or she is otherwise eligible.

For More Information

The Allstate Benefits Center provides Continuation Coverage administration services on behalf of the Plan Administrator. If you need additional information, access the Your Benefits Resources™ website through Allstate Good Life (https://allstategoodlife.com/benefits) or call the Allstate Benefits Center toll-free at (888) 255-7772. Allstate Benefits Center Representatives are available between 8:00 a.m. and 6:00 p.m., Central time, Monday through Friday.

PLAN DEFINITIONS

Accident means a sudden, unforeseen and unexpected event which occurs without the covered person's intent which results in an injury to the covered person independent of disease or infirmity.

Active employment or **actively employed** means you are working for your employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. For the purposes of this coverage:

- you must be working at least the minimum number of hours as required by your employer; and
- you will be deemed to be in active employment on a day which is not the employer's scheduled work days only if you were actively employed on the preceding scheduled work day.

Your work site must be:

- the employer's usual place of business; or
- an alternative work site at the direction of your employer; or
- a location to which the job requires you to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

Allstate Benefits Center is the central administration office responsible for providing Employees with information pertaining to benefits. The Allstate Benefits Center collects, processes, and maintains benefit and enrollment records. The Allstate Benefits Center can be contacted at the *Your Benefits Resources*™ website through Allstate Good Life (https://allstategoodlife.com/benefits) or (888) 255-7772.

Your Benefits Resources™ is a trademark of Hewitt Associates LLC.

Annual Enrollment Period means the time each year as determined by the Policyholder and agreed to by American Heritage Life Insurance Company, during which you may elect insurance under the Policy that you previously declined.

Calendar Year means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Care Provider means a Community Integrated Living Arrangement, group home, supervised apartment, or other residential services licensed or certified by the Department of Human Services, the Department of Public Health or the Department of Public Aid.

Common carrier means only the following: commercial airlines; or passenger trains; or intercity buslines. It does not include: taxis; or intracity buslines; or private charter planes.

Confined or **confinement** means admitted to and confined as an inpatient in an institution for which a room and board charge is made by the institution. It does not include confinement for an observation room.

Continuous confinement means 1 continuous confinement or 2 or more confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Covered person means any of the following:

- any eligible family member (including you) as named in the enrollment form and acceptable for coverage by us; or
- any eligible family member added by endorsement after the effective date; or
- a newborn child.

Day means a 24 hour period.

Eligibility Period means the continuous period of time that you must be in active employment in an eligible class before you are eligible for coverage.

Employee means a person in an Employee-Employer relationship with the Employer who is classified by the Employer as either a Regular Full-Time Employee or Regular Part-Time Employee (as defined below) of an Employer:

- A "Regular Full-Time Employee" means any employee of an Employer who is regularly scheduled to work the full work week in the unit to which he/she is assigned.
- A "Regular Part-Time Employee" means any employee of an Employer who is (1) regularly scheduled to work less than the hours that comprise a full work week in the unit to which he/she is assigned, (2) has at least one year of continuous service, and (3) has accumulated at least 1,000 hours of service in an anniversary year.

The term Employee does not include the following persons who are performing services for and/or are classified by an Employer in one of the following categories, regardless of whether such persons are classified as common law employees of any Employer for tax or other purposes:

- Independent contractors, including those persons who are an Exclusive Agent Independent Contractor or an Exclusive Financial Specialist Independent Contractor;
- Full-time temporary employees;
- Part-time employees;
- Leased employees;
- An employee agent contracted under the Allstate R3000 Exclusive Agent Employee Agreement or the Allstate Agent Trainee Employment Agreement (R2672);
- International employees, which are those persons employed by an Employer whose permanent employment location is outside of the United States, regardless of whether such persons are on temporary assignment within the United States, and those persons who are neither a citizen nor a resident of the United States;
- Other persons excluded from participation by another provision of the Plan or an agreement with an Employer; or
- Other persons covered by a collective bargaining agreement unless such collective bargaining agreement provides for their coverage under the Plan.

If a person is not considered to be an Employee for purposes of Plan eligibility, a later change in the person's status, even if the change in status is applicable to prior years, will not have a retroactive effect for Plan purposes.

Employer refers to Allstate Insurance Company and all other participating affiliates and subsidiaries defined in the "Participating Allstate Companies" section.

Family Coverage means coverage that includes you, as defined, your eligible spouse, civil union partner or domestic partner and children.

Grace Period means a period of 31 days following the premium due date during which premium payment may be made.

Hospital means a legally operated institution with established facilities (either on its premises or available to the hospital on a contractual, pre-arranged basis and under the supervision of a staff of one or more duly licensed physicians), for the care and treatment of sick and injured persons for diagnosis, surgery, and 24-hour nursing service. Hospital does not include:

- any institution which is mainly a rest home, nursing home, convalescent home, or home for the aged; or
- any institution which is mainly for the care and treatment of alcoholics or drug addicts, or mental or nervous disorders.

Hospital intensive care unit means a hospital area of special care, including cardiac and coronary care units, surgical intensive care units or cardiovascular intensive care units, which at the time of admission are separate and apart from the surgical recovery room, or other rooms, beds or wards normally used for patient confinement. In addition, such a unit must provide the following:

- 24-hour continuous nursing care and attendance by nurses assigned to the unit on a full-time basis; and
- direction and/or supervision by a full-time physician director or a standing "intensive care" committee of the medical staff; and
- special medical apparatus used to treat the critically ill.

The following do not qualify as "hospital intensive care units":

- progressive care units;
- sub-acute intensive care units;
- intermediate care units;
- private rooms with monitoring;
- step-down units; or
- any other lesser care treatment units.

Individual Coverage means coverage that includes only you, as defined.

Individual and Children Coverage means coverage that includes only you, as defined, and eligible children.

Individual and Spouse/Civil Union Partner/Domestic Partner Coverage means coverage that includes only you, as defined, and your eligible spouse, civil union partner or domestic partner.

Injury means accidental bodily injury to a covered person as the result of an accident while coverage under this certificate is in force and the injury is the direct cause of the loss independent of disease or bodily infirmity, which results in medical treatment received within 180 days after the injury is sustained. All injuries sustained in any 1 accident and all complications and recurrences of complications are considered to be a single "injury".

Inpatient means a covered person who is a resident patient using the room and board facilities of an institution.

Material and substantial duties means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified, except that if you are required to work on average in excess of 40 hours per week, we will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

Nurse means any one of the following who is not a member of the covered person's immediate family or employed by the hospital where the covered person is confined:

- licensed practical nurse (L.P.N.); or
- licensed vocational nurse (L.V.N.); or
- graduate registered nurse (R.N.).

Payable Claim means a claim for which the Insurer is liable under the terms of the Policy.

Physician means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

The Insurer will not recognize you, your spouse, civil union partner or domestic partner, children, parents, or siblings as a physician for a claim.

Policyholder means the legal entity to whom the Policy is issued.

Temporary layoff or **leave of absence** or **family and medical leave of absence** means you are absent from active employment for a period of time that has been agreed to in advance in writing by the current employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

Under the Influence means a condition as defined and determined by the laws of the jurisdiction where the loss or cause of the loss was incurred.

You, Your or Yours means the named insured employee who is a member of an eligible class as described in the Policy and for whom premiums are remitted.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of EBSA.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for a covered person if there is a loss of coverage under the Plan as a result of a qualifying event. The qualifying person will be required to pay a premium for Continuation Coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing a covered person's Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court. Refer to each benefit plan section for specific time limitations and other conditions applicable to the filing of lawsuits.

In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay the person you have sued to pay these costs and fees, for example, if it finds Your claim is frivolous. Refer to each benefit plan section for specific time limitations and other conditions applicable to the filing of lawsuits.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Allstate Benefits Center. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the EBSA, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA.