
Group Hospital Indemnity Insurance Plan

This Summary Plan Description (SPD) represents a general summary of the features of the Allstate Group Hospital Indemnity Insurance Plan (the “Plan”). The Plan is insured under Group Hospital Indemnity Insurance Policy No. 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.

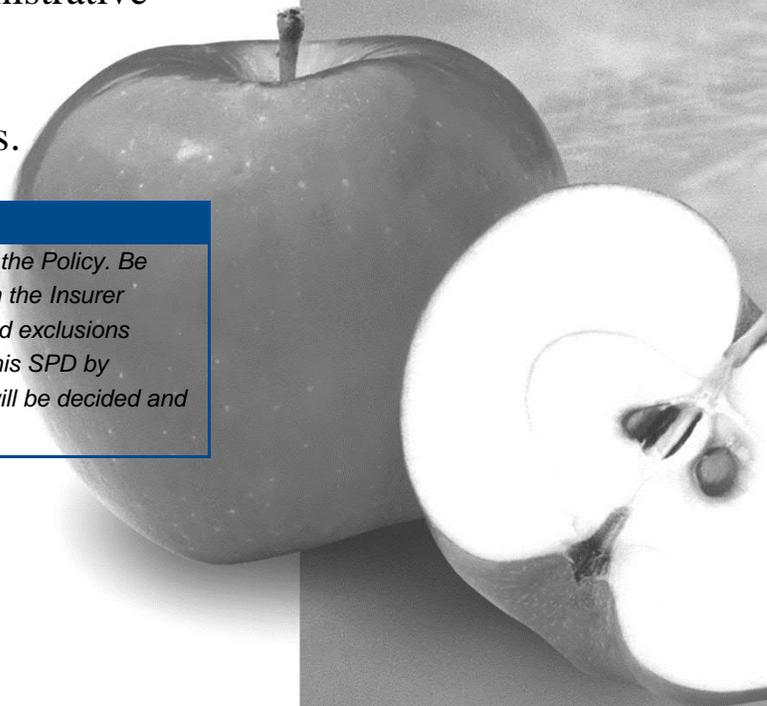


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FACTS ABOUT THE PLAN

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 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 Hospital Indemnity 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 Hospital Indemnity 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:

555

Type of Plan

Employee welfare benefit plan providing group hospital indemnity 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	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ You may add, drop, or decrease coverage. Coverage will end for deceased spouse/civil union partner/domestic partner.
Death of a dependent child	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ Coverage will drop for ineligible dependents. ➤ No other changes allowed.
Dependent child satisfies eligibility requirements	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> ➤ Automatically continues. No change allowed.
Change in work assignment which results in a change in eligibility	<ul style="list-style-type: none"> ➤ You may add coverage.
Change in residence that results in a change of the participant's currently enrolled medical option	<ul style="list-style-type: none"> ➤ Automatically continues. No change allowed.
Other non-Allstate medical coverage is lost	<ul style="list-style-type: none"> ➤ Automatically continues. No change allowed.
Employee and/or dependents gain eligibility for Medicaid coverage	<ul style="list-style-type: none"> ➤ Automatically continues. No change allowed.
Change in employment status	<ul style="list-style-type: none"> ➤ 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 the portability 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 the portability 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 the portability 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 Hospital Indemnity Insurance Plan pays the following benefits for service and treatment administered to or received by a covered person. Such service or treatment must be: (a) incurred by a covered person while coverage is in force on that person; and (b) provided for the care and treatment of sickness or injury of a covered person. Any loss not 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
First Day Hospital Confinement Benefit	\$500	\$1,000
Limit to Number of Occurrences	No Limit	No Limit
➤ Daily Hospital Confinement Benefit	\$100	\$100
➤ Maximum Number of Days per Continuous Confinement	10 Days Max	10 Days Max
➤ Hospital Intensive Care Benefit	\$100	\$100
➤ Maximum Number of Days per Continuous Confinement	10 Days Max	10 Days Max

Benefit Description

First Day Hospital Confinement Benefit: the Policy pays this benefit for the first day a covered person is confined in a hospital. This benefit is payable only once per continuous confinement in a hospital per covered person. The number of such confinements is not limited.

This benefit is not payable for a newborn child's initial confinement in a hospital. A newborn child's initial confinement in a hospital includes any transfers to another hospital before such child is discharged to his or her home.

The covered person must provide proof that a hospital room and board charge is incurred.

Daily Hospital Confinement Benefit: the Policy pays this benefit per day when a covered person is confined in a hospital.

If the First Day Hospital Confinement benefit is payable, this benefit pays for each day after the first day of a continuous confinement in a hospital for a maximum of 9 days. If the First Day Hospital Confinement benefit is not payable, this benefit pays for each day of a continuous confinement in a hospital for a maximum of 10 days.

This benefit is not payable for:

- any day for which the First Day Hospital Confinement benefit is payable; or
- a newborn child's routine nursing or routine well baby care during the initial confinement in a hospital.

The covered person must provide proof for each day that a hospital room and board charge is incurred.

Hospital Intensive Care: the Policy pays this benefit for each day a covered person is confined in a hospital intensive care unit. This benefit is paid in addition to the First Day Hospital Confinement benefit and Daily Hospital Confinement benefit.

The maximum number of days this benefit is payable is 10 days for each continuous confinement in a hospital intensive care unit.

The covered person must provide proof for each day that a hospital room and board charge is incurred.

Exclusions and Limitations

The Policy does not pay benefits for any loss caused by or resulting from:

- any act of war whether or not declared, participation in a riot, insurrection or rebellion; or
- suicide, or any attempt at suicide, whether sane or insane; or
- injury incurred while engaging in an illegal occupation or committing or attempting to commit an assault or felony; or
- dental or plastic surgery for cosmetic purposes except when such surgery is required to: (a) treat an injury; or (b) correct a disorder of normal bodily function; or
- intentionally self-inflicted injuries; or
- confinement that begins before the covered person's effective date of coverage; or
- the reversal of a tubal ligation or vasectomy; or
- artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or physician services, unless required by law; or
- participation in any form of aeronautics (including parachuting and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or

- a newborn child's routine nursing or routine well baby care during the initial confinement in a hospital; or
- driving in any organized or scheduled race or speed test or while testing an automobile or any motorized vehicle on any racetrack or speedway; or
- mental or nervous disorders; or
- drug addiction or dependence upon any controlled substance.

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 our 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 95. 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 coverage in force that covers more than one child and there are other eligible dependents still insured under the Policy.

Coverage may be eligible for continuation as outlined in the Portability Privilege section.

PORTABILITY PRIVILEGE

The Insurer will provide Group Hospital Indemnity Insurance portability coverage, subject to these provisions.

Such coverage will not be available for you, unless:

- coverage under the Policy terminates under the “Termination of Coverage” provision;
- 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 insurance under the Policy terminated due to your failure to make required premium payments.

Portability Coverage

The benefits, terms and conditions of the portability coverage will be the same as those provided under the Policy 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 insurance under the Policy terminates.

Portability Premiums

Premiums for portability coverage 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 premium rates are based on the table of rates in effect on any premium due date. The Insurer has the right to change the rate table on any premium due date. Written notice will be given at least 30 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 you are the Policyholder.

Termination of Insurance

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

- The date you again become eligible for Group Hospital Indemnity 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 dependent ceases to be an eligible dependent, as defined.

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.

Portability coverage will remain in effect for no longer than 36 months.

Termination of the Policy

If the Policy terminates, you and your covered dependents will be eligible to exercise the portability provision on the termination date of the Policy. 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

Active employment 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 described under the Eligible Class(es); 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:

- your 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 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.

Complications of pregnancy mean any of the following:

- a condition whose diagnosis is distinct from pregnancy but that is adversely affected by or caused by pregnancy, such as acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar medical and surgical conditions of comparable severity; and
- a non-elective caesarean section; and
- termination of ectopic pregnancy; and
- spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible; and
- hyperemesis gravidarum; and
- pre-eclampsia

Complications of pregnancy do not include: false labor; or occasional spotting; or morning sickness; or body aches; or body pains; or prescribed rest; or premature births; or multiple births (twins, triplets, etc.); or any condition caused by the pregnancy that places the covered person or the pregnancy at risk.

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 one continuous confinement or two or more confinements not separated by more than 24 hours. If there are more than 24 hours between confinements, they are considered separate confinements.

Cosmetic means surgery or other treatment to improve a person's appearance which is not required for treatment of a sickness or injury.

Covered person means any of the following:

- any eligible family member (including the employee) named on 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 or adopted 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.

Emergency treatment center means the emergency room of a hospital or ambulatory surgical center, or satellite emergency center of a hospital.

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 the policy is in force, and the injury is the direct cause of the loss independent of disease or bodily infirmity. All injuries sustained in any one 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 mean 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 has the capacity to work 40 hours per week.

Mental or nervous disorder means a psychiatric or psychological condition regardless of cause, such as schizophrenia, depression, manic depressive or bipolar illness, anxiety, post traumatic stress disorder, personality disorders and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar methods.

Nurse means any one of the following who is not a member of the covered person's immediate family:

- 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, or your spouse, civil union partner, domestic partner, children, parents, or siblings as a Physician for a claim.

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

Residential treatment facility means an institution which provides coordinated inpatient treatment of mental or nervous disorders or chemical dependency by trained medical personnel and counselors pursuant to a written treatment plan approved and monitored by a physician. The institution must also be affiliated with a hospital under a contractual agreement with an established system for patient referral, be accredited as a treatment facility by the Joint Commission on Accreditation of Hospitals, and licensed, certified or approved as a mental health or chemical dependency treatment program or center by any federal, state or municipal agency having legal authority to so license, certify or approve.

Sickness means an illness or disease that must begin while the covered person is insured under the policy.

Skilled nursing facility means an institution that meets all of the following standards:

- it is licensed by the state in which it is located; and
- it is a separate facility or a distinct part of another facility physically separated from the rest of such facility; and
- it provides confined nursing care to individuals who are not able to care for themselves and who require nursing care; and
- its primary function is to provide nursing care, and room and board; and the facility charges for these services. The care must be performed under the direction of a licensed physician or licensed nurse; and
- it is not a hospital, a home for the aged, a retirement home, a rest home, a community living center, or a place mainly for the treatment of alcoholism, mental illness or drug abuse.

Surgery means manual procedures involving cutting of body tissue, debridement or permanent joining of body tissue for repair of wounds, treatment of fractured bones or dislocated joints, endoscopic procedures, and other manual procedures, when used in lieu of cutting for purposes of removal, destruction or repair of body tissue.

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.

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 for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing a covered person's portability privilege 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.