Allstate Benefits Critical Illness Coverage Frequently Asked Questions (FAQs)

Q. How is the plan designed?
A. The coverage is divided into 3 Benefit Categories (2 required Critical Illness and 1 optional Cancer*) and 2 additional Optional Benefits. Category 1 coverage pays benefits for Heart Attack, Heart Transplant, Stroke and Coronary Artery By-Pass Surgery. Category 2 coverage pays benefits for Major Organ Transplant (other than heart), End Stage Renal Failure, Paralysis (not as a result of stroke) and Alzheimer's disease. If the employer chooses to offer optional Category 3 Cancer Benefits, or the situs state of the policy requires cancer coverage, a covered person will receive benefits for the initial diagnosis of an invasive cancer or for the initial diagnosis of Carcinoma in Situ.
Additional optional benefits (which are chosen by the employer and may be offered to the Employee) are a Wellness Benefit for specified cancer and heart screenings and a Recurrence Benefit for a previously diagnosed condition.
*Unless state mandated

Q. How does the coverage work?
A. The Critical Illness plan pays the insured a lump sum benefit when a covered person is diagnosed with any of the listed critical illnesses in Categories 1 and 2. Benefits for Category 3 will only be payable if the employer has chosen this coverage or it is state mandated. To receive the Critical Illness Cancer Benefit (Category 3), a covered person must be initially diagnosed or diagnosed with a new form of invasive cancer or carcinoma in situ after the effective date of the coverage.

Q. Are there additional benefits in the Critical Illness policy?
A. Yes, if the employer has chosen to offer the coverage or state mandates require it, the policy may include a Wellness Benefit for cancer and heart related screenings. A predetermined benefit will be paid to an insured when documentation is submitted showing that a specified cancer or heart-screening test has been performed. This benefit does not require proof of out of pocket expenses and is limited to 1 test per covered person, per calendar year. There is also a Recurrence Benefit which will pay 25% of a previously paid Category 1 or 2 benefit if the covered person has been diagnosis-free and treatment-free for more than 18 months.

Q. How is the Basic Benefit Amount paid out?
A. Upon claim for diagnosis of one of the listed critical illnesses, a basic benefit amount is paid directly to the insured based on the schedule shown in the policy. It is possible to receive the maximum benefit in each of the three categories. A lifetime total benefit could be paid if an insured experiences ONE of the medical events in EACH of the three categories. Note, the Category 3 Benefit requires an initial diagnosis or a diagnosis of a new form of cancer.

Q. Is it possible to collect benefits for more than two specified illnesses or events in one category?
A. Yes, as long as the total of all benefits does not exceed 100% for that category. For example, an insured could collect 25% of the basic benefit amount for a Coronary Artery By-Pass surgery in Category 1 and then have a Heart Attack. The insured would still be able to collect 75% of the basic benefit amount in Category 1 for the Heart Attack.

Q. Once an insured collects 100% of the basic benefit amount for a particular category, are there any benefits left?

A. Once a basic benefit amount has been paid out at 100% for a particular category, there are no benefits left in that one category. However, the policy will remain in force until 100% of the basic benefit amounts have been paid within each category of the three categories, individually.

Q. What is the basic benefit amount for spouse or children?
A. The basic benefit amount for spouse and/or children is 50% of the primary insured's benefit. The Annual Wellness Benefit is the same for employee, spouse and each child.

Q. Is there a waiting period before using the Critical Illness benefits?
A. No. Once the coverage becomes effective, there is no waiting period.

Q. Do benefits decrease, or rates increase with age?
A. No.

Q. Is there a pre-existing conditions limitation?
A. Yes, this policy includes a 12/12 pre-existing condition limitation provision. There will be no coverage under the policy for 12 months from the effective date for conditions considered to be pre-existing. This limitation does not apply to Heart Attacks or Strokes, as these are considered events and not conditions.

Q. What is the definition of a pre-existing condition?
A. It means a disease or physical condition for which symptoms existed within the 12-month period prior to the effective date of coverage or medical advice or treatment was recommended or received from a member of the medical profession within the 12-

month period prior to the effective date. A pre-existing condition can exist even though a diagnosis has not yet been made.

Q. Are there medical questions to answer for this coverage?
A. If an employee enrolls themselves or their spouse when they are initially eligible for the coverage there will be no medical questions to answer, the coverage is Guarantee Issue. Should they choose to enroll at the next annual enrollment period, regular Evidence of Insurability (EOI) will apply for employees and spouses who did not enroll when initially eligible. EOI does not apply to dependent children.

Q. Is domestic partner coverage available?
A. Yes, unless prohibited by the situs state of the policy.

Q. To what age can dependent children be covered?
A. Children may be covered until age 26 regardless of financial, marital or student status. He or she may be covered longer if they continue to meet the definition of a covered dependent.