General Provisions

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INTRODUCTION

TERMS

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

This is the Allstate Cafeteria Plan (Cafeteria Plan) Summary Plan Description (SPD) of Allstate Insurance Company (Allstate). The Cafeteria Plan enables **Employees** to choose among a menu of benefits. This SPD summarizes the provisions of the following benefit plans and coverage options:

- Medical Plan (not all options are available to all employees)
  - Allstate Medical Savings Plan
  - Allstate Medical Value Plan
  - Health Maintenance Organizations (HMOs)
- Dental Plan
  - Preferred Provider Organization – Preferred Dentist Program (PDP)
  - Dental Maintenance Organization (DMO)
- Vision Plan
- Flexible Spending Accounts (FSA) Program
  - Health Care FSA
  - Limited Use FSA
  - Dependent Day Care FSA
- Life Insurance and Accidental Death and Dismemberment (AD&D) Plan
  - Basic Life Insurance
  - Supplemental Life Insurance
  - Dependent Life Insurance
    - Spouse Life Insurance
    - Child Life Insurance
  - Basic Accidental Death and Dismemberment (AD&D) Insurance
  - Supplemental Accidental Death and Dismemberment (AD&D) Insurance
- Long Term Disability (LTD) Insurance Plan
- Group Legal Plan

The Plan Document for the Cafeteria Plan contains additional information about the benefit plan provisions. If any discrepancies exist between the SPD and the Plan Document, the SPD shall govern.

Allstate offers other benefits which are not part of the Cafeteria Plan and are described in separate SPDs or Human Resources Policies.

PLAN IDENTIFICATION

Name of Plan:

Allstate Cafeteria Plan

Plan Number:

511

Type of Plan:

Employee welfare benefit plan providing group medical, dental, vision, life, LTD, and pre-paid legal service coverage

Plan Year:

The 12-month period beginning on January 1, 2018 and ending on December 31, 2018.

Plan Sponsor:

Allstate Insurance Company

Employer Identification Number:

36-0719665

Participating Allstate Companies:

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

Plan Administrators and Agent for Service of Legal Process:

The Plan Administrators, Allstate Cafeteria Plan
Allstate Insurance Company
2775 Sanders Road, Suite F5
Northbrook, IL 60062-6127
(847) 402-8827

HOW TO USE THIS SPD

The Cafeteria Plan SPD has been designed to assist you in understanding your Cafeteria Plan benefits. It consists of the General Provisions (which provide information common to all or several benefit plans); separate sections for each benefit plan; a Qualified Change in Status; and a Glossary.

PLAN ADMINISTRATION

A Plan Administrator or The Plan Administrators ("Plan Administrator") who is appointed by Allstate administers the Cafeteria Plan. The Plan Administrators shall have all the duties and responsibilities imposed upon a Plan Administrator by the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Plan Administrators have the discretionary authority to determine all questions arising under the provisions of the Cafeteria 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 Cafeteria Plan, and to remedy ambiguities, inconsistencies or omissions. Any construction, interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. The Plan Administrators shall have the authority to adopt procedures in order to administer the Cafeteria Plan.

The Plan Administrators may delegate to other persons responsibilities for performing certain duties under the terms of the Cafeteria Plan and may seek such expert advice as the Plan Administrators deems reasonably necessary with respect to the Cafeteria Plan. Refer to each benefit plan for additional information regarding plan administration.

PLAN AMENDMENT AND TERMINATION

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

NO EMPLOYMENT OR VESTING RIGHTS

Participation in the Cafeteria 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 participants or beneficiaries of the Cafeteria Plan do not have a vested right in any of the Cafeteria Plan's benefits.

THIRD PARTY ADMINISTRATOR FOR PARTICIPANTS' RECORDS

Hewitt Associates LLC is the Plan's record keeper for participants and Hewitt provides various support services for participants. You may access these services as follows:

Website:

Your Benefits Resources™ — http://resources.hewitt.com/allstate

Toll-Free:

(888) 255-7772 — Representatives are available to answer your questions between 8 a.m. and 6 p.m., Central time, Monday through Friday.

EMPLOYER CONTRIBUTIONS — BENEFIT CREDITS

If you enroll in the Medical Plan or Dental Plan, you will receive **Credits** (employer contributions) applied to your premium based on your elections. If you enroll in the Medical Plan, the amount of your Credits will be determined by the coverage option, your employment status, and your tobacco-use status (tobacco-free or tobacco user).

If you enroll in the Dental Plan, the amount of your Credits will be determined by your coverage option and employment status.

PRE-TAX AND AFTER-TAX PAYROLL DEDUCTIONS

Coverage Paid with Pre-Tax Payroll Deductions

Pre-tax deductions reduce your gross pay, which lowers your taxable income and certain taxes. Pre-tax deductions will not be subject to federal income taxes, most state and local income taxes, and **Social Security** (FICA) taxes. The following benefits are paid with pre-tax payroll deductions:

- Medical
- Dental
- Vision
- FSA
- Employee Supplemental Accidental Death and Dismemberment (AD&D)
- PTO Days Bought

Coverage Paid with After-Tax Payroll Deductions

The following benefits are paid with after-tax payroll deductions:

- Supplemental Life Insurance
- Dependent Life Insurance
  - Spouse Life Insurance
  - Child Life Insurance
- LTD Insurance
- Group Legal

ADDITIONAL NOTES

Domestic Partner Benefits — Taxability

The cost for covering a domestic partner and a domestic partner's child(ren) will be deducted from an Employee's pay on a pre-tax basis. However, in accordance with Plan provisions and tax regulations, the entire cost (both the Employer-paid and the Employee-paid portions) for covering a domestic partner and the domestic partner's child(ren) under the Medical, Dental, and Vision Plans will be added to the taxable income of the Employee and will be subject to federal and applicable state income and payroll taxes, including FICA withholding. If an Employee covers both his/her children and the children of his/her domestic partner, the entire cost associated with coverage for all children will be added to the Employee's taxable income. Consult a qualified tax advisor concerning the taxability of domestic partner benefits.

Domestic Partner Premiums in California and Connecticut

*Employees residing in California who provide **AskHR** (800-340-0475) with a copy of the registered form of Declaration of Domestic Partnership will have premiums for domestic partners deducted on a pre-tax basis for purposes of California state income tax only. Employees residing in Connecticut who provide the Ask HR with proof of a Civil Union will have premiums for domestic partners deducted on a pre-tax basis for purposes of Connecticut state income tax only.*

Basic Life Insurance

You will pay income tax on the cost of Basic Life Insurance coverage if your coverage is over $50,000. This taxable amount is called "imputed income" and is calculated based on the amount of coverage in excess of $50,000. Imputed income is based on IRS published rates.

To avoid imputed income taxation if your Basic Life coverage amount is in excess of $50,000, you will need to contact the Allstate Benefits Center at 888-255-7772 during the designated Annual Benefits Enrollment period. This is the only time you may take action to avoid imputed income.

New hires will need to contact the Allstate Benefits Center within 31 days of their date of hire to take action to avoid imputed income taxation.

Supplemental Life Insurance Contribution Information

Your contribution is determined each Plan Year using your age at the time of Annual Benefits Enrollment. Your Supplemental Life Insurance contribution will not increase during the year if an increase in age shifts you to a higher age-rated contribution bracket.

PLAN FINANCING

Benefit Plan Coverage	Type of Plan	Third Party Administrator or Insurer	Source of Contributions Under the Plan
Medical*	Self-funded: Ø Allstate Medical Savings Plan Ø Allstate Medical Value Plan Insured: Ø **HMOs**	Depending on state of residence: Aetna or Blue Cross Blue Shield of Illinois (self-funded medical and mental health/substance abuse benefits) CVS Caremark (self-funded prescription drug benefits) Various **HMOs** (insured medical benefits)	Employee and Employer contributions
Dental*	Self-funded: Preferred Dentist Program (PDP) Insured: Dental Maintenance Organization (DMO)	Aetna Aetna	Employee and Employer contributions
Vision*	Insured	Vision Service Plan (VSP)	Employee contributions
FSA	Self-funded	Your Spending Account (Health Care and Dependent Day Care FSAs)	Employee contributions
Basic Life Insurance	Insured	Securian Life	Employer contributions
Supplemental Life Insurance*	Insured	Securian Life	Employee contributions
Dependent Life Insurance: Spouse Life; Child Life Insurance*	Insured	Securian Life	Employee contributions
Basic AD&D Insurance	Insured	Securian Life	Employer contributions
Supplemental AD&D Life Insurance*	Insured	Securian Life	Employee contributions
LTD Insurance*	Insured	The Hartford	Employee contributions
Group Legal*	Insured	Hyatt Legal Plan	Employee contributions

* Rates and premiums may include administrative fees and other expenses allowed by the Cafeteria Plan.

ELIGIBILITY AND EFFECTIVE DATES OF COVERAGE

Eligible Classes of Coverage

Unless otherwise provided in the provisions of a specific benefit plan under the Cafeteria Plan, the following are the eligible classes of coverage:

Employee Coverage

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

For the 2018 Plan Year, you can choose from the following Medical Plan options (if available):

- Allstate Medical Savings Plan,
- Allstate Medical Value Plan,
- An HMO, if available where you live, or
- No Allstate Medical Plan coverage.

Dependent Coverage

As a covered Employee, you may enroll your eligible dependents. When enrolling an eligible dependent for the first time under the Cafeteria Plan, you will be required to provide written proof of the dependent's eligibility for coverage under the Cafeteria Plan to the Allstate Benefits Center (such as a marriage certificate, birth certificate, adoption certificate, etc.) before coverage can be added for the dependent. The Affordable Care Act requires SSN to be reported to the Internal Revenue Service. Therefore, when enrolling your dependent, you will be required to provide their Social Security Number (SSN). If your dependent is a newborn or you do not know the SSN, you may enroll them; however you should contact the Allstate Benefits Center at 888-255-7772 as soon as you obtain the SSN. If you fail to provide your dependent's SSN, you may be subject to an IRS tax penalty of $50.

NOTE

You cannot be covered as both an Employee and a dependent at the same time. Also, a child may be covered as the dependent of only one Employee.

In the event both parents are employed by Allstate, only one parent may elect coverage for a dependent under the Allstate Cafeteria Plan or any Allstate or Allstate-affiliate sponsored Plan which provides coverage for Former Employees.

Those eligible for dependent coverage are:

- Your lawful spouse. For purposes of the Cafeteria Plan, "spouse" means a person to whom you are legally married.
- Civil Union/Party to a Civil Union/Domestic Partner.
  - "Domestic partner" for benefits means the Employee's civil union partner or domestic partner of the same or opposite sex. 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 Administrators, submit proof satisfactory to the Plan Administrators that supports the nature of the domestic partner's eligibility for coverage.

- Your child who:
  - is less than 26 years old; or
  - has a mental or physical disability, regardless of age, provided such child:
    - enrolled during his or her initial eligibility period, or was covered in the Cafeteria Plan immediately prior to age 26;
    - is continuously enrolled for coverage under the Cafeteria Plan after such age (i.e., coverage does not terminate or end, for whatever reason or length of time, after reaching age 26, as applicable); and
    - is incapable of self-sustaining employment, as determined by the Plan Administrators.

Certain states may allow for dependent child(ren) to be covered in HMOs beyond Allstate Cafeteria Plan eligibility provisions. Please contact the HMO for additional information.

The term "child" means:

- your biological child;
- a child you have legally adopted or who have been placed with you for adoption. "Placement" or being "placed" for adoption in connection with any placement for adoption of a child with any Employee, means the assumption and retention by such Employee of a legal obligation for total or partial support of such child in anticipation of adoption. The child's placement with such Employee terminates upon the termination of such legal obligation;
- a child for whom you are the full legal guardian or have full legal custody; a step-child who is residing on a permanent and full-time basis in your household; and a child of your domestic partner who is residing on a permanent and full-time basis in your household; or
- a biological or adopted child who is recognized under a **Qualified Medical Child Support Order (QMCSO)** as having a right to enroll in medical, dental, or vision coverage if you are enrolled.
- You can obtain QMCSO procedures by contacting the Allstate Benefits Center at 888-255-7772. Additional information:
  - QMCSO fax: 847-442-0899
  - U.S. mail address: Allstate QMCSO, P.O. Box 1542, Lincolnshire, IL 60069-1542
  - Upload electronic documents via www.QOCenter.com

IMPORTANT NOTES

Neither you nor your dependent(s) can receive benefits under both the Allstate Cafeteria Plan and any Allstate or Allstate-affiliate sponsored Plan providing coverage for Former Employees at the same time.

Domestic partners and their eligible dependent children are eligible to participate in the Medical, Dental, Vision, and Group Legal Plans, and Child Life. ***HMO*** *coverage that may otherwise be available may not be available for an Employee's domestic partner.*

Child Life Insurance coverage will not be provided prior to age six months or after age 26 (unless other dependency provisions apply, such as children with mental or physical disabilities).

In the event both parents are employed by Allstate, only one parent may elect coverage for a dependent under the Allstate Cafeteria Plan or any Allstate or Allstate-affiliate sponsored Plan which provides coverage for Former Employees.

Proof of Eligibility

When you enroll yourself or a dependent, you are certifying that you have read and understand the eligibility provisions of the Cafeteria Plan and certify that you and/or your dependents satisfy these requirements.

When enrolling a new dependent under the Cafeteria Plan, you will be required to provide written proof of the dependent's eligibility for coverage under the Cafeteria Plan to the Allstate Benefits Center before coverage can be added for the dependent. In addition, the Plan Administrators may request documentation confirming an individual's eligibility at any time. Misrepresentation of eligibility may result in disciplinary action, including termination of employment.

Examples of Acceptable Documentation Showing Proof of Eligibility Include:

If you wish to add a new Spouse:	Ø Government Issued Marriage Certificate and Federal Tax Return Within the Last 2 Years Listing Spouse **OR** Ø Government Issued Marriage Certificate and Proof of Joint Ownership* Issued Within Last 6 Months **OR** Ø Government Issued Marriage Certificate Only (if married within the last 12 months)
If you wish to add a new Domestic Partner/Civil Union Partner:	Ø Affidavit of Domestic Partnership/Civil Union Partnership, signed by both partners and notarized, and Proof of Joint Ownership* Issued Within Last 6 Months Ø In order to be eligible, you and your domestic partner/civil union partner must meet all of the following: · The relationship is an exclusive committed relationship and you intend that the relationship will continue indefinitely; · You share and maintain the same primary residence and are 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; · You both are at least 18 years old and legally capable to enter into a contract; · Neither of you is married to, legally separated from, or in another domestic partner/civil union relationship with anyone else; and · You are not related by blood more closely than is permissible for marriage in the state of residence.
If you wish to add a new Biological Child:**	Ø Government Issued Birth Certificate (Including Parents' Names)
If you wish to add a new Adopted Child:**	Ø Adoption Certificate (including child's date of birth) **OR** Ø Adoption Placement Agreement (including child's date of birth) or Petition for Adoption (including child's date of birth)

If you wish to add a new Step Child:**	Ø Government Issued Birth Certificate (including parents' names), Proof of Spouse/Partner Relationship and Federal Tax Return Within Last 2 Years Listing Spouse/Partner; **OR** Ø Government Issued Birth Certificate (including parents' names), Proof of Spouse/Partner Relationship, and Proof of Joint Ownership Issued Within Last 6 Months; **OR** Ø Government Issued Birth Certificate (including parents' names) and Proof of Spouse/Partner Relationship (if married within the last 12 months)
If you wish to add a new Legal Ward:**	Ø Government Issued Birth Certificate and Court Ordered Document of full Legal Custody

***Examples of Proof of Joint Ownership include:**

- Mortgage Statement listing spouse/domestic partner
- Bank Statement (Bank account verification letter showing active status) listing spouse/domestic partner
- Active Lease Agreement listing spouse/domestic partner
- Credit Card Statement listing spouse/domestic partner
- Property Tax Statement listing spouse/domestic partner
- Current Year State Tax Return listing spouse/domestic partner
- Current Year Mortgage Interest/Mortgage Insurance Statement listing spouse/domestic partner
- Warranty Deed listing spouse/domestic partner
- Auto Loan Statement listing spouse/domestic partner
- Current Year Federal Tax Return listing the spouse/dependent as a dependent

Proof of Joint Ownership documents must be issued within the last six months.

**If you are enrolling a disabled dependent over age 26 for the first time, you will be required to provide a copy of the Federal Tax Return within the last 2 years claiming the child along with the applicable document(s) listed above.

Note: Alternate documents *may* be offered in place of some of the documents listed above. You will be able to request additional information about alternate documents after your dependent is placed in a verification window.

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.

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."

If you are a newly hired Employee and first become eligible for coverage during the months of November or December of a Plan Year, you are not eligible to enroll in a Health Care or Dependent Day Care FSA nor are you eligible for any **Wellness Incentives** for that Plan Year. If you wish to enroll in a Health Care or Dependent Day Care FSA for the following Plan Year, you will need to contact the **Allstate Benefits Center** within 31 calendar days from the actual date of hire. These 31 days include the first day of eligibility.

NOTE

*You must be **Actively at Work** in order for the AD&D Plan and LTD Insurance Plan coverage to be effective.*

Dependents must not be: confined at home under a Physician's care; receiving or applying to receive disability benefits from any source; or hospitalized in order for Spouse Life Insurance and/or Child Life Insurance coverage to be effective.

Medical coverage for a newborn dependent or for a child you have legally adopted or who has been placed with you for adoption is automatically in effect for 31 calendar days from the date of birth, adoption or placement for adoption. However, you must still contact the Allstate Benefits Center to add your child to your benefit coverage and you have 60 calendar days of the birth to do so. If you add the child as a dependent and enroll the child within 60 calendar days of the birth, adoption or placement for adoption (these 60 days include the date of birth, adoption or placement for adoption, the date of loss of eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage, or the date of becoming eligible for a premium assistance subsidy under Medicaid or CHIP), coverage would then be effective on the date of birth, adoption, or placement for adoption and contributions are due from that date.

When enrolling an eligible dependent under the Cafeteria Plan, you will be required to provide written proof of the dependent's eligibility for coverage under the Cafeteria Plan to the Allstate Benefits Center (such as a marriage certificate, birth certificate, adoption certificate, etc.) before coverage can be added for the dependent.

All other conditions regarding dependent enrollment must be satisfied.

Coverage Election Changes Outside the Initial 31-Day Eligibility Period

If you or your eligible dependents do not enroll within the initial 31-day eligibility period, then your next opportunity typically will be during Annual Benefits Enrollment, with new coverage effective the following January 1. When enrolling a new dependent under the Cafeteria Plan, you will be required to provide written proof of the dependent's eligibility for coverage under the Cafeteria Plan to the Allstate Benefits Center (such as a marriage certificate, birth certificate, adoption certificate, etc.) before coverage can be added for the dependent.

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, see the Qualified Change in Status section of the Cafeteria Plan SPD.

Denial of Eligibility – Review and Appeal Procedures

Request for Review of a Denial of Enrollment or Eligibility

If you or your eligible dependent(s) are denied enrollment due to missing your enrollment period, or for not providing written proof of the dependent's eligibility to the Allstate Benefits Center for coverage under the Cafeteria Plan and you wish to have the denial reviewed, you will need to contact the Allstate Benefits Center immediately at (888) 255-7772 for further instruction. In any event, you must provide all required documentation to the Allstate Benefits Center within 90 days of receiving the denial decision in order for your appeal to be considered and reviewed. Your request for review will be assigned to the Claims and Appeals Management (CAM) Team, which will notify you of its decision no more than 30 calendar days after receipt of your request. However, the time period for notice of decision may be extended for 15 calendar days provided that, prior to any extension period, the CAM Team notifies you 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.

The CAM Team will thoroughly research the circumstances surrounding your request for review in accordance with the Eligibility provisions of the Cafeteria Plan. Once the CAM Team has reached a decision on the request, it will provide a written decision, which shall include, in addition to other information required by applicable law:

- Specific reasons for the decision; and
- A description of the appeal review procedures and time limits applicable to such procedures.

Appealing a Denial of Enrollment or Eligibility

If the Claims and Appeals Management (CAM) Team denied your request, you may appeal the denial to the Office of the Plan Administrators within 180 calendar days of the denial. You may also request, free of charge, copies of all documents, records, and other information relevant to your appeal and submit written comments, documents, records, and other information related to your appeal.

Send your appeal to the following address:

The Plan Administrators, Allstate Cafeteria Plan
Allstate Insurance Company
2775 Sanders Road, F5
Northbrook, IL 60062-6127

The Plan Administrators will notify you of a decision no more than 60 calendar days after your appeal is received. The review will take into account all comments, documents, records and other information you submit relating to your appeal without regard to whether such information was submitted or considered in the initial determination.

The written decision shall 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 may request, free of charge, copies of all documents, records, and other information relevant to your claim.

The decision of the Plan Administrators is final.

Time Limits on Starting Lawsuits or Other Legal Action

No claimant (including Plan participants or their beneficiaries) or claimant's representative may file or commence any lawsuit or legal action (under § 502 of ERISA or otherwise) to obtain enrollment under the Allstate Cafeteria Plan, without first having complied with and exhausted all levels of review and appeal required by the Allstate Cafeteria Plan, and in any event not more than one (1) year after the final appeal is denied by the Plan Administrators or his or her delegate(s).

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

Annual Benefits Enrollment

You can enroll or make changes in most benefit plans each year during Annual Benefits Enrollment. Annual Benefits Enrollment is usually held in the fall, with new coverage elections effective the following January 1. Here are some important points to keep in mind about the Annual Benefits Enrollment process:

- Certain coverage elections are not permitted or may require EOI and carrier approval before coverage becomes effective.
- These elections generally cannot be changed until the next Annual Benefits Enrollment or upon an earlier Qualified Change in Status.
- If you do not make an election during Annual Benefits Enrollment, your previous coverage elections will generally remain in effect for the following year (subject to annual changes in coverage and costs). Certain exceptions may apply, however, including the following:
  - 2018 Annual Benefits Enrollment
    - If you were previously enrolled in the Allstate Medical Savings or Value Plan coverage option and you wish to remain covered under the same coverage option, there is nothing for you to do during Annual Benefits Enrollment. Your 2017 coverage option will automatically rollover to become your 2018 coverage option.
    - If you were previously enrolled in the Allstate Medical Savings or Value Plan coverage option and you wish to switch coverage options, you will need to enroll in a new coverage option that is available during 2018 Annual Benefits Enrollment period.

- If you were previously enrolled in the Blue Advantage HMO or a Kaiser Savings or Value HMO coverage option (except Hawaii) and wish to be covered in the Allstate Medical Savings or Value Plan, you will need to enroll in a new coverage option that is available during the 2018 Annual Benefits Enrollment period.
- If you do not make any Medical coverage changes during the 2018 Annual Benefits Enrollment period your 2017 medical coverage will automatically carry forward. If you had no Allstate-sponsored medical coverage in 2017, you will not have Allstate-sponsored medical coverage in 2018.

- FSA elections do not carry forward from year to year. You must re-enroll in the Health Care and Dependent Day Care FSAs each year that you wish to participate.
- HSA elections under the Allstate Medical Savings Plan , Allstate Medical Value Plan, and all Kaiser HMOs except in Hawaii do not carry forward from year to year.
- Spouse Life and Child Life Insurance elections carry forward from year to year.

- You will be required to elect your tobacco status each year during Annual Benefits Enrollment. This election applies for Medical and Supplemental Life Insurance coverage. If you do not elect your tobacco use status during Annual Benefits Enrollment, you will default to "tobacco-user" status. A $600 tobacco-user surcharge for Medical coverage and tobacco-user rates for Supplemental Life Insurance will be applied.

NOTE

You cannot be covered as both an Employee and a dependent at the same time. Also, a child may be covered as the dependent of only one Employee

Here is a summary of the Annual Benefits Enrollment changes that may be available:

Medical

You can choose a coverage option available in your home zip code area, waive coverage, or add or drop eligible dependents.

For the 2018 Plan Year and subject to all eligibility requirements, you can choose from the following Medical Plan coverage options:

- Allstate Medical Savings Plan,
- Allstate Medical Value Plan,
- An **HMO**, if available where you live, or
- No Allstate Medical Plan coverage.

NOTE

A change in coverage option may impact your tax-favored account eligibility (Health Care Flexible Spending Account (FSA), Limited Use Health Care Flexible Spending Account, Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA)). Additional action may be necessary, as you cannot have an HRA and an HSA at the same time. See the Medical Plan section of the Cafeteria Plan SPD for additional information.

Dental

You can choose a coverage option available in your home zip code area, waive coverage, or add or drop eligible dependents. Refer to the *Dental Plan* SPD for complete information about this coverage.

Vision

You can choose coverage, waive coverage, or add or drop eligible dependents. Refer to the *Vision Plan* SPD for complete information about this coverage.

FSA

You can elect to participate at any available contribution level up to the maximum allowable level. Refer to the *Flexible Spending Accounts* SPD for complete information about this coverage.

Life Insurance

Basic Life coverage is automatically provided to eligible Employees.

Supplemental Life — you can enroll, elect a different coverage option, or waive coverage, subject to EOI rules.

Refer to the *Life Insurance and Accidental Death & Dismemberment Plan* SPD for complete information about this coverage.

Spouse Life Insurance and Child Life Insurance

You can enroll your eligible dependents in Spouse Life Insurance and/or Child Life Insurance, elect different coverage options, or waive coverage, subject to EOI rules.

Refer to the *Life Insurance and Accidental Death & Dismemberment Plan* SPD for complete information about this coverage.

Accidental Death & Dismemberment (AD&D)

Basic AD&D coverage is automatically provided to eligible Employees.

Supplemental AD&D — you can enroll, elect a different coverage option, or waive coverage.

Refer to the *Life Insurance and Accidental Death & Dismemberment Plan* SPD for complete information about this coverage.

LTD

You can enroll subject to EOI, change your coverage option, or waive coverage. Refer to the *Long Term Disability Insurance Plan* SPD for complete information about this coverage.

Group Legal

You can choose any coverage option, waive coverage, or add or drop eligible dependents. Refer to the *Group Legal Plan* SPD for complete information about this coverage.

PREPARING FOR RETIREMENT

General Information

Enrollment Qualifications

You may be eligible to enroll in an Allstate or Allstate Affiliate-sponsored medical plan for former employees if you meet the following qualifications:

- Ø You must retire in accordance with the company retirement policy:
  - attain age 55 and 20 years of service; or
  - attain age 60 with any length of service; and
- Ø You must have been enrolled in an Allstate or Allstate Affiliate-sponsored medical coverage for at least three continuous years immediately before retirement.

If you are eligible, you will have 31 calendar days after your retirement date to enroll in coverage. If you enroll, your eligible dependents may also participate in the plan provided they are covered under an Allstate or Allstate Affiliate-sponsored medical plan on the day your employment terminates due to your retirement or your classification as a **Terminated Totally Disabled (TTD)** Employee.

If you are eligible and do not enroll by the deadline, you will be assigned “no coverage” under the plan, and neither you nor your dependents will have coverage. You will not be eligible to enroll for coverage in the future.

Suspension of Coverage Qualifications

At retirement or in the future, if you are not **Medicare**-eligible, you may suspend enrollment in the former employee retiree medical plan for you and your eligible dependents only if you enroll in other employer-sponsored, COBRA or federal/state-sponsored group coverage, (i.e., Medicaid). You may be able to un-suspend coverage at a later time for you and your eligible dependents if you meet certain qualifications. **NOTE:** TTDs are not eligible to suspend coverage.

You may only reinstate coverage under certain circumstances.

Waiving Coverage

If you are eligible and do not elect coverage at retirement, you will not be eligible to enroll in the future.

NOTES

Refer to the appropriate Summary Plan Description (SPD) for Former Employees, which governs participation in the applicable plan before making any coverage selection. If you are not Medicare-eligible, contact the Allstate Benefits Center at (888) 255-7772. If you are Medicare-eligible, contact OneExchange at (866) 259-2944.

Neither you nor your dependents can receive benefits under both the Allstate Cafeteria Plan and the Allstate Insurance Company Group Medical Coverage for Former Claims Employees Plan or The Allstate Corporation Group Medical Coverage for Former Non-Claims Employees Plan at the same time.

Any dependent child whose parents have coverage in the Allstate Cafeteria Plan and/or the Allstate Insurance Company Group Medical Coverage for Former Claims Employees Plan or the Allstate Corporation Group Medical Coverage for Former Non-Claims Employees Plan can only be considered a dependent of one parent's coverage.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If the Allstate Benefits Center receives a medical child support order requiring that group health coverage (medical, dental and/or vision) be provided to an Employee's biological or adopted dependent child(ren), or a child(ren) placed for adoption, and Allstate determines the order to be qualified, Allstate will be obligated to provide coverage for the dependent child(ren) from the Medical, Dental, and/or Vision Plans and make the appropriate deductions from the Employee's pay. Coverage will be terminated in accordance with Cafeteria Plan provisions or the QMCSO. If you are not already enrolled, then you will automatically be enrolled with your dependent.

If you are subject to a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody, including a QMCSO, that requires health coverage for your eligible dependent child, you may:

- Ø change your election to provide coverage for the child if the order requires health coverage under the Cafeteria Plan; or
- Ø cancel coverage for the child if the order requires your spouse, former spouse, or other individual to provide health coverage for the child, and that coverage is, in fact, provided.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

It may be necessary for information to be obtained or released in order to coordinate benefit payments with other plans, including government programs and government-approved programs, to facilitate administration of the Cafeteria Plan or to assist the Plan Administrators in meeting his/her fiduciary responsibilities. This can be from or to any other insurance company, organization, or person, without notice or your consent.

Any person claiming benefits must furnish any information needed to coordinate benefit payments.

SUBROGATION

The Subrogation and Right to Reimbursement section apply when another party (including insurance carriers) is, or may be considered, liable for an Employee or covered dependent's **Injury, Sickness** or other condition and the Cafeteria Plan has provided or paid for benefits. The provisions of the Subrogation and Right to Reimbursement sections apply to all current or former Cafeteria Plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Cafeteria Plan. The Cafeteria Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of an Employee or covered dependent's estate, an Employee or covered dependent's heirs, minors, and incompetent or disabled persons. No adult Employee or adult covered dependent hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Cafeteria Plan.

The Cafeteria Plan's rights of subrogation and reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the Cafeteria Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Cafeteria Plan's subrogation and reimbursement interests are fully satisfied.

To the extent of the reasonable value of the services provided, the Cafeteria Plan is subrogated to all of the Employee's or covered dependent's rights against any party liable for the Employee's or covered dependent's Injury or Sickness or any party (including any insurance carrier) liable for the payment for the medical treatment of such Injury or Sickness. The Cafeteria Plan may assert this right independently of the Employee or covered dependent. The Cafeteria Plan's right of subrogation shall be deemed a first priority right, regardless of whether the Employee or covered dependent is fully compensated or partially compensated. The made whole doctrine is explicitly rejected.

The Employee or covered dependents are obligated to cooperate with the Cafeteria Plan in order to protect the Cafeteria Plan's subrogation rights. Such cooperation shall include providing the Cafeteria Plan with any relevant information, signing and delivering such documents as the Cafeteria Plan reasonably requests to secure its subrogation claim, and obtaining the Cafeteria Plan's consent before releasing any party from liability for payment of medical **Expenses.**

If the Employee or covered dependents enter into litigation or settlement negotiations regarding the obligations of other parties, the Employee or covered dependent must not prejudice, in any way, the rights of the Cafeteria Plan under this section.

The costs of legal representation of the Cafeteria Plan in matters related to subrogation shall be borne solely by the Cafeteria Plan. The costs of legal representation of the Employee or covered dependent shall be borne solely by the Employee or covered dependent.

The Cafeteria Plan's rights of subrogation and reimbursement shall apply and the Cafeteria Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Cafeteria Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Cafeteria Plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Cafeteria Plan's claim will not be reduced due to an Employee's or covered dependent's own negligence.

RIGHT TO REIMBURSEMENT

This section applies when the Employee, or any of the Employee's dependents or legal representatives of the Employee or any dependent under the Cafeteria Plan (hereafter collectively referred to as the "Parties"), recovers compensation, by settlement, verdict or otherwise, for an Injury, Sickness or other condition. If the Parties have made, or in the future may make, such a recovery, including a recovery from an insurance carrier, the Cafeteria Plan will not cover either the reasonable value of the services to treat such an Injury or Sickness or the treatment of such an Injury or Sickness.

However, if the Cafeteria Plan does pay or provide benefits for such an Injury, Sickness or other condition, the Parties shall promptly reimburse the Cafeteria Plan, from the settlement, verdict or insurance proceeds received by the Parties, for the reasonable value of the medical benefits paid for or provided by the Cafeteria Plan. The Cafeteria Plan's right to reimbursement shall be deemed a first priority right, regardless of whether the Employee or covered dependent is fully compensated or partially compensated. The made whole doctrine is explicitly rejected.

The Parties hereby grant to the Cafeteria Plan an automatic lien against the proceeds of any such settlement, verdict or other amounts received by the Parties. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Cafeteria Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Cafeteria Plan. The Parties hereby assign to the Cafeteria Plan any benefits the Parties may have under any automobile or other first party coverage, to protect the rights of the Cafeteria Plan hereunder. The Parties shall sign and deliver, at the Cafeteria Plan's request, any documents needed to protect such lien or to effect such assignment of benefits.

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) the Parties agree that if the Parties receive any payment as a result of an injury, illness or condition, the Parties will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of the Parties' fiduciary duty to the Cafeteria Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Cafeteria Plan's subrogation and reimbursement interests are fully satisfied.

The Parties shall cooperate with the Cafeteria Plan, including signing and delivering any documents the Cafeteria Plan reasonably requests to protect its rights of reimbursement, providing any relevant information, and taking such actions as the Cafeteria Plan reasonably requests to assist the Cafeteria Plan's making a full recovery of the reasonable value of the benefits provided. It is the Parties' duty to notify the Cafeteria Plan within 30 days of the date when any notice is given to any individual or company responsible for the Parties' **Injury** or **Sickness**, including an insurance company or attorney, of the Parties' intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. The Parties and their agents agree to provide the Cafeteria Plan or its representatives notice of any recovery the Parties or their agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, the Parties and their agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. Failure to provide this information, failure to assist the Cafeteria Plan in pursuit of its subrogation rights or failure to reimburse the Cafeteria Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Cafeteria Plan is reimbursed in full, termination of the Parties' health benefits or the institution of court proceedings against the Parties.

The Parties shall not prejudice the Cafeteria Plan's rights of subrogation or reimbursement. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Cafeteria Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Cafeteria Plan's subrogation and reimbursement interest.

The Cafeteria Plan shall be responsible only for those legal fees and expenses to which it agrees in writing, and shall not otherwise bear the fees or expenses of legal representatives retained by the Parties.

The Parties acknowledge that the Cafeteria Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Cafeteria Plan reserves the right to notify all Parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

The Parties acknowledge that they have access to the Privacy Notice pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, and that the Cafeteria Plan has the right to share personal health information in exercising its subrogation and reimbursement rights.

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator for the Cafeteria Plan, or its designee, shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

By accepting benefits from the Cafeteria Plan, the Parties agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Cafeteria Plan may elect. By accepting such benefits, the Parties hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of their present or future domicile. By accepting such benefits, the Parties also agree to pay all attorneys' fees the Cafeteria Plan incurs in successful attempts to recover amounts the Cafeteria Plan is entitled to under this section.

RIGHT OF RECOVERY

If the Cafeteria Plan pays benefits to you, an insurance company or any organization for Expenses incurred by you or a dependent, and it is found that the Cafeteria Plan paid more benefits to you, an insurance company or any organization than the Cafeteria Plan should have paid, the Cafeteria Plan will have the right to a refund from you, an insurance company, or any organization. The amount of the refund is the difference between:

- the amount of benefits paid by the Cafeteria Plan for those Expenses; and
- the amount of benefits which should have been paid by the Cafeteria Plan for those Expenses.

MISREPRESENTATION OF ELIGIBILITY OR CLAIM INFORMATION

Your participation in the Cafeteria Plan and that of your dependents will be terminated if, while enrolling in the Cafeteria Plan, you knowingly and intentionally:

- submit any materially false information;
- conceal any information material to enrollment in the Cafeteria Plan; or
- assist another person to submit or conceal any such information.

If a material misstatement or failure to disclose important information occurs, coverage may be rescinded by the Plan Administrators or insurer, subject to appropriate review procedures as required by ERISA. You will be obligated to refund the Cafeteria Plan any benefit payments resulting from the material misstatements or omissions, less overpaid contributions.

CLERICAL ERRORS

A clerical error by Allstate, the Plan Administrators, a Third Party Administrator or an 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 Plan Administrators reserve the right to determine whether a correction to contributions and/or benefits will be made and will determine the time period for which the adjustment will be made.

COORDINATION OF BENEFITS

If a person covered under this Cafeteria Plan is also covered under another plan, or no-fault compulsory plan, benefits will be coordinated to prevent duplicate payment for the Expense. Each Plan will pay benefits in the order as explained in this provision, but will only pay the amount needed to bring the total up to the Cafeteria Plan's regular benefit. The Coordination of Benefits provision assures that the total benefits paid from all plans are not more than the actual allowable Expenses under this Cafeteria Plan. This considers all benefits that a plan paid or would have paid had the claim been filed.

NOTE

Coordination of Benefits applies to Medical (excluding HMOs), Dental (excluding DMO), Vision, and Group Legal Plans only.

The Cafeteria Plan coordinates benefits with other plans under which a **Covered Person** is covered, including:

- group coverage or blanket insurance, excluding school accident insurance;
- any **Hospital** or medical service plan for prepaid group coverage;
- labor-management trustee plans, union welfare plans, employer organization plans, employee benefit organization plans, and professional association plans;
- any other employer welfare benefit plan (excluding the Group Critical Illness Plan) as defined in ERISA;
- government programs and government-approved programs, including compulsory no-fault automobile insurance and Medicare, unless coordinating benefits with this type of plan is prohibited by law; and
- medical benefits or medical payments coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts.

Expenses Allowed Under Coordination of Benefits Provisions

Reasonable and Customary Charges that are covered at least in part by one or more of the plans under which the person is covered are allowed for reimbursement when Plan payments are coordinated.

For Medical Plan coverages, the difference between the charge of a private and semi-private Hospital room is not considered an allowable Expense, unless the person's stay in a private room is:

- **Medically Necessary**; or
- uniformly or professionally endorsed as standard **Medical Care**.

If a plan provides services directly, the reasonable cash value of each service is an allowable Expense and is considered paid.

Effect on Benefits

Under this Coordination of Benefits provision, if the Cafeteria Plan is the primary plan (the plan that pays first), benefits will be paid without regard to any other plans. The secondary plans then adjust their payments.

If the Cafeteria Plan is the secondary plan, benefits will be determined as follows:

- If the primary plan's payment is the same as or greater than the benefits provided under the Cafeteria Plan, then no payment will be made in addition to payments made by the primary plan.
- If the primary plan's payment is less than the benefits provided under the Cafeteria Plan, then the Cafeteria Plan will be reduced by the primary plan's payments, or the amount of the primary plan's payment if a claim had been filed.

In no event will the Cafeteria Plan pay more than it would without the Coordination of Benefits provision.

If the other plan provides services directly, the reasonable cash value of each service is deemed to be a benefit paid.

If a person was eligible at any time to enroll in Medicare but did not do so, and Medicare should pay benefits first, benefits under this Cafeteria Plan will be paid as if the person had received full benefits under Medicare.

Benefits under this Cafeteria Plan will nevertheless be calculated as if the person had received benefits under the HMO if a Covered Person is enrolled in an HMO as well as the Cafeteria Plan, the HMO is the primary plan, and the Covered Person fails to obtain services through the HMO.

Coordination with No-Fault Vehicle Insurance

The Cafeteria Plan is subject to ERISA, which pre-empts the application of state laws that relate to the Cafeteria Plan. Some people covered under the Cafeteria Plan are also covered under the mandatory provisions covering medical Expenses in a no-fault motor vehicle insurance policy, which are generally referred to as personal injury protection or PIP benefits, and which are hereafter referred to as No-Fault PIP Benefits. Some state laws permit a person who is covered by both such plans to choose which one pays benefits first. Such state laws do not apply to the Cafeteria Plan.

Even if state law provides otherwise, benefits under the Cafeteria Plan, if any, will be paid secondary to the No-Fault PIP benefits.

This Cafeteria Plan also always pays secondary to any medical payment coverage under any automobile policy available to you.

In addition, the provisions of the Cafeteria Plan for **Deductibles**, **Copayments**, reimbursement levels, and/or exclusions will apply to the **Eligible Expenses** remaining after such reduction.

Determining Which Plan Pays First

If a person is covered under the Cafeteria Plan and another plan at the same time, benefits will be paid in this order:

- Any plan that has no Coordination of Benefits provision will pay first.
- Any plan that has a Coordination of Benefits provision will then pay as follows:
  - **First:** Any plan in which the Covered Person is covered as an Employee, primary plan Member, or subscriber.
  - **Second:** Any plan in which the Covered Person is covered as a dependent of an Employee.
- Any plan in which the child is covered as a dependent of the parent whose birth date occurs later in the calendar year.

The other plan may have a rule based on the gender of the parent. In this case, and if the plans do not agree on the order of payment, then the rule of the other plan will determine the order of payment.

When a claim is made for a dependent child who is covered under the plans of both parents, and the parents are separated or divorced:

If the parent with custody of the dependent child has not remarried, the plans will pay in this order:

- **First:** Any plan in which the child is covered as a dependent of the parent who has custody.
- **Second:** Any plan in which the child is covered as a dependent of the parent who does not have custody.

If the parent with the custody of the dependent child has remarried, the plans will pay in this order:

- **First:** Any plan in which the child is covered as a dependent of the parent who has custody.
- **Second:** Any plan in which the child is covered as a dependent of the step-parent.
- **Third:** Any plan in which the child is covered as a dependent of the parent who does not have custody.

When a claim is made for a covered terminated or retired Employee or a covered dependent of that person, benefits will be paid in this order:

- **First:** Any plan in which the person is covered other than as a terminated or retired Employee or a dependent of that person.
- **Second:** Any plan in which the person is covered as a terminated or retired Employee or a dependent of that person.

If the birth dates of the parents are the same, the plan that has covered the dependent longer will pay first.

In some cases, the order of payment may be unclear. Priority then goes to the plan which has covered the person for the longest continuous time.

NOTE

These rules do not apply when a QMCSO fixes the responsibility for the health care Expenses of a child whose parents have separated or divorced. Any plan in which the child is covered as the dependent of a parent with this legal responsibility will always pay first.

If you or a dependent is diagnosed with end stage renal disease (ESRD—permanent kidney failure), you will be eligible for Medicare. The Cafeteria Plan will be the primary plan for 30 months. Thereafter, Medicare will pay benefits as the primary plan. You should call your medical coverage customer service unit to discuss the coordination of benefits with Medicare if you are diagnosed with ESRD.

Right to Make Payments

Payments may be made to any other organization as needed to properly carry out the Coordination of Benefits provision. Payments that are made in good faith are considered benefits paid under this Cafeteria Plan. Also, they discharge the Cafeteria Plan from further liability, to the extent that the payments are made.

TERMINATION OF COVERAGE

Employee Coverage

Your coverage ends on the earliest of:

- the date your employment terminates;
- the date the Cafeteria Plan ends or is changed to end coverage for the class or business unit to which you belong;
- the date you cease to be an eligible Employee;
- the date your Employer is no longer a Participating Allstate Company;
- the end of the last period for which you have made a required contribution;
- the date of a Qualified Change in Status, if you elect to cancel coverage; or
- December 31 of the year you terminate coverage, if you terminate coverage during Annual Benefits Enrollment.

In addition to the above, for LTD coverage only:

- the date you are placed on a family, personal, or military leave of absence as defined in a separate Human Resource Policy.

Dependent Coverage

Dependent coverage ends on the earliest of:

- the date your coverage ends;
- the date the Cafeteria Plan ends or is changed to end dependent coverage;
- for a dependent child, the date the child is no longer eligible for coverage under the Cafeteria Plan. If coverage is terminating because the child reaches age 26, coverage will terminate at midnight on the last day of the month of the child's 26th birthday. If coverage terminates because you failed to furnish proof acceptable to the Plan Administrators of your child's disability within 60 days of the request, coverage will be terminated upon the later of the attainment of the limiting age or the expiration of the 60-day period.
- for a spouse, the date of divorce or, for a domestic partner, termination of a domestic partner relationship;
- the date of a Qualified Change in Status, if you elect to cancel coverage; or
- December 31 of the year in which you make an Annual Benefits Enrollment election to cancel dependent coverage for the following Plan Year.

The end of coverage will not affect any claim made for a loss that took place while the coverage was in force.

COBRA CONTINUATION COVERAGE

This section of the Cafeteria Plan SPD contains important information about COBRA continuation coverage, which is a temporary extension of Medical, Dental and Vision Plan coverage and Health Care FSA participation under the Cafeteria Plan. 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 under the Medical, Dental and Vision Plan(s) and/or participation under the Health Care FSA. It can also become available to other members of the Employee's family who are covered under the Cafeteria Plan when they would otherwise lose their group health coverage. The coverage described below may change as permitted or required by changes in applicable law.

In addition to continuation coverage under COBRA, some state law provisions grant broader continuation rights that may apply to HMO plans offering benefits under the Cafeteria Plan. For more information, please contact your HMO **Member Services** department for details specific to your plan.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan coverage under the Medical, Dental and Vision Plan(s) and/or participation under the Health Care FSA 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." The Employee, Employee's spouse and dependent children could become qualified beneficiaries if coverage under the Cafeteria Plan is lost because of a qualifying event.

An Employee will become a qualified beneficiary if coverage is lost under the Cafeteria 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 Cafeteria 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 Cafeteria 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 Cafeteria Plan as a "dependent child."

NOTE

Although not specifically required under COBRA, the Cafeteria Plan may extend continuation coverage to eligible civil union partners, 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. HMO availability may be limited or subject to additional terms and conditions. Please contact your HMO Member Services department for details.

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 Cafeteria 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, access the *Your Benefits Resources*™ website at http://resources.hewitt.com/allstate, or 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.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. If you are eligible for medical COBRA continuation coverage, enrollment will be in the same medical plan you were enrolled in prior to loss of coverage. During Annual Benefits Enrollment, you will be able to review and change medical coverage options. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

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 Cafeteria 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 Cafeteria 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 Cafeteria 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.

Special Rules for Health Care FSA

Generally, continued participation in the Health Care FSA on an after-tax basis under COBRA will not be available unless, as of the date of your qualifying event, the amount of claims you have filed for reimbursement from your account for the Plan Year is less than the amount you have already contributed to the account for that Plan Year. In addition, enrollment in the Health Care FSA is limited to individuals participating in the Health Care FSA at the time of the qualifying event, and continues only until the end of the current Plan Year.

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 Cafeteria 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

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 Cafeteria 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 Cafeteria 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 Cafeteria Plan.

90-Day Company-Subsidized Survivor Coverage

If an active Employee dies and the Employee's spouse, dependent child or their representative elects to continue Medical and/or Dental Plan coverage under COBRA, the first 90 days of such coverage will be provided at no cost. After the Company-subsidized coverage period, the participant must pay any required premium in order for coverage to continue. If the required premiums are not paid, continued coverage will end and coverage cannot be reinstated. Vision Plan coverage and Health Care FSA participation will not be subsidized by the Employer.

Events that May Change Continued Coverage

Once COBRA coverage begins, COBRA coverage elections may be able to be changed based on the Cafeteria 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 Cafeteria 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 Cafeteria Plan would terminate coverage of an individual who is not receiving continuation coverage (such as fraud).

Coverage History Notice

When your COBRA coverage ends, you automatically will be sent a Coverage History Notice that confirms that you had whatever medical coverage you continued through COBRA and states how long you were covered. In addition to the notice you are sent automatically, you also may request an additional notice within 24 months after coverage ends.

Conversion

You may be able to convert your group health plan and your group life insurance plan coverage to a personal policy directly with the insurance carrier, if the benefit is insured. Generally, you must apply for conversion within 30 or 31 calendar days of your coverage termination. Contact the insurance carrier directly for more information about conversion options, if any, and the corresponding cost.

Trade Adjustment Assistance

The Trade Act of 2002 created a second COBRA election right and new tax credit for certain individuals who become eligible for trade adjustment assistance (TAA) and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC), also called eligible individuals. Under the new provisions, eligible individuals who decline COBRA when they were first eligible can elect COBRA within 60 days of the first day of the month in which they become eligible for TAA (but no later than six months after the date of the eligible individual's group health plan coverage ended) and can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Center toll-free (866) 628-4282. TTD/TTY callers may call toll-free at (866) 626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/.

Address Information

Be sure to keep your current address information up to date with the Allstate Benefits Center by calling (888) 255-7772. This will help ensure that any necessary COBRA information, including enrollment instructions, will reach you. This obligation applies to Employees as well as spouses, domestic partners and dependent children who do not reside at the same address as the Employee. Your rights to COBRA coverage and important benefit information could be lost if you fail to notify the Allstate Benefits Center of an address change.

Your Rights Under ERISA

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

For More Information

The Allstate Benefits Center provides COBRA administration services on behalf of the Plan Administrators. If you need additional information, access the *Your Benefits Resources* website (http://resources.hewitt.com/allstate) 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.

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 information (beginning April 14, 2003). As employee welfare benefit plans under ERISA, the Medical, Dental, Vision and Health Care FSA Plans under the Cafeteria Plan are subject to the HIPAA privacy rules. Pursuant to HIPAA privacy rules, the Cafeteria Plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, plan administration or as required or permitted by law. A description of the Cafeteria 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 Cafeteria Plan's Notice of Privacy Practices which can be accessed on the Allstate Intranet, or by contacting the office of the Plan Administrators.

COVERAGE HISTORY NOTICE

A Coverage History Notice will be automatically mailed to the last known address of any Employee (and dependent, if living separately) when they lose coverage under the Cafeteria Plan or when COBRA continuation coverage ends, if such coverage was elected under the Cafeteria Plan.

You may also request a notice within 24 months of the end of coverage (including COBRA continuation coverage under the Cafeteria Plan). To request a certificate, please contact:

The Plan Administrators, Allstate Cafeteria Plan
Allstate Insurance Company
2775 Sanders Road, Suite F5
Northbrook, IL 60062-6127
(847) 402-8827

STATEMENT OF ERISA RIGHTS

As a participant in the Cafeteria 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 Administrators, 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 Administrators may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrators are 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 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.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing conditions exclusions for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 Administrators 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 Administrators, 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.

Glossary

When reading this Summary Plan Description (SPD), you should be aware of the following definitions. Please note that:

- unless indicated, the definitions apply to all the benefit plans in the Allstate Cafeteria Plan;
- defined terms may be used in the singular, plural, or possessive form in this SPD;
- definitions may vary among coverages within the Cafeteria Plan. Be sure to refer to the appropriate definition;
- not all defined terms are in this Glossary—some that are specific to one coverage are defined in the section of the SPD devoted to that coverage.

Actively at Work or **Active Work** for the Basic Life Insurance, Supplemental Life Insurance, Spouse Life Insurance, Child Life Insurance, Basic AD&D Insurance and Supplemental AD&D Insurance coverages means the Employee works his/her full number of hours for his/her full rate of pay for the Employer at the regular place of employment in accordance with established employment practices.

If an Employee was Actively at Work, as defined above, on his/her last regular working day, then he/she shall be deemed to be Actively at Work:

- on each day of designated PTO;
- on each day of a family or military leave of 12 weeks or less; or
- on a regular non-working day.

You are not deemed to be Actively at Work if you are on a leave of absence, other than a family or military leave of 12 weeks or less.

Actively at Work or **Active Work** for the Long Term Disability Insurance and Group Legal Plans means the Employee works his/her full number of hours for his/her full rate of pay for the Employer at the regular place of employment in accordance with the Employer's established employment practices.

If an Employee was Actively at Work, as defined above, on his/her last regular working day, then he/she 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 he/she is 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 (http://resources.hewitt.com/allstate) or (888) 255-7772 from 8 a.m. to 6 p.m. Central time, Monday through Friday.

Alternative Birthing Center means:

A freestanding facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped, and run to provide prenatal care, delivery, and immediate postpartum care.

- Charges for its services.
- Is directed by at least one physician who is a specialist in obstetrics and gynecology.
- Has a physician or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area hospital.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery, and the immediate postpartum period, full-time skilled nursing services directed by an R.N. or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle emergency medical conditions and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Alternative Level of Treatment means treatment that does not require 24-hour acute care such as Partial Hospitalization, Residential Treatment, Intensive Outpatient Treatment, and Outpatient care.

Alternative Recipient means any child of an Employee enrolled in the Cafeteria Plan who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under a group health plan with respect to such Employee.

Ambulatory Care Center means a licensed surgical or medical center operating within the scope of its license or operating as a part of a Hospital, solely engaged in providing surgical or medical care on an outpatient basis.

Any Occupation means an occupation for which you are qualified by education, training, or experience, and that has an earnings potential greater than an amount equal to the lesser of the product of your Indexed Pre-Disability Earnings and the Benefit Percentage and the maximum monthly benefit under the Long Term Disability Insurance Plan.

Basic Monthly Earnings (Long Term Disability Insurance) means your Qualified Annual Earnings (QAE) in effect at the time your Total Disability began, divided by 12, then rounded to the nearest $100.

Basic Monthly Earnings (Basic Life Insurance, Supplemental Life Insurance, Basic AD&D Insurance and Supplemental AD&D Insurance) means your Qualified Annual Earnings (QAE) rounded to the nearest $1,000 then multiplied.

Coinsurance or **Coinsurance Level** (as it relates to Medical Plan Coverage) means the percentage of Reasonable and Customary Charges the Cafeteria Plan pays for covered services less any applicable Deductible or Copayment.

Coinsurance or **Coinsurance Level** (as it relates to the Prescription Drug Program) means a percentage of the total cost paid by the participant in the Allstate Medical Savings Plan for each non-preventive prescription filled. The Coinsurance applies to generic and brand medications for retail, mail order, and specialty drugs only after the annual deductible has been satisfied.

Common Carrier means any air, land or water vehicle operated under a license for the transportation of fare-paying passengers.

Copayment (as it relates to the Allstate Good Life Wellness Center and Premier In-Network Providers) means the flat dollar amount a Covered Person is responsible for paying directly to the provider when receiving certain covered services.

Copayment (as it relates to Prescription Drug Program) means the amount paid by a Covered Person for each prescription filled in the Allstate Medical Savings Plan and the Allstate Medical Value Plan. The Copayment applies to generic, formulary and non-formulary medications for retail, mail order, and specialty drugs. The Copayment for each prescription of preventive medication in the Allstate Medical Savings Plan and the Allstate Medical Value Plan is a flat dollar amount.

Cosmetic Procedures means procedures or services that change or improve appearance without significantly improving physiological function, as determined by Care Coordination.

Covered Person means an Employee or dependent who is enrolled in the Cafeteria Plan and is eligible to receive benefits.

Covered Person for the Group Legal Plan means a person who is enrolled in the Group Legal Plan either as a participant or a Qualified Dependent.

Credits are the amount of money Allstate contributes towards your Medical and/or Dental Insurance coverages. The amount of Credits you receive for Medical or Dental coverage is based on your employment status (regular full-time, regular part-time, or part-time), your coverage tier, and your tobacco status (Tobacco-Free or Tobacco-User. Participants will only receive the Tobacco-Free credit if they are enrolled in the Medical Plan).

Current Monthly Earnings means the monthly earnings you receive from the Employer while Totally Disabled or from other employment. Current Monthly Earnings will also include the amount of pay for another or modified job position, which may be offered to you by the Employer. The requirements of such position must be within your capabilities as described by your Physician, and consistent with your education, training, and experience.

Custodial Care for the Allstate Medical Savings Plan and the Allstate Medical Value Plan means care consisting of services and supplies which:

- are furnished mainly to train or assist the individual in personal hygiene and other activities of daily living;
- do not assist such person in recovering from an Injury or Sickness; or
- can be provided by persons without the technical skills of a provider of health care covered by the Plan.

Such care is considered custodial regardless of:

- where the care is provided; or
- who recommends, directs, or provides the care.

Custodial Care for the Mental Health and Substance Abuse Treatment Program of the Allstate Medical Savings Plan, and the Allstate Medical Value Plan means care rendered to a patient who:

- is disabled mentally or physically and such disability is expected to continue and be prolonged;
- requires a protected, monitored, and controlled environment whether in an institution or in the home;
- requires assistance to support the essentials of daily living; and
- is not under active and specific mental health or substance abuse treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment.

Deductible means the portion of the Reasonable and Customary Charges a Covered Person must pay out-of-pocket during the Plan Year before any Plan benefits are paid. Certain medical expenses, such as Copayments for medical services or prescription medication, do not apply toward your Deductible, with the exception of the preventive drug copayments in the Allstate Medical Savings Plan and the Allstate Medical Value Plan.

Dental Care or **Treatment** means services or supplies for the teeth, natural or otherwise, and their supporting tissues and structures, including but not limited to orthodontic service.

+**Dentist** means a person who is:

- licensed or legally authorized to furnish dental services; and
- acting within the scope of the license or authorization.

Detoxification means a medically supervised treatment, conducted under the supervision of a Physician, designed to:

- systematically reduce the amount of a toxic agent in a Cafeteria Plan member's body;
- provide reasonable control of active withdrawal symptoms; and
- avert a life-threatening medical crisis.

Detoxification may precede Substance Abuse Rehabilitation, but it is separate from Substance Abuse Rehabilitation and is intended to alleviate consequences of withdrawal.

Disability or **Disabled** (excluding pilots, co-pilots and crewmembers) for Long Term Disability means a person is prevented from performing one or more of the Essential Duties of:

- their occupation during the Elimination Period;
- their occupation for the 24 months following the Elimination Period, and as a result their Current Monthly Earnings are less than 80 percent of their Indexed Pre-Disability Earnings; and
- after that, Any Occupation.

If at the end of the Elimination Period, you are prevented from performing one or more of the Essential Duties of your occupation, but your Current Monthly Earnings are greater than 80 percent of your Pre-Disability Earnings, your Elimination Period will be extended for a total period of 12 months from the original date of Disability, or until such time as your Current Monthly Earnings are less than 80 percent of your Pre-Disability Earnings, whichever occurs first.

For the purposes of extending your Elimination Period, your Current Monthly Earnings will not include the pay you could have received for another job or a modified job if such job was offered to you by your Employer, or another employer, and you refused the offer.

Disability must result from:

- accidental bodily injury;
- Sickness;
- Mental Illness;
- Substance Abuse; or
- Pregnancy.

Failure to pass a physical examination required to maintain a license to perform the duties of your occupation, alone, does not mean that you are Disabled.

Disability or **Disabled** (for pilots, co-pilots and crewmembers) for the Long Term Disability Insurance Plan means a person is prevented from performing one or more of the Essential Duties of Any Occupation as a result of:

- accidental bodily injury;
- Sickness;
- Mental Illness;
- Substance Abuse; or
- Pregnancy.

DSM V means the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.

Durable Medical Equipment means a device or item which:

- is prescribed or recommended by a Physician;
- is durable in nature and is not disposable;
- is primarily used as a medical device and is not generally used in the absence of Sickness or Injury;
- must be necessary for the treatment or management of a Sickness or Injury; and
- is not used by anyone other than the patient.

Eligible Expenses for In-Network covered health services are the medical services and supplies provided to you by an In-Network provider, but only if those medical services and supplies are not excluded from coverage under the Medical Plan options.

Eligible Expenses for Out-of-Network covered health services also must be for a service or supply which is performed or prescribed by a Physician and is determined to be not excluded from coverage under the plan.

Any amount of Expense in excess of the **Reasonable and Customary Charges** is not an Eligible Expense and therefore is not reimbursable. In no event may the benefit payable exceed the amount of the Eligible Expense.

Elimination Period means a period of consecutive days of Total Disability or Partial Disability for which no benefit is payable. The Elimination Period begins on the first day of Total Disability or Partial Disability. Attempts to return to Active Work during the Elimination Period will not interrupt the Elimination Period, if the number of days the **Covered Person** returns to work as an Active Employee are less than one-half ($\frac{1}{2}$) the number of days in the Elimination Period.

Emergency for the Allstate Medical Savings Plan and the Allstate Medical Value Plan means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy;
- serious impairment to bodily function;
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency for the Mental Health and Substance Abuse Treatment Services of the Allstate Medical Savings Plan and the Allstate Medical Value Plan means a sudden, serious condition for which failure to receive immediate mental health or substance abuse care could result in an individual being a real and present danger to himself/herself or others.

Some examples of an Emergency are attempted suicide and violent and aggressive behavior towards others.

A psychiatric Emergency does not necessarily require an inpatient level of care, but does require adequate security and medical supports to evaluate and treat the psychiatric Emergency without risk to the individual or others.

Emergency for the Group Legal Plan means a matter that needs immediate attention outside of normal business hours and involves an imminent threat to loss of life, health, freedom, or property.

Employee means a person in an Employee-Employer relationship with the Employer who is classified by the Employer as either a Regular Full-Time, Regular Part-Time, or 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, and (2) has accumulated at least 1,000 hours of service in an anniversary year
- A "Part-Time Employee" means any employee of an Employer who has not completed 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;
  - 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 Cafeteria 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 Cafeteria Plan.

If a person is not considered to be an Employee for purposes of Cafeteria 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 Cafeteria Plan purposes.

An Employee who is covered under the Cafeteria Plan also may be referred to as "you" or "your."

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

Essential Duty means a duty that is (i) substantial, not incidental; (ii) fundamental or inherent to the occupation; and (iii) cannot be reasonably omitted or changed. To be at work for the number of hours in your regularly scheduled workweek is also an Essential Duty.

Evidence of Insurability (EOI) means you may be required to provide evidence of your health to the Third Party Administrator and you may be required to provide additional underwriting information.

Expense means a charge a person is legally obligated to pay. Expense is deemed to be incurred on the date the service or supply is furnished, and not when the person is formally billed or is charged for, or pays for the services or supplies. Certain exceptions may apply under the Dental Plan. Expenses are applied in the order incurred.

Experimental or **Investigational Services** means medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time a determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment), we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Explanation of Benefits (EOB) means a statement from the insurer or the Third Party Administrator sent to a Plan member who files a claim. It gives specific details about how and why benefit payments were or were not made. It summarizes the charges submitted and processed, the amount allowed, the amount paid, and the balance owed by the Plan member, if any.

Extended Care Facility means a licensed institution accredited by the Joint Commission on Accreditation of Healthcare Organizations, other than a Hospital, which provides:

- inpatient medical care and treatment to convalescing patients;
- full-time supervision by at least one Physician or registered nurse;
- 24-hour nursing service by licensed professional nurses;
- complete medical records for each patient; and
- Utilization Review plans for all patients.

An Extended Care Facility also includes any Extended Care Facility which meets the Medicare definition, if the patient is eligible for Medicare.

Family Medical Leave means a leave of absence for the birth, adoption, or foster care of a child or for the care of the Covered Person's child, spouse, or parent or for the Covered Person's own serious health condition as those terms are defined by the federal Family and Medical Leave Act of 1993 (FMLA) and any amendments, or by applicable state law.

Health Care Management Program means a program offered by a Medical Plan third party administrator– either the Aetna In Touch Care or the Blue Cross Care Programs – to help you manage certain condition(s). The Health Care Management Program identifies individuals who are potential participants through medical and pharmacy claims. Claims information is sent directly from health plan providers to the Health Care Management Program at the applicable third party administrator and is kept strictly confidential.

Health Maintenance Organization (HMO) is a health plan that provides services through a select group of independent practicing Physicians, Hospitals, and other providers who are under contract with the HMO to provide services at a discounted rate. Generally, benefits are only payable when using In-Network providers and covered services.

Health Reimbursement Arrangement (HRA) means a tax-favored trust or custodial account established by the employee to provide tax free reimbursement/payment of qualified medical expenses while covered under the Allstate Medical Basic Plan, the Allstate Medical Plus Plan, or an HMO.

Health Savings Account (HSA) is a tax-favored, employer-funded account designed to reimburse employees, their spouses, and dependents for qualified health care expenses incurred while covered under the Allstate Medical Savings Plan or Allstate Medical Value Plan which are High-Deductible Health Plans.

High-Deductible Health Plan (HDHP) means a plan with an In-Network deductible of at least $1,300 for individuals and $2,600 for family coverage. The plan must also have In-Network out-of-pocket limits no greater than $6,550 for individuals and $13,100 for family coverage.

Home Health Care means the following services and supplies. The Home Health Care must replace a needed Hospital stay or a stay in an Extended Care Facility. Also, it must be for the care or treatment of sick or injured persons and must be:

- ordered in writing by the Covered Person's Physician; and
- provided in the Covered Person's home by a Home Health Care Agency team.

Home Health Care consists of these services and supplies:

- part-time or intermittent home nursing care from or supervised by a registered nurse;
- part-time or intermittent home health aide services;
- physical therapy, occupational therapy, and speech therapy; and
- medical supplies, drugs, and medications prescribed by a Physician, and laboratory services (but only to the extent that they would have been covered in a Hospital or Extended Care Facility).

Each visit from a Home Health Care Agency team of four hours or less is considered a single visit.

Home Health Care Agency means a public or private agency that:

- specializes in giving nursing or therapeutic services in the home;
- is licensed as a Home Health Care Agency; and
- operates within the scope of its license.

Hospice means a facility, or a part of one, which:

- provides inpatient Hospice Care;
- is licensed as such and operating within the scope of the license;
- maintains medical records on each patient and provides an ongoing quality assurance program;
- has full-time supervision by at least one Physician; and
- provides 24-hour nursing service by registered nurses.

Hospice Care means a coordinated program of home and/or inpatient care for the special physical, psychological, and social needs of terminally ill persons and their families. A terminally ill person is one who has been diagnosed by a Physician as having a life expectancy of six months or less. The program must be accredited by the National Hospice Association.

Hospital for the Allstate Medical Savings Plan and the Allstate Medical Value Plan means a licensed institution, or an institution authorized by the Cafeteria Plan's professional review organization, other than an Extended Care Facility, that provides inpatient medical care and treatment for sick and injured persons. Services provided by a Hospital must also include:

- diagnosis of Sickness and Injury;
- full-time supervision by at least one Physician;
- 24-hour nursing service by registered nurses;
- surgery or formal arrangements for available surgical facilities; and
- therapeutic care of patients who are convalescing from Sickness or Injury.

The surgery requirement will be waived if:

- treatment or services are provided for rehabilitation from an Injury or Sickness; and
- the institution would otherwise qualify as a Hospital.

Hospital also includes any Hospital which meets the Medicare definition, if the patient is eligible for Medicare.

However, the Cafeteria Plan does not provide benefits for charges by any such Hospital or institution for Custodial Care, training, or schooling.

Hospital for the Mental Health and Substance Abuse Treatment Services of the Allstate Medical Savings Plan and the Allstate Medical Value Plan means an acute care facility, approved by the Joint Commission on the Accreditation of Healthcare Organizations and licensed by the state, which provides intensive psychiatric and/or substance abuse services in a setting that offers:

- 24-hour on-site nursing care;
- Physician coverage; and
- access to emergency medical care. Primarily intended for crisis intervention and stabilization, inpatient treatment program components including individual/group/family therapies, medical supervision, medication management, discharge planning and aftercare.

Indexed Pre-Disability Earnings means your Pre-Disability Earnings adjusted annually by adding the lesser of 7% or the percentage change in the Consumer Price Index (CPI-W). The adjustment is made January 1st each year after you have been Disabled for 12 consecutive months, and if you are receiving benefits at the same time the adjustment is made.

Injury for the Allstate Medical Savings Plan and the Allstate Medical Value Plan means accidental bodily injury.

Injury for Dental coverage means accidental harm or damage to sound natural teeth.

Injury for the Accidental Death and Dismemberment Insurance and Long Term Disability Insurance Plans means an insured's death or dismemberment results, directly and independently of all other causes, from an accidental injury which is unintended, unexpected, and unforeseen.

Intensive Outpatient Program means non-residential mental health or substance abuse treatment in which attendance ranges from three to five days per week.

In-Network means benefits provided under the Allstate Medical Savings Plan or the Allstate Medical Value Plan if covered medical services are obtained from or arranged by a participating network provider (including any Premier In-Network Providers)**.**

Medical Care is received when a Physician is consulted or medical advice is given, or treatment is recommended, prescribed by, or received from a Physician. For purposes of Medical Care, treatment includes, but is not limited to: medical examinations, tests, attendance or observation; and use of drugs, medicines, medical services, supplies, or equipment.

Medically Necessary or **Medical Necessity** for the Allstate Medical Savings Plan and the Allstate Medical Value Plan means health care services and supplies rendered by a Physician or medical provider which are determined by the Third Party Administrator to be medically appropriate and:

- necessary to meet the basic health needs of the Covered Person;
- rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply;
- consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical research, health care coverage organizations, or governmental agencies that are accepted by the Third Party Administrator;
- consistent with the diagnosis of the condition;
- required for reasons other than the comfort or convenience of the Covered Person or his or her Physician; and
- demonstrated through prevailing peer-reviewed medical literature to be either:
  - safe and effective for treating or diagnosing a Sickness or Injury for which their use is proposed, or,
  - safe with promising efficacy:
    - for treating a life threatening Sickness or Injury;
    - in a clinically controlled research setting; and
    - using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life threatening" is used to describe a Sickness or Injury which is more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular Injury, Sickness, or pregnancy does not mean it is Medically Necessary, as defined. The definition of Medically Necessary used herein relates only to coverage under the Medical Plan provision and differs from the way in which a Physician engaged in the practice of medicine may define Medically Necessary.

Medically Necessary for the Mental Health and Substance Abuse Treatment Program of the Allstate Medical Savings Plan and the Allstate Medical Value Plan means that a service or confinement must be:

- in keeping with the national standards of mental health and substance abuse practice;
- adequate and essential for the diagnosed mental health and substance abuse condition;
- determined to produce a reasonable expectation that services will improve an individual's condition or level of functioning; and
- provided at the most cost-effective level of care.

The fact that a Physician prescribes a service or confinement does not in itself mean that such a service or confinement will be considered Medically Necessary, or that it is included as a covered mental health or Substance Abuse expense under the Cafeteria Plan.

Medically Necessary for the Dental Plan means the reasonable and appropriate diagnosis, treatment, and follow-up care (including supplies, appliances, and devices) as determined and prescribed by qualified, appropriate health care providers in treating any condition, illness, disease, injury, or birth developmental malformations. Care is Medically Necessary for the purpose of:

- controlling or eliminating infection, pain, and disease; and
- restoring facial configuration or function necessary for speech, swallowing, or chewing.

Medicare means the medical care program described in Title XVIII of the Social Security Act of 1965, as amended.

Member Doctor means a vision care provider who has contracted with VSP to provide vision services and/or vision care materials to Covered Persons.

Member Services means the Third Party Administrator's administration team which handles a variety of plan participant issues including benefit questions, claim issues, and eligibility inquiries. Refer to your plan ID card for information on the Third Party Administrator that administers your claims.

Mental Health Disorder means an illness, condition, or disorder defined or described as a mental disorder, in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV), or its successor volume, published by the American Psychiatric Association.

Mental or **Nervous Disorder** means a mental or emotional disease or disorder of any kind, including but not limited to neurosis, psychoneurosis, psychopathy, and psychosis.

Mental Illness for the Long Term Disability Insurance Plan means any psychological, behavioral, or emotional disorder or ailment of the mind, including physical manifestations of psychological, behavioral, or emotional disorders, but excluding demonstrable structural brain damage.

Miscellaneous Services means Medically Necessary services and supplies, other than Room and Board and professional services. These services or supplies must be provided by a Hospital, Hospice, or Extended Care Facility or other provider of service such as laboratories, pharmacies, and rehabilitation centers.

Non-Member Provider means any optometrist, optician, ophthalmologist, or other licensed or qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons.

Nurse-Midwife means a person who is:

- licensed or certified as such and acting within the scope of the licensure or certification; and
- acting under proper medical direction furnished in affiliation with an Alternative Birthing Center or Hospital.

Orthodontic Service means a service, including any surgical therapy, performed to prevent or correct abnormal positioning of the teeth in relation to the jaws.

Orthopedic Device means a device which is Medically Necessary for the correction of locomotor disorders, particularly as it pertains to the skeleton, joints, muscles, and fascia.

Other Income Benefits means:

- Ø The amount for which you are eligible under:
  - Workers' or Workers' Compensation Laws;
  - Occupational Disease Law;
  - Title 46, United States Code Section 688 (The Jones Act);
  - any work loss provision in mandatory "No-Fault" auto insurance;
  - Railroad Retirement Act;
  - any governmental compulsory benefit act or law; or
  - any other act or law of like intent.
- Ø The amount of any disability benefits which you are eligible to receive under:
  - any other group insurance plan of the Employer (excluding the Supplemental Long Term Disability Plan);
  - any governmental retirement system as a result of your employment with the Employer; or
  - any individual insurance plan where the premium is wholly or partially paid by the Employer. However, the Long Term Disability Insurance Plan administrator will only reduce your monthly benefit if your monthly benefit under the Long Term Disability Insurance Plan plus any benefits that you are eligible to receive under such individual insurance plan exceed 100% of your Pre-Disability Earnings. If this sum exceeds 100% of your Pre-Disability Earnings, your monthly benefit under the Long Term Disability Insurance Plan will be reduced by such excess amount.
- Ø The amount of benefits you receive under the Employer's Retirement Plan as follows:
  - the amount of any Disability Benefits under a Retirement Plan, or Retirement Benefits under a Retirement Plan you voluntarily elect to receive as a direct payment under the Employer's Retirement Plan; and
  - the amount you receive as retirement payments when you reach the later of age 62, or normal retirement age as defined in the Employer's plan.
- Ø The amount of Disability and/or Retirement Benefits under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act, which:
  - you receive or are eligible to receive; and
  - your spouse, child, or children receive or are eligible to receive because of his or her Disability; or
  - your spouse, child, or children receive or are eligible to receive because of your eligibility for retirement benefits.
- Ø Any amount you receive from any unemployment benefits.
- Ø Other Income Earnings, including:
  - any amount you receive from any formal or informal sick leave or salary continuation plan(s); and
  - the amount of earnings you earn or receive from any form of employment including severance.

Other Income Earnings means benefits except Retirement Benefits that must be payable as a result of the same Disability for which the Long Term Disability Insurance Plan administrator pays a benefit. The sum of Other Income Benefits and Other Income Earnings will be deducted in accordance with the provisions of the Long Term Disability Insurance Plan.

Out-of-Pocket Maximum means the maximum amount of money a Covered Person will pay in addition to premium payments during a Plan Year for Plan-related benefits. The Out-of-Pocket Maximum equals the sum of the Deductible, Coinsurance payments, medical services, and preventive drug Copayments in the Allstate Medical Savings Plan and the Allstate Medical Value Plan.

Outpatient Treatment means treatment that generally occurs once a week at the provider's office for a psychiatric or Substance Abuse Disorder.

Own Occupation means your occupation you were performing at the time your Total Disability began, as it is recognized in the national economy. Your Own Occupation does not mean the specific job you are performing for a specific employer or at a specific location.

Partial Hospitalization means non-residential mental health or substance abuse treatment which provides the range of psychiatric services found in an inpatient setting.

Participating Provider means:

- a Physician;
- a Hospital; or
- other ancillary providers

who have entered into a contract to provide In-Network services to Covered Persons in the Allstate Medical Savings Plan and the Allstate Medical Value Plan.

Physician for the Allstate Medical Savings Plan and the Allstate Medical Value Plan means a person who is:

- licensed to practice medicine and/or surgery; and
- acting within the scope of the license.

Physician also means a legally qualified:

- Doctor of Medicine (M.D.)
- Doctor of Chiropody (D.P.M.; D.S.C.)
- Doctor of Chiropractic (D.C.)
- Doctor of Dental Surgery (D.D.S.)
- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Osteopathy (D.O.)
- Doctor of Podiatry (D.P.M.)
- Physician Assistant (P.A.)

Physician for the Mental Health and Substance Abuse Treatment Services of the Allstate Medical Savings Plan and the Allstate Medical Value Plan means a person who is:

- licensed (MD/DO) to practice medicine and/or surgery and psychotherapy; and
- acting within the scope of the license.

Physician also means a masters degreed social worker (MSW) or registered nurse (MSN) who is licensed or certified by the state, working within the scope of the license or certification, and providing care or treatment of a Mental Health or Substance Abuse Disorder, or a Psychologist (PhD/PsyD/EDD) who is licensed, registered, or certified by the jurisdiction in which he/she is practicing.

Physician for the Long Term Disability Insurance Plan means a person who is a doctor of medicine, osteopathy, psychology, or other healing art recognized by the Long Term Disability Insurance Plan administrator, licensed to practice in the state or jurisdiction where care is being given, and practicing within the scope of that license.

Physician for the Basic Life Insurance, Supplemental Life Insurance, Spouse Life Insurance, Child Life Insurance, Basic AD&D Insurance and Supplemental AD&D Insurance coverages means an individual who is licensed to practice medicine or treat illness in the state in which treatment is received. This does not include the certificate holder, or a member of the certificate holder's immediate family.

Plan Year means the period beginning each January 1 and ending the following December 31.

Pre-Admission Tests means tests made before Hospital confinement where:

- Ø the tests are regularly and routinely required by the Hospital; and
- Ø admittance to the Hospital is made within seven days following determination of the test results.

However, if the confinement is canceled by the Hospital or Physician, the second requirement is waived.

Pre-certification means a Plan member or his/her provider calls the Mental Health and Substance Abuse Program using a toll-free number prior to receiving Mental Health and Substance Abuse treatment and is certified for at least an initial visit/day of treatment.

Pre-Disability Earnings means your Basic Monthly Earnings in effect on the day before you became Totally Disabled.

Preferred Provider Organization (PPO) means a medical plan that has networks of Physicians and Hospitals within a specific geographical area that provides medical care at a discounted rate. PPO plans provide In-Network and Out-of-Network benefits. In-Network services receive a higher level of coverage than services received Out-of-Network.

Pre-Treatment Estimate means a Dentist's report which is on a form that is acceptable to the Dental Plan and which:

- Ø itemizes the recommended dental services;
- Ø shows the charge for each dental service; and
- Ø is accompanied by pre-operative X-rays or other appropriate diagnostic material the Dental Plan requires.

Price means total cost of each Plan option.

Primary Care Physician (PCP) means a Physician who is legally licensed to practice one of the following branches of medicine:

- Ø family or general practice; or
- Ø internal medicine; or
- Ø pediatrics.

Program Compliance means Covered Persons pre-certify care and pursue treatment with Program Providers.

Program Providers means:

- Ø a Hospital or facility;
- Ø a Physician; or
- Ø other ancillary providers

who have contracted with a Medical Plan Third Party Administrator to provide services to Covered Persons of the applicable plan.

Proof of Loss for the Long Term Disability Insurance Plan must describe the event, the nature and the extent of the cause for which a claim is made, and must be satisfactory to the Long Term Disability Insurance Plan administrator. In addition, Proof of Loss may include, but is not limited to, the following:

- Ø documentation of:
  - · the date your disability began;
  - · the cause of your disability;
  - · the prognosis of your disability;
  - · your earnings or income, including but not limited to copies of your filed and signed federal and state tax returns; and
  - · evidence that you are receiving Appropriate Care and Treatment from a Physician;
- Ø any and all medical information, including X-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;

- the names and addresses of all:
  - Physicians and practitioners of healing arts you have seen or consulted;
  - Hospitals or other medical facilities in which you have been seen or treated; and
  - pharmacies which have filled your prescriptions within the past three years;
  - your signed authorization for the Long Term Disability Insurance Plan administrator to obtain and release:
    - medical, employment, and financial information; and
    - any other information the Long Term Disability Insurance Plan administrator may reasonably require;
- your signed statement identifying all Other Income Benefits; and
- proof that you and your dependents have applied for all Other Income Benefits which are available. You will not be required to claim any retirement benefits which you may only get on a reduced basis.

Prosthetic Device means an item which replaces a missing part of the body to restore function.

Qualified Annual Earnings (QAE) means annual compensation as determined by your Employer's Human Resource Policies and practices. QAE is used to calculate Basic Life Insurance, Supplemental Life Insurance, Basic AD&D Insurance, Supplemental AD&D Insurance and Long Term Disability Insurance. While your annual compensation may be composed of many different types of pay, not all are included in QAE.

QAE includes:

- salary;
- wages; bonuses; pay for Paid Time Off (PTO) Bank days taken;
- holiday pay;
- overtime pay;
- compensation deferred under a deferred compensation plan of the Company;
- Employer payments for short term disability;
- Employer payments for temporary military service;
- pre-tax Employee deposits under the Allstate 401(k) Savings Plan or any other qualified profit sharing or stock bonus plan maintained by the Employer;
- pre-tax contributions to the FSA Program; and
- payments in the nature of salary continuation.

QAE excludes:

- wellness incentives;
- lump sum and periodic payments paid upon termination or retirement, including payments in accordance with any severance policy or plan maintained by the Employer;
- service allowance;
- stay and sign-on bonuses;
- lump sum payments for PTO Bank days bought but not taken;
- payments made in settlement of disputes (including amounts in lieu of wages or salary);
- retainers, payments, or reimbursements in connection with moving or living expenses;
- foreign allowances;
- medical expense reimbursements;
- prizes or awards, including awards for special merit or achievement;

- taxable fringe benefits including tax gross-up payments on fringe benefits;
- dividends paid with respect to shares of restricted stock and dividend equivalents on restricted stock units;
- value of stock options or stock appreciation rights and tax benefit rights relating to stock options;
- cash payments received pursuant to stock options;
- payments under any long-term executive compensation plans;
- performance units;
- restricted stock awards and stock received in settlement of restricted stock units;
- payments (including bonuses) for Plan Business, i.e., business which is placed through or reinsured with a plan, association, or organization established pursuant to a statute or regulation or a cooperative plan of the insurance industry (including assigned risk business, California Earthquake Authority, facility business, flood business, and Hawaii Hurricane Relief Fund);
- involuntary insurance business, including business written under a Joint Underwriting Association or FAIR Plan, and business which is written by the Company and its subsidiaries pursuant to an order mandating depopulation of Plan Business;
- General Underwriters Agency, Inc., business;
- any business owned by an agent;
- retirement or profit sharing benefits;
- distributions from any deferred compensation plan;
- amounts paid after death, disability (except for the Employer Short Term Disability), termination, or retirement;
- debt forgiveness by the Employer;
- Employer-paid contributions and benefit credits for any welfare benefit plans or any profit participation or stock plans;
- Long Term Disability Insurance benefit payments;
- Workers' Compensation payments; and
- any other similar types of compensation which may be specifically excluded by the Employer.

QAE is reclassified each year on September 1, based on eligible earnings in the preceding 12 months ending August 31, and benefit coverage amounts and deductions are updated the following January 1.

If you've been on an LOA at any time during the 12 months leading up to September 1, your QAE will not be reclassified. Your current QAE will carry forward. Your QAE will not be reclassified until the next September 1 when you have a consecutive 12 months of pay history at August 31.

If you are newly hired, your annual base pay will be used to calculate QAE. Your QAE will not be reclassified until the next September 1 when you have 12 consecutive months of pay history as an eligible Employee at August 31.

If you are newly eligible for coverage, your annual base pay on the date you become eligible is used to determine QAE. Your QAE will not be reclassified until you have 12 consecutive months of pay history at August 31.

Qualified Change in Status means an occurrence entitling you to change, add, or drop coverage for yourself, your spouse or domestic partner, and your eligible dependent children. If you have a Qualified Change in Status and want to change your coverage during the year, you must do so within 31 days of the event unless otherwise stated in the General Provisions SPD under "Qualified Change in Status." If you don't request the change within the required time period, you may not make a coverage change until the next Annual Enrollment period, unless you experience another Qualified Change in Status.

Qualified Medical Child Support Order (QMCSO) means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or issued through an administrative process established under state law and that has the force and effect of state law which provides for child support with respect to a child of an Employee covered under a group health plan (including the Medical Plan, the Vision Plan, or the Dental Plan) or provides for health benefit coverage to such child, and is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under a group health plan. A medical child support order must be qualified by the Medical Plan, the Vision Plan, or the Dental Plan. To be "qualified," a medical child support order must:

- create or recognize the existence of an Alternate Recipient's right to, or assign to an Alternate Recipient the right to receive benefits for which a participant or beneficiary is eligible under the Medical Plan, the Vision Plan, or the Dental Plan;
- state the name and last known mailing address (if any) of the participant and each Alternate Recipient covered by the order;
- provide a reasonable description of the type of coverage to be provided by the Medical Plan, the Vision Plan, or the Dental Plan to each Alternate Recipient or the manner in which such type of coverage is to be determined;
- specify the period to which the order applies; and
- not require the Medical Plan, the Vision Plan, or the Dental Plan to provide any type or form of benefit, or any option, not otherwise provided under the Medical Plan, the Vision Plan, or the Dental Plan.

QMCSO procedures can be obtained free of charge from:

QDRO Consultants
110 Huntington Street
Attn: Allstate QMCSO Compliance Team
Hudson, OH 44256
Phone (800) 527-8481

Reasonable and Customary Charge means an Eligible Expense that does not exceed what the Cafeteria Plan determines to be the usual and reasonable level of charges made for similar services or supplies in the locality where the expense is incurred. The Reasonable and Customary amount is determined by a third party using regional cost and utilization information. If a charge exceeds what the Cafeteria Plan determines to be Reasonable and Customary, or exceeds a Physician's contracted rate, the excess portion is considered an ineligible Expense and will not be paid by the Cafeteria Plan. Reasonable and Customary Charges for a medical service or supply will be calculated as the lowest of:

- the usual charge by the Physician or provider for the services or supplies as determined by the Third Party Administrator;
- the usual charge of most other Physicians or other providers in the same geographic area for the same or similar services or supplies as determined by the Third Party Administrator; or
- the actual charge for services or supplies.

Residential Treatment Center (RTC) means a program providing substantial mental health and/or substance abuse treatment and specialized programming on a 24-hour residential basis.

Retirement Plan for the Long Term Disability Insurance Plan means a plan which provides retirement benefits to Employees and which is not funded wholly by Employee contributions. The term shall not include a profit-sharing plan, informal salary continuation plan, registered retirement savings plan, stock ownership plan, 401(k), or a non-qualified plan of deferred compensation.

Review Organization means the entity responsible for assessing whether the proposed care is Medically Necessary under Plan provisions. The Review Organization may be an integral part of the Third Party Administrator's business, or a separate entity providing services pursuant to a contract with the Third Party Administrator. "Review Organization" may refer to more than one entity.

Room and Board means the following charges to inpatients by a Hospital, Hospice, or Extended Care Facility:

- a bed;
- meals; and
- the general services essential to daily medical care.

Screening means a test used to determine the need for vision or hearing correction. In the case of vision screening, this does not include procedures used to detect errors of refraction in the eye and to determine their correction (exams for eyeglasses or lenses).

Sickness means the following conditions:

- when the body's organs do not function normally;
- when a temporary ailment reduces the body's ability to function normally; or
- pregnancy.

Sickness includes Mental or Nervous Disorders for the Long Term Disability Insurance Plan only.

Social Security means the United States Social Security Act or any similar law, plan, or act including the initial enactment and all amendments.

Sound Natural Tooth means a tooth which is in basically good condition; that is, the supporting bone structure is not widely damaged by periodontal disease, the root structure is intact, the pulp chamber is viable, and the natural crown is not heavily involved with decay or extensively replaced by restoration.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by impairments in social and/or occupational functioning, debilitating physical condition, inability to abstain from or reduce consumption of the substance, or the need for daily substance use to maintain adequate function. Substance Abuse includes alcohol and drugs but excludes tobacco and caffeine.

Substance Abuse Course of Treatment means a planned sequence of intensive continuous services, received at one or more levels of care, that aim to eliminate abuse of alcohol or drugs. A course is completed if:

- 90 or more days have elapsed since the last date of service;
- a provider discharges the patient for administrative reasons; or
- the patient signs out against medical advice.

Substance Abuse Disorder means a physical and/or emotional dependence caused by the improper or wrongful use of a substance which modifies mood or behavior, including but not limited to alcohol, amphetamines, cannabis, cocaine, hallucinogens, hypnotics, inhalants, opioids, phencyclidine (PCP), tranquilizers, and sedatives.

Surgical Expense means the fees charged for:

- performance of surgery;
- pre-operative care; and
- post-operative care, including pain management.

In addition to the above, when surgery is performed in a Physician's office, Surgical Expense also means fees for:

- supplies; and
- use of a surgical suite, room, or facility.

The overall surgical fee customarily includes all of the above charges; therefore, separate fees for these services will be combined for the purpose of determining benefits.

Terminated Totally Disabled means an Employee who has terminated after two years on an illness leave of absence and who continues to be Totally Disabled.

Third Party Administrator means the carrier/vendor retained by Allstate to provide administrative services for a particular benefit plan.

Total Disability or **Totally Disabled** for the Allstate Medical Savings Plan and the Allstate Medical Value Plan means an Injury or Sickness which results in the:

- inability of an Employee to perform the main duties of his/her normal occupation or business, and such Employee is not engaged in Any Occupation or business for wage or profit other than any program of rehabilitative employment approved in writing by the Plan; or
- for all other persons, the inability to engage in the activities, duties, or responsibilities of people of the same age and sex.

Total Disability for the Basic Life Insurance, Supplemental Life Insurance, Basic AD&D Insurance and Supplemental AD&D Insurance coverages means a disability which occurs while a certificate holder's insurance is in force and which results from an accidental injury or an illness that continuously prevents the certificate holder from engaging in any occupation for which he or she is reasonably suited by education, training or experience. The certificate holder must be under the care of a licensed physician. The licensed physician cannot be the certificate holder's immediate family. For purposes of this rider, the certificate holder's immediate family consists of his or her spouse, children, parents, grandparents, grandchildren, brothers and sisters and their spouses.

Unproven Services means services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures, and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and the Third Party Administrator may, in our discretion, determine that an Unproven Service meets the definition of a covered health service for that Sickness or condition. For this to take place, we and the Third Party Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care means treatment for a sudden and acute Injury or Sickness that demands immediate medical attention but is not life threatening. It is a condition which is just now manifesting itself in the Covered Person. The Covered Person is experiencing the problem for the first time and it is neither long-term nor chronic.

Urgent Care Center means a licensed medical center operating within the scope of its license to provide immediate medical care which is required because of the sudden and acute nature of an Injury or Sickness on an outpatient basis.

Utilization Review means an evaluation of medical information to assess whether proposed medical care is Medically Necessary under Plan provisions.

Wellbeing Coaching Program means a program offered to help people better manage their health and wellness. The Wellbeing Coaching Program provides tools, education, motivation, and phone-based support to help individuals identified as having certain lifestyle health challenges including stress, nutrition, weight management, physical activity, and tobacco cessation.

Wellness Incentives means financial rewards you and your eligible spouse/domestic partner may earn by participating in certain wellness activities designed to help you achieve or maintain good health—if enrolled in a medical plan through Allstate.