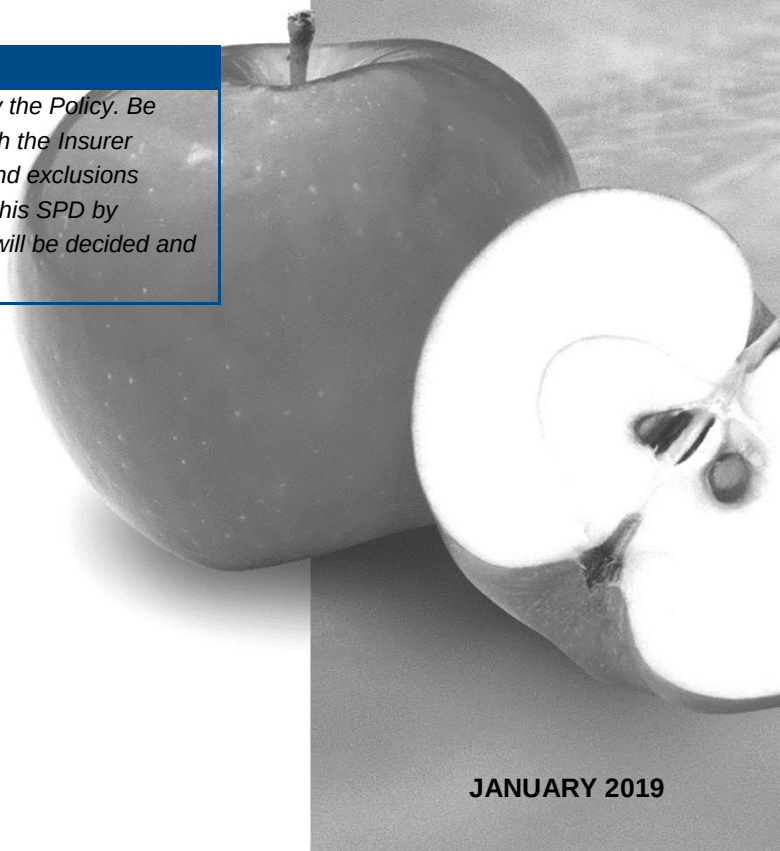
# Group Critical Illness Plan

This Summary Plan Description (SPD) represents a general summary of the features of the Group Critical Illness Plan (the "Plan"). The Plan is insured under Group Critical Illness Policy No. G-90343 (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 "Plan Definitions" on page 23 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 Critical Illness 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 Critical Illness 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:**

546

**Type of Plan**

Employee welfare benefit plan providing group critical illness 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. Coverage requiring **Evidence of Insurability (EOI)** will not be effective until approved by the Insurer.

You must be **Actively at Work** 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 or the date EOI is approved by the Insurer, if required.

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.

Coverage requiring EOI will not be effective until approved by the carrier.

## *Tobacco Use*

Employees and covered dependent(s) who enroll in the Group Critical Illness Plan and attest to being tobacco-free will not be subject to the tobacco-user rates. You must actively elect your tobacco status during your initial eligibility period and during each subsequent Annual Enrollment Period.

Specific terms are used when determining the applicability of the tobacco-user rates. Those terms are defined as follows:

- Tobacco products includes cigarettes, e-cigarettes, electronic cigarettes (e-cig or E-cigarettes), personal vaporizer (PV) or electronic nicotine delivery system (ENDS), cigars, pipes, snuff, chewing tobacco and/or any other product containing tobacco.
- Home means your primary residence.
- Smoke-free indoor environment at home is one in which no one uses or smokes "tobacco products" within the "home."

In order to be considered "tobacco-free," the following requirements must be met:

- You and your covered dependents must not use or smoke tobacco products at the time of Annual Benefits Enrollment and must pledge not to use or smoke tobacco products at any time during the **Plan Year** for which you are enrolling; **and**
- You and your covered dependents must have a smoke-free indoor environment at home at the time of Annual Benefits Enrollment and must pledge to maintain a smoke-free indoor environment at home throughout the Plan Year for which you are enrolling; **and**
- You must actively attest to being tobacco-free on the *Your Benefits Resources* website (YBR) (http://resources.hewitt.com/allstate).

If you do not actively attest to being tobacco-free on the *Your Benefits Resources* (YBR) website during Annual Benefits Enrollment, you will be subject to the per-paycheck tobacco-user rates. No changes to the tobacco use status will be allowed once the Plan Year begins.

## *Annual Benefits Enrollment*

You must actively elect your tobacco status annually on the Group Critical Illness Plan enrollment screen on the *Your Benefits Resources* website (YBR) through Allstate Good Life (https://allstategoodlife.com/benefits) during Annual Benefits Enrollment. If you do not actively elect your tobacco status on the YBR website during Annual Benefits Enrollment, your status will default to "Tobacco-User" and you will not receive the tobacco-free rates for the Plan Year for which you are enrolling. Changes to your tobacco status will not be allowed mid-year.

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/domestic partner and/or dependent child(ren). EOI is required for you and your spouse/domestic partner. EOI is not required for children.

You may increase your coverage option from Low to High. EOI is required for you and your spouse/domestic partner. EOI is not required for children. 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.<br>➢ You may not increase to High option if currently enrolled in Low option.<br>➢ If you are currently covered, you may add your spouse/domestic partner and/or dependent child(ren) without EOI.<br>➢ If you are not currently covered and are electing coverage for yourself or yourself and spouse/domestic partner and/or dependent child(ren), EOI is required for you and your spouse/domestic partner. |

| Event | Changes Allowed |
|---|---|
| Divorce, legal separation, annulment or termination of dependent partnership | ➢ You may add, drop, or decrease coverage.<br>➢ You may not increase to High option if currently enrolled in Low option.<br>➢ If you are currently covered, you may add dependent child(ren) without EOI.<br>➢ If you are not currently covered and are electing coverage for yourself and/or dependent child(ren), EOI is required for you only. |
| Birth, adoption or placement for adoption | ➢ You may add, drop, or decrease coverage.<br>➢ You may not increase to High option if currently enrolled in Low option.<br>➢ If you are currently covered, you may add dependent child(ren) without EOI.<br>➢ If you are not currently covered and are electing coverage for yourself or yourself and spouse/domestic partner and/or dependent child(ren), EOI is required for you and your spouse/domestic partner. |
| Death of a spouse or domestic partner | ➢ You may add, drop, or decrease coverage. Coverage will end for deceased spouse/domestic partner.<br>➢ You may not increase to High option if currently enrolled in Low option without EOI.<br>➢ If you are currently covered, you may add dependent child(ren) without EOI.<br>➢ If you are not currently covered and are electing coverage for yourself and/or dependent child(ren), EOI required only for you. |
| Death of a dependent child | ➢ You may add, drop, or decrease coverage. Coverage will end for deceased dependent child.<br>➢ You may not increase to High option if currently enrolled in Low option.<br>➢ If you are not currently covered and are electing coverage for yourself or yourself and spouse/domestic partner and/or dependent child(ren), EOI is required for you and your spouse/domestic partner. |
| Dependent child ceases to satisfy eligibility requirements | ➢ Coverage will drop for ineligible dependents.<br>➢ No other changes allowed. |
| Dependent child satisfies eligibility requirements | ➢ You may add, drop, or decrease coverage.<br>➢ You may not increase to High option if currently enrolled in Low option.<br>➢ If you are currently covered, you may add dependent child(ren) without EOI.<br>➢ If you are not currently covered and are electing coverage for yourself or yourself and spouse/domestic partner and/or dependent child(ren), EOI is required for you and your spouse/domestic partner. |
| Loss of spouse's or domestic partner's employment or decrease in hours that includes loss of coverage | ➢ You may add, drop, or decrease coverage.<br>➢ You may not increase to High option if currently enrolled in Low option.<br>➢ If you are currently covered, you may add spouse/domestic partner or other dependent child(ren). EOI is required for spouse/domestic partner.<br>➢ If you are not currently covered and are electing coverage for yourself or yourself and spouse/domestic partner and/or dependent child(ren), EOI is required for you and your spouse/domestic partner. |
| Commencement of spouse's or domestic partner's employment or increase in hours that includes gain of coverage | ➢ You may drop coverage.<br>➢ No other changes allowed. |
| Spouse's/domestic partner's plan year (not annual enrollment period) does not correspond with Employee's plan year | ➢ Automatically continues. No change allowed. |

| Event | Changes Allowed |
|---|---|
| Change in work assignment which results in a change in eligibility | ➢ You may add coverage.<br>➢ If you, your spouse/domestic partner and/or dependent child(ren) are enrolling, EOI is required for you and your spouse/domestic partner. |
| 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 portability provision or COBRA. |
| Death of Employee | ➢ Coverage ends on the last day of the period for which any required premiums are paid. Dependents may continue coverage via portability provision or COBRA. |
| 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 portability provision or COBRA. |
| 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, any application for coverage will require EOI and the change must be made within 31 days of returning to work.

# AVAILABLE BENEFITS

## *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. The amount payable for any covered Illness is determined by multiplying the option amount you selected by the coverage percentage for the covered Illness.

| | Low Option Plan Amount | High Option Plan Amount |
|---|---|---|
| **Basic Critical Illness Benefit** | | |
| ➢ Insured | $20,000 | $40,000 |
| ➢ Insured Spouse/Domestic Partner | $10,000 | $20,000 |
| ➢ Each Insured Child | $10,000 | $20,000 |
| **Critical Illness Cancer Benefit** | | |
| ➢ Insured | $20,000 | $40,000 |
| ➢ Insured Spouse/Domestic Partner | $10,000 | $20,000 |
| ➢ Each Insured Child | $10,000 | $20,000 |
| **Wellness Benefit (one per year)** | $100/Test | $100/Test |

## *Basic Critical Illness Benefit*

The Policy pays a Basic Critical Illness Benefit if you are diagnosed with one of the **Illnesses** shown below if:

- the **Date of Diagnosis** is after the effective date of coverage; and
- the Date of Diagnosis is while insured; and
- the Illness is not otherwise excluded.

The Illnesses covered under the Policy are shown in the following chart. The Basic Critical Illness Benefit amount payable for each Illness shown below is the percentage shown in the following table for each Illness multiplied by the Basic Critical Illness Benefit option amount you choose from the chart under "Schedule of Benefits" on page 11.

| Specified Critical Illness | Coverage Percentage for Basic Critical Illness Benefit |
|---|---|
| **Advanced Parkinson's Disease** | 25% |
| **Advanced Alzheimer's Disease** | 25% |
| **Benign Brain Tumor** | 100% |
| **Carcinoma in Situ** | 25% |
| **Coma** | 100% |
| **Complete Blindness** | 100% |
| **Complete Loss of Hearing** | 100% |
| **Coronary Artery Bypass Surgery** | 25% |
| **End Stage Renal Failure** | 100% |
| **Heart Attack** | 100% |
| **Invasive cancer** | 100% |
| **Major Organ Transplant** | 100% |
| **Paralysis** (not as a result of Stroke) | 100% |
| **Stroke** | 100% |

## *Basic Critical Illness Benefit Coverage*

A covered person can receive a benefit for each critical illness listed above, provided all other conditions for eligibility and coverage have been met.

A benefit can be paid for different Illnesses for the same covered person for the amount indicated for each Illness if the Illnesses are separated by 90 days.

The Basic Critical Illness benefit provides coverage only for the Illnesses shown in the chart above. It does not cover any other disease, **Sickness** or incapacity, unless specifically stated.

Claims for benefits not satisfying all the criteria for diagnosis are subject to review by an independent **Physician** consultant.

All covered Illnesses must be diagnosed by a Physician. Emergency situations that occur while you are outside the United States will be reviewed and considered for approval by a United States Physician on foreign soil or when you return to the United States.

As used in this section, Date of Diagnosis means the date of the following:

- **For Heart Attack:** The date of death (infarction) of a portion of the heart muscle.
- **For Stroke:** The date a Stroke occurred based on documented neurological deficits and neuroimaging studies.
- **For End-Stage Renal Failure:** The date you begin renal dialysis.
- **For Major Organ Transplant or Coronary Artery Bypass Surgery:** The date the actual surgery occurs for covered transplants or bypass surgery.
- **For Paralysis:** The date the diagnosis is established by the Physician based on clinical and/or laboratory findings as supported by your medical records.
- **For Alzheimer's Disease:** The date of the diagnosis is the date a Physician diagnoses you as incapacitated due to Alzheimer's Disease.
- **For Benign Brain Tumor:** The date a physician determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or a specific neuroradiological examination.
- **For Coma:** The date of the first day of the period for which a physician confirms a coma has lasted for 14 consecutive days.
- **For Complete Blindness:** The date an ophthalmologist makes an accurate certification of complete blindness.
- **For Complete Loss of Hearing:** The date an audiologist makes an accurate certification of total and permanent hearing loss.
- **For Paralysis:** The date a physician establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.
- **For Advanced Parkinson's Disease:** The date a physician diagnoses the covered person as incapacitated due to Parkinson's disease.
- **Invasive Cancer:** The date the tissue specimen, culture and/or titer(s) are taken on which the diagnosis of cancer is based.
- **Carcinoma in Situ:** The date the tissue specimen, culture and/or titer(s) are taken on which the diagnosis of cancer is based.

## *Critical Illness Cancer Benefit*

The Policy pays a Critical Illness Cancer Benefit if a covered person is diagnosed with a new form or type of **Invasive Cancer** or **Carcinoma in Situ**, as defined, subject to all of the following:

- clear and definitive diagnosis by either a pathological or clinical method; and
- the Date of Diagnosis is after the effective date of coverage; and
- the Date of Diagnosis is while this benefit is in force; and
- the Illness is not otherwise excluded.

## *Wellness Benefit*

The Policy pays a Wellness Benefit when the Insured has a preventive test performed while not hospital confined.

This benefit is limited to 1 test per **Calendar Year**, per person. The benefit amount is for each Calendar Year.

Eligible tests are as follows:

- Bone Marrow Testing; and
- Biopsy for skin cancer; and
- Blood test for triglycerides; and
- CA15-3 (cancer antigen 15-3-blood test for breast cancer); and
- CA125 (cancer antigen 125—blood test for ovarian cancer); and
- CEA (carcinoembryonic antigen—blood test for colon cancer); and
- Carotid Doppler; and
- Chest X-ray; and
- Colonoscopy; and
- Doppler screening for peripheral vascular disease; and
- Echocardiogram; and
- EKG (Electrocardiogram); and
- Flexible sigmoidoscopy; and
- Hemoccult stool analysis; and
- HPV (Human Papillomavirus) Vaccination; and
- Lipid panel (total cholesterol count); and
- Mammography, including Breast Ultrasound; and
- Pap Smear, including ThinPrep Pap Test; and
- PSA (prostate-specific antigen — blood test for prostate cancer); and
- Serum Protein Electrophoresis (test for myeloma); and
- Stress test on bike or treadmill; and
- Thermography; and
- Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms.

Information on filing claims including the Express Wellness Claims Process and payment to your bank account by ACH can be accessed at www.allstateatwork.com/mybenefits.

## *Exclusions and Limitations*

The Policy does not pay benefits for an Illness due to, or resulting directly from:

- any act of war, whether or not declared, participation in a riot, insurrection or rebellion; or
- intentionally self-inflicted injuries; or
- **Injury** incurred while engaging in an illegal occupation or committing or attempting to commit a felony; or
- suicide, while sane or self destruction while insane, or any attempt at either; or
- drug addiction or dependence upon any controlled substance.

### Pre-Existing Condition Limitation

The Policy does not pay any benefit due to, or caused by, a **Pre-Existing Condition**, as defined, during the 12-month period beginning on the date that person became Insured.

## *Exclusions and Limitations*

The Policy does not pay benefits for an Illness due to, or resulting directly from:

- any act of war, whether or not declared, participation in a riot, insurrection or rebellion; or
- intentionally self-inflicted injuries; or
- **Injury** incurred while engaging in an illegal occupation or committing or attempting to commit a felony; or
- suicide, while sane or self destruction while insane, or any attempt at either; or
- drug addiction or dependence upon any controlled substance.

### Pre-Existing Condition Limitation

The Policy does not pay any benefit due to, or caused by, a **Pre-Existing Condition**, as defined, during the 12-month period beginning on the date that person became Insured.

# PINNACLECARE BENEFIT OPTION

If you enroll in Group Critical Illness Coverage, you may also elect to have the PinnacleCare Benefit option. The PinnacleCare Benefit option provides access to the PinnacleCare Health Advisory team who can help you navigate through any covered Illness and guide you through the medical decisions or complex healthcare needs you may be facing. Your PinnacleCare Advisor, supported by M.D./Ph.D. researchers, will help to connect you with the most appropriate specialists and best course of treatment for your critical illness.

The following assistance can be accessed through your PinnacleCare Health Advisory Team:

- Collection, organization and physician review of your medical records.
- Identification of a top medical expert to review and confirm the details of your diagnosis and treatment options.
- Personalized research and reports on top-ranked specialists, evidence-based treatment options, and clinical trials.
- Scheduling of appointments with top medical experts and Centers of Excellence.
- Transfer of your medical records for physician review prior to your appointment.
- Virtual consultation (if geographic and/or health limitations warrant).

For a confidential consultation with a PinnacleCare Advisor, please call 1-888-442-7380. You may also submit a secure online request or access additional details at www.pinnaclecare.com/support.

# CLAIMS PROCEDURES

## *How to File a Claim*

Notice of a claim must be given by you, as the insured, within 20 calendar days after an occurrence or commencement of any illness covered by the Policy. If notice cannot be given within that time, it must be given as soon as reasonably possible. Notice will be sufficient if it identifies you and the Policy. You may provide notice by calling the Insurer at 1-888-643-8319. Notice may also be provided in writing and sent to the following address:

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

## *Written Proof of Claim*

Written proof must be given to the Insurer within 90 calendar days after the date of each illness. If this is not reasonably possible, proof must be given to the Insurer as soon as possible. Unless you are legally incapacitated, written proof must be given within one year of the time it is otherwise due.

After the Insurer receives the written notice of claim, the Insurer will furnish claim forms within 15 calendar days. If the Insurer does not, it will consider you to have met the requirements for written proof of claim if the Insurer is given written proof of the extent and nature of the claim.

## *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 time period for notice of decision may be extended for one additional 90-calendar-day period provided that, prior to any extension period, the Insurer notifies you or your representative in writing that an extension is necessary due to circumstances beyond its control, identifies those circumstances, and gives the date by which it expects to render a decision.

During this period, the Insurer may require a medical examination, at its own expense, in order to make a determination on your claim. If a medical examination is necessary, you will be given the time of the appointment and the doctor's name and location.

### If Your Claim is Approved

After receiving written proof of claim, the Insurer will pay all benefits due under this Plan and will make payments to you immediately. 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 30$^{th}$ 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 the Insured or their 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. Any payment will discharge the Insurer's liability for the amount so paid.

### 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 Starting Lawsuits*

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 benefits under the Plan, without first having complied with and exhausted all levels of appeal required by the Plan, and in any event not less than 60 calendar days or more than three years and 90 calendar days after the final appeal is denied by the Insurer.

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

## *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 at Work, except for periods while you are on an Employer-approved Leave of Absence, and you continue to make required premium contributions;
- the date you are no longer in an eligible class;
- the date your class is no longer eligible; or
- the date you have received the maximum total percentage of the basic benefit amount for each Critical Illness.

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

If you have **Individual and Spouse/Domestic Partner** or **Family Coverage**, your spouse's/domestic partner's coverage ends upon valid decree of divorce, termination of domestic partnership, or your death, whichever occurs first.

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 6. 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 an Insured, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if the Insured has **Individual and Children Coverage** or Family Coverage and there are other eligible dependents insured under the Policy.

Upon your death, the dependent's coverage, if any, continues for a period of at least 90 days, subject to any other provisions relating to termination of dependent coverage.

# CONTINUATION OF INSURANCE (COBRA)

This section of the SPD contains important information about COBRA continuation coverage, which is a temporary extension of Plan coverage. This section generally explains COBRA continuation coverage, when it may become available to Employees, their spouses and dependent children, and what needs to be done to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to an Employee when the Employee would otherwise lose group health coverage. It can also become available to other members of the Employee's family who are insured when they would otherwise lose such insurance. The coverage described below may change as permitted or required by changes in applicable law.

## *What Is COBRA Continuation Coverage?*

COBRA continuation coverage is a continuation of group health coverage under the Plan when coverage or participation would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary", including the Employee, Employee's spouse and dependent children.

An Employee will become a qualified beneficiary if coverage is lost under the Plan because either one of the following qualifying events happens:

- the Employee's hours of employment are reduced; or
- the Employee's employment ends for any reason other than gross misconduct.

The spouse of an Employee will become a qualified beneficiary if coverage is lost under the Plan because any of the following qualifying events happens:

- the Employee's hours of employment are reduced;
- the Employee's employment ends for any reason other than gross misconduct;
- death of the Employee; or
- the spouse divorces or legally separates from the Employee.

The dependent children of an Employee will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens;

- the Employee's hours of employment are reduced;
- the Employee's employment ends for any reason other than gross misconduct;
- death of the Employee;
- the Employee divorces or legally separates; or
- the dependent stops being eligible for coverage under the Plan as a "dependent child."

**NOTE**

*Although not specifically required under COBRA, the Plan may extend continuation coverage to eligible domestic partners and/or their eligible covered dependent children upon specified qualifying events. This continuation coverage will generally follow many of the same rules for COBRA continuation coverage that apply to spouses or an Employee's own dependent children, including notice and enrollment deadlines.*

*If an Employee's employment ends immediately following a Family and Medical Leave Act (FMLA) protected leave of absence, the qualifying event occurs on the last day of FMLA leave regardless of whether the Employee paid premiums or declined coverage during the FMLA leave.*

## When Is COBRA Coverage Available?

The Allstate Benefits Center will offer COBRA continuation coverage to qualified beneficiaries only after it has been notified that a qualifying event occurred. For the following qualifying events, the Employer will notify the Allstate Benefits Center of the qualifying event:

- the Employee's hours of employment are reduced; or
- the Employee's employment ends for any reason other than gross misconduct;
- death of the Employee.

It may take up to 30 days for your Employer to send certification of your COBRA eligibility to your benefits administrator. Written confirmation of your COBRA election rights, cost information, and enrollment instructions will be mailed to you within 14 days of the date that your benefits administrator receives COBRA eligibility certification from your Employer.

## You Must Give Notice of Some Qualifying Events

For the following qualifying events, the Employee, Employee's spouse, dependent child or their representative must notify the Allstate Benefits Center within 60 days after the qualifying event occurs:

- the Employee divorces or legally separates; or
- a dependent child's loss of eligibility for coverage under the Plan.

You must notify the Allstate Benefits Center of the qualifying event by calling (888) 255-7772. You will forfeit your rights to COBRA coverage if you don't notify the Allstate Benefits Center within the above 60-day time frame.

## How Is COBRA Coverage Provided?

Once the Allstate Benefits Center receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. An Employee may elect continuation coverage on behalf of his or her spouse and dependent children. An Employee's spouse may also elect continuation coverage on behalf of eligible dependent children. To elect continuation coverage, you must call the Allstate Benefits Center at (888) 255-7772 by the enrollment deadline provided on the COBRA Enrollment Notice. If you don't enroll within that time frame, you forfeit your rights to COBRA coverage.

## How Much Does COBRA Continuation Coverage Cost?

Generally, each qualified beneficiary is required to pay the entire cost of continuation coverage on an after-tax basis. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in the COBRA Enrollment Notice. The total cost of continuation coverage may vary from the sum of the Employee contribution and Employer Credits reflected on the Employee's pay notice and may change periodically.

## When Does COBRA Coverage Become Effective?

Your COBRA coverage will take effect with the receipt of your first monthly premium payment and is retroactive to the date that your Employer-provided coverage ends (as long as you pay the premium on time).

# *Length of COBRA Coverage*

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 36 months for the spouse and dependent children of an Employee:

- death of the Employee;
- divorce or legal separation from the Employee; or
- the dependent child stops being eligible for coverage under the Plan as a "dependent child."

When the qualifying event is one of the following events, COBRA continuation coverage lasts for up to a total of 18 months for qualified beneficiaries:

- the Employee's hours of employment are reduced; or
- the Employee's employment ends for any reason other than gross misconduct.

There are two ways in which an 18-month period of COBRA continuation coverage can be extended:

## Disability Extension of 18-Month Period of Continuation Coverage

COBRA coverage may be available for up to a total of 29 months if:

- the Employee (or former Employee), covered spouse or covered dependents (including newborn and newly adopted children) are determined to be disabled as defined by the Social Security Act prior to the qualifying event or during the first 60 days of COBRA coverage;
- the Social Security Administration's disability determination is received within the disabled individual's 18 months of COBRA coverage;
- the disability must last at least until the end of the 18-month period of continuation coverage; and
- the Allstate Benefits Center is notified of the Social Security Administration's disability determination within 60 days of the disabled individual's receipt of a Social Security Disability award. If the disability determination occurred before COBRA coverage started, you're required to notify the Allstate Benefits Center within the first 60 days of COBRA coverage.

The Employee (or former Employee), covered spouse, covered dependents or their representative must notify the Allstate Benefits Center within 60 days of receipt of the disability determination and prior to the end of the initial 18-month continuation period in order to receive the coverage extension. To notify the Allstate Benefits Center of the disability determination event, call (888) 255-7772. You will forfeit your rights to the coverage extension if you don't notify the Allstate Benefits Center within the 60-day time frame.

The Employee (or former Employee), covered spouse, covered dependents or their representative must notify the Allstate Benefits Center within 30 days of the date of the disability ends by calling (888) 255-7772.

## Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If certain other qualifying events occur while receiving 18 months of COBRA continuation coverage, an Employee's (or former Employee's) spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. Additional continuation coverage is available only if the event would have caused a loss of coverage under the Group Critical Illness Plan had the first qualifying event not occurred. These events include:

- death of the Employee (or former Employee);
- divorce or legal separation from the Employee (or former Employee); or
- the dependent child stops being eligible for coverage under the Group Critical Illness Plan as a "dependent child."

The Employee (or former Employee), covered spouse, covered dependents or their representative must notify the Allstate Benefits Center within 60 days after the event occurs in order to receive this additional coverage. To notify the Allstate Benefits Center of the additional qualifying event, call (888) 255-7772. You will forfeit your rights to the coverage extension if you don't notify the Allstate Benefits Center within the 60-day time frame.

# *When and How Must Payment for COBRA Continuation Coverage Be Made?*

## First Payment for Continuation Coverage

If you elect continuation coverage, you will receive a billing notice from the Allstate Benefits Center. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. If you do not make your first payment for continuation coverage, in full, no later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You will receive a Billing Notice confirming the amount of the payment. Contact the Allstate Benefits Center at (888) 255-7772 if you have questions about your first payment.

Payment should be sent to:

Allstate Benefits Center
P.O. Box 0637
Carol Stream, IL 60132-0637

When you mail your payment, make sure you allow for normal mail delivery time — plus an additional two business days — for your payment to be received and processed by your local benefits administrator.

## Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary will be shown on the COBRA Enrollment Notice. The periodic payments are made on a monthly basis. Under the Plan, each of the periodic payments for continuation coverage is due as described in the Billing Information section on the COBRA Enrollment Notice. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without a break. You will receive a Billing Notice each period that lists the amount due for the coverage period.

## Grace Periods for Monthly Payments

Although monthly payments are due on the due date, you'll be given a **Grace Period** after the first day of the coverage period to make each monthly payment. The due date and the length of the Grace Period are listed in the Billing Information section of the COBRA Enrollment Notice. 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 if you make a monthly payment during the Grace Period, claims incurred during this 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 May Change Continued Coverage*

Once COBRA coverage begins, COBRA coverage elections may be able to be changed based on the Plan rules if you experience a Qualified Change in Status. The Employee (or former Employee), covered spouse, covered dependents or their representative must notify the Allstate Benefits Center by calling (888) 255-7772 within 31 days of the Qualified Change in Status to change coverage elections. Adding family members to COBRA coverage may result in a higher premium for this additional coverage.

COBRA coverage may also be changed if a child is born to the Employee (or former Employee), adopted or placed for adoption with the covered Employee (or former Employee) during the 18-, 29-, or 36-month continuation period. In such case, the Employee (or former Employee), covered spouse, covered dependents or their representative must notify the Allstate Benefits Center by calling (888) 255-7772 within 60 days of the birth, adoption or placement to cover the new dependent as a qualified beneficiary under COBRA. The continuation period for such child will be measured from the date of the Employee's (or former Employee's) original qualifying event and there may be a higher premium for this additional coverage.

## *Events that End Continued Coverage*

COBRA coverage will end automatically upon the expiration of the 18-, 29-, or 36-month continuation period described above. In addition, COBRA coverage will end automatically if any of the following situations occur:

- your Employer stops providing group health benefits;
- premiums are not paid within 30 days of the due date (with the exception of the initial premium which is due within 45 days of the election date); or
- a person eligible for continued benefits becomes covered under any other group health plan (unless the health plan has an enforceable Pre-Existing Condition clause) or becomes entitled to Medicare.

The Plan reserves the right to terminate your continuation coverage retroactively if it is determined that you are ineligible for coverage or for any reason the Plan would terminate coverage of an individual who is not receiving continuation coverage (such as fraud).

## *For More Information*

The Allstate Benefits Center provides COBRA 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.

# PORTABILITY PROVISION

The Insurer will provide Critical Illness insurance portability coverage, subject to these provisions.

Such coverage will not be available for you, unless:

- coverage under the Policy terminates under the General Provision entitled "Termination of Coverage";
- the Insurer receives a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and
- the request is made for that purpose.

No portability coverage will be provided for you, if your Critical Illness insurance under the Policy terminated due to your failure to make required premium payments.

## *Coverage*

The benefits, terms and conditions of the portability coverage will be the same as those provided under the Policy for Critical Illness when the insurance terminated. Portability coverage may include any eligible dependents who were covered under the Policy. Any change made to the Policy after you are insured under the portability provision will not apply to you unless it is required by law.

Portability coverage will be effective on the day after Critical Illness insurance under the Policy terminates or the day after COBRA coverage terminates.

## *Premiums*

Premiums are due and payable in advance to the home office of American Heritage Life Insurance Company. Premium due dates are the first day of each calendar month. The portability premium rate may differ from the premium rate in effect for Insureds under the Policy. The Insurer has the right to change the rate table on any premium due date. Written notice will be given at least 31 days before the change is to take effect.

## *Grace Period*

The Grace Period, as defined, will apply to each certificate holder of portability coverage as if such Insured is the Policyholder.

## *Termination of Insurance*

Insurance under this portability provision will automatically end on the earliest of the following dates:

- The date you again become eligible for Critical Illness insurance under the 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 dependents cease to be eligible under the Policy.

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

## *Termination of the Policy*

If the Policy terminates, Insureds and family members will be eligible to exercise the portability provision on the termination date. Portability coverage may continue beyond the termination date, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the Policy had remained in full force and effect.

# PLAN DEFINITIONS

**Actively at Work or Active Work** means that you are working your full number of hours for your full rate of pay for the Employer at the regular place of employment in accordance with established employment practices.

If you were Actively at Work, as defined above, on your last regular working day, then you shall be deemed to be Actively at Work:

- on each day of designated PTO;
- on each day for which Short Term Disability is paid; or
- on a regular non-working day on which you are not disabled.

Being on a leave of absence means you are not Actively at Work.

**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.

**Alzheimer's Disease** means a clinically established diagnosis of the disease by a psychiatrist or neurologist, resulting in the inability to perform, independently, three or more of the following activities of daily living:

- bathing; or
- bladder and bowel continence; or
- eating; or
- dressing; or
- transferring in and out of bed, chair, or wheelchair; or
- toileting.

**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.

**Carcinoma in Situ** means a diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Carcinoma in Situ includes:

- early prostate cancer diagnosed as stage A or equivalent staging; and
- melanoma not invading the dermis.

Carcinoma in Situ does not include:

- other skin malignancies; or
- pre-malignant lesions (such as intraepithelial neoplasia); or
- benign tumors or polyps.

Carcinoma in Situ must be identified pursuant to a pathological or clinical diagnosis as defined in the clinical or pathological diagnosis.

**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.

**Clinical Diagnosis** means a clinical identification of cancer based on history, laboratory study and symptoms. Benefits will be paid for a clinical diagnosis only if:

- a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and
- there is medical evidence to support the diagnosis.

**Coronary Artery Bypass Surgery** means the undergoing of a surgical operation to correct narrowing or blockage of one or more coronary arteries with bypass grafts on the advice of a cardiologist registered in the United States.

Angiographic evidence to support the necessity for this surgery will be required.

The following procedures are not considered coronary artery by-pass surgery: abdominal aortic bypass; balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.

**Date of Diagnosis** for cancer means the earliest of the date of: tentative diagnosis, clinical diagnosis or the day the tissue specimen, culture and/or titer(s) are taken, upon which the positive or tentative diagnosis of cancer is made.

**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.

**End Stage Renal Failure** means failure of both kidneys to perform their essential functions, with the Insured undergoing peritoneal dialysis or hemodialysis or a renal transplant.

**Evidence of Insurability (EOI)** means any statement or proof of a person's physical condition, occupation or other factor affecting his or her acceptance for insurance. If you are required to submit EOI, you may be required, at your own expense, to complete and sign a health and medical history form, submit to a medical exam, and/or provide additional information and attending Physician statements.

**Family Coverage** means coverage that includes you, your spouse/domestic partner and eligible children.

**Grace Period** means a period of 30 days following the premium due date during which premium payment may be made.

**Heart Attack** means the death of a portion of heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be based on both:

- new electrocardiographic changes; and
- elevation of cardiac enzymes or biochemical markers showing a pattern and to a level consistent with a diagnosis of Heart Attack.

Heart Attack does not include an established (old) myocardial infarction.

**Heart Transplant** means the surgical transplantation of the heart from a patient who died and whose heart was intact and capable of functioning in the recipient. The transplanted organ must come from a human donor.

**Illness** means one of the specified Critical Illnesses listed under "Basic Critical Illness Benefit" on page 11 and "Critical Illness Cancer Benefit" on page 13 of this SPD.

**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/Domestic Partner Coverage** means coverage that includes only you, as defined, and your eligible spouse/domestic partner.

**Injury** means accidental bodily Injury sustained by you while coverage under the Policy is in force.

**Insured** means an employee or member who is age 18 or older and has: (1) fulfilled all eligibility requirements set forth in the Policy; and (2) properly completed and signed the enrollment form, provided that the form has been received by the Insurer and any required Evidence of Insurability has been approved by the Insurer.

**Invasive Cancer** means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. This includes Leukemia and Lymphoma.

The following are not considered invasive cancer for purposes of this benefit: Carcinoma in Situ; tumors in the presence of any human immunodeficiency virus; skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic; and early prostate (stage A) cancer.

**Major Organ Transplantation** means the surgical transplantation of a lung, liver, pancreas, heart, or kidney. The transplanted organ must come from a human donor.

**Paralysis** means the complete and permanent loss of function of two or more limbs. Paralysis as a result of Stroke is excluded. (Note: Stroke is a separate benefit.)

**Pathological Diagnosis** means identification of cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis of malignancy is in keeping with the standards set by the American Board of Pathology.

**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, or your spouse/domestic partner, children, parents, or siblings as a Physician for a claim.

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

**Pre-Existing Condition** means a disease or physical condition for which:

- symptoms existed within the 12-month period prior to the effective date of coverage; or
- medical advice or treatment was recommended or received from a member of the medical profession within the 12-month period prior to the effective date of coverage.

A Pre-Existing Condition can exist even though a diagnosis has not yet been made.

**Sickness** means an Illness or disease that must begin while you are insured under the Policy.

**Stroke** means the death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit. Transient ischemic attacks (TIAs), head Injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are excluded.

**Under the Influence** is a condition as determined by the laws of the state in which the loss occurred.

**You, Your or Yours** means the Insured who meets the eligibility requirements.

# 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 Yourself, spouse/domestic partner or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing Your COBRA 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 your 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.