Notice of Limited Benefits

This coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. Even if you have this coverage, you still may be subject to the Federal tax assessed against individuals without minimum essential coverage.

ACACNAR

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

CERTIFICATE OF INSURANCE

This certificate explains the policy of insurance underwritten by us. It is not the contract of insurance. The policy (called the "policy"), as issued to the policyholder by us, alone makes up the agreement under which insurance coverage is provided and benefits are determined. The policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. The policy may be inspected at the office of the policyholder during normal business hours.

The critical illness coverage under this policy is a benefit offered as part of the Associates' Health and Welfare Plan (Plan). The Plan is an employer-sponsored health and welfare employee benefit plan governed under ERISA.

This document, together with the current version of the Associate Benefits Book, constitutes the summary plan description (SPD) for the critical illness coverage portion of the Plan. The SPD, together with Walmart Inc. Associates' Health and Welfare Plan Wrap Document, are the Plan documents for the Plan.

As a summary, this SPD does not describe every provision of the controlling Plan, nor does it modify any provision of the applicable Plan documents.

CONSIDERATION

Your coverage under the policy is issued to you in consideration of your enrollment form or other form of application and the payment of the first premium. Your coverage under the policy is effective from 12:01 a.m. Standard Time on your effective date.

INSURING CLAUSE

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due. All such coverage is subject to the terms of the policy.

In this certificate the insured certificate holder (associate) will be referred to as "you", "your" or "yours".

This certificate supersedes and replaces any certificate previously issued to you under the policy.

Secretary

President

THIS IS A GROUP CRITICAL ILLNESS CERTIFICATE WHICH ONLY PROVIDES STATED BENEFITS FOR SPECIFIED CRITICAL ILLNESSES OR OTHER BENEFITS THAT MAY BE ADDED. THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

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GENERAL PROVISIONS

COVERAGE SUBJECT TO POLICY

The coverage described in this certificate is subject in every way to the terms of the policy that is issued to the policyholder. It alone makes up the agreement by which the insurance is provided. The policy may be amended or discontinued by agreement between us and the policyholder in accordance with the terms of the policy. Your consent is not required for this. Neither are we required to give you prior notice.

ELIGIBILITY OF DEPENDENTS

Eligible dependents are the individuals defined as "Eligible Dependents" under the policyholder's Health and Welfare Plan.

A child born to you or your spouse or domestic partner, while Associate and Child(ren) Coverage or Family Coverage is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for other dependent children covered under this certificate.

If you have Associate-Only Coverage or Associate and Spouse Coverage, newborn children are automatically covered from the moment of birth for a period of 60 days. If you desire uninterrupted coverage for a newborn child, you must notify your employer within 60 days of that child's birth. Upon notification to us, we will convert your Associate-Only Coverage to Associate and Child(ren) Coverage or the Associate and Spouse Coverage to Family Coverage and provide notification of the additional premium due. If you do not notify the policyholder within 60 days of the birth of the child, the temporary automatic coverage ends.

If you have Associate-Only Coverage or Associate and Child(ren) Coverage, then marry and desire coverage for your spouse, your employer must be notified within 60 days of your marriage. We will convert your coverage to Associate and Spouse Coverage or Family Coverage and provide notification of the additional premium due.

If you have Associate-Only Coverage or Associate and Child(ren) Coverage and enter into a domestic partnership and desire coverage for your domestic partner, you must notify your employer within 60 days of entering into the domestic partnership. We will convert your coverage to Associate and Spouse Coverage or Family Coverage and provide notification of the additional premium due.

An adopted child or child pending adoption will be covered as follows:

- Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption has been entered into by you within 60 days after the date of birth.
- If adoption proceedings have been instituted by you within 60 days after the date of birth and you have temporary custody, coverage is provided from the moment of birth.
- children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within 1 year from the institution of the proceedings, coverage will begin upon temporary custody for 1 year, unless extended by the order of the court by reasons of the special needs of the child.

Coverage must be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.

If you have Associate-Only Coverage or Associate and Spouse Coverage, we will convert your Associate-Only Coverage to Associate and Children Coverage or the Associate and Spouse Coverage to Family Coverage and provide notification of the additional premium due.

ELIGIBILITY DATE

If you are working for the policyholder in an eligible class, the date you are eligible for coverage is the later of:

- the policy's effective date; or
- the date that you become eligible for coverage under the terms of the policyholder's Health and Welfare Plan.

WHEN YOU CAN ENROLL OR CHANGE YOUR COVERAGE

You may apply for or change coverage as permitted under the terms of the policyholder's Health and Welfare Plan.

GENERAL PROVISIONS (Continued)

EFFECTIVE DATE OF COVERAGE

If you enrolled for this coverage provided by us during your employer's initial enrollment period during the Fall of 2009, your coverage is effective on January 1, 2010. If you enrolled for coverage any time after your employer's initial enrollment period or anytime on or after January 1, 2010, your coverage will be effective in accordance with the terms of the policyholder's Health and Welfare Plan.

For any change in coverage, the change in coverage is effective in accordance with the terms of the policyholder's Health and Welfare Plan.

CERTIFICATE OF INSURANCE

This certificate of insurance provides a description of the insurance provided by the policy issued to your employer. It describes the essential features of the insurance coverage and to whom benefits are payable.

If there is any discrepancy between the provisions of this certificate and the provisions of the policy, the provisions of the policy govern.

TERMINATION OF COVERAGE

Your coverage under the policy ends subject to the "Portability Coverage" provision of this certificate on the earliest of:

- the date the policy is canceled by the policyholder;
- the last day of the period for which you made any required premium payments;
- the last day you are in active employment, except as provided under the "Leave of Absence" provision;
- the date you are no longer in an eligible class; or
- the date your class is no longer eligible.

We will provide coverage for a payable claim that occurs while you are covered under the policy.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death, or when you move to an eligible class that does not provide spouse coverage.

If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death, or when you move to an eligible class that does not provide domestic partner coverage.

Coverage for a dependent child ends on the certificate anniversary next following the date the child is no longer eligible for coverage under the terms of the policyholder's Health and Welfare Plan. Coverage does not terminate for an unmarried child who:

- is incapable of self-sustaining employment by reason of mental or physical incapacity;
- became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
- is chiefly dependent upon you for support and maintenance.

The child's coverage continues as long as your coverage remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished to us, at our expense, when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims incurred after termination will not be paid. There may be no refund due if you have Associate and Child(ren) Coverage or Family Coverage and there are other dependent children insured under the policy.

Coverage may be eligible for continuation as outlined in the "Portability Coverage" provision.

GENERAL PROVISIONS (Continued)

AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed our agent.

LEAVE OF ABSENCE

If you cease active employment because of a leave of absence while coverage is in force, you will have the opportunity to continue your coverage while you are away from active employment. Coverage will be in accordance with the terms of the policyholder's Health and Welfare Plan. This includes, but is not limited to how coverage is provided, how premiums are paid for during the absence, and whether coverage is reinstated upon return to employment.

INCONTESTABILITY

After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim.

DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of the policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of the policy, such determinations shall be final and conclusive.

LEGAL ACTION

Prior to filing any legal action for benefits under this certificate, you or your beneficiary must appeal the denial of such benefit.

The time limit on legal actions for loss covered by this certificate is subject to applicable law in the state where the policy was issued.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

BENEFICIARY; CHANGE OF BENEFICIARY

If no beneficiary is named, or the named beneficiary does not survive you, we will pay any benefits due at your death in the following order:

- to your surviving spouse or domestic partner; otherwise
- to your surviving children, in equal shares; otherwise
- to your surviving parents, in equal shares; otherwise
- to your surviving siblings, in equal shares; otherwise
- to your estate.

Any change of beneficiary must be made by going to the WIRE or WalmartOne.com to update the beneficiary information. This change will not take effect unless updated by this method. This will be true whether or not you are living on the date it is filed. There will be no prejudice to us on account of any payment we make prior to its receipt by us at our home office.

GENERAL PROVISIONS (Continued)

PREMIUMS

Premiums for this coverage are age banded and based on your attained age. On the policy anniversary on or after your age reaches the next age band, your premium will change in accordance with the premium rate currently being charged for that age band.

UNPAID PREMIUM; EXCESS PREMIUM

Upon the payment of a claim under this certificate, any premium owed by you in an individual capacity that is more than 60 days past due may be deducted from the benefit amount payable to you. Any excess premium will be refunded to you.

PORTABILITY COVERAGE

We will provide portability coverage, subject to these provisions.

Such coverage will be available for a covered person, if the following criteria are satisfied:

- coverage under the policy terminates as described in the General Provision entitled “Termination of Coverage”; and
- we receive a request for portability and payment of the first premium for the portability coverage not later than 60 days after such termination.

No portability coverage will be provided for any person, if his or her insurance under the policy terminated due to his or her failure to make required premium payments.

PORTABILITY COVERAGE

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

Portability coverage will be effective on the day after covered person’s coverage under the policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance of each month of coverage to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate is the rate in effect under the policy for active associates who have the same coverage. Written notice will be given at least 31 days before any change is to take effect.

GRACE PERIOD

The grace period, as defined, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

TERMINATION OF PORTABILITY COVERAGE

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

- the date you again become eligible for insurance under the policy according to the terms of the policyholder’s Health and Welfare Plan;
- the last day for which premiums have been paid, if the covered person fails to pay premiums when due, subject to the grace period; or
- with respect to insurance for dependents:
  - the date your insurance terminates; or
  - the date your dependent ceases to be an eligible dependent as defined.

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

TERMINATION OF THE POLICY

If the policy terminates, you and your covered dependents will be eligible to exercise the portability privilege on the termination date of the policy. Portability coverage may continue beyond the policy’s termination date, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.

LIMITATIONS AND EXCLUSIONS

The policy does not pay benefits for any critical illness due to, or resulting from, (directly or indirectly):

- any act of war, whether or not declared, participation in a riot, insurrection or rebellion;
- intentionally self-inflicted injuries;
- engaging in an illegal occupation or committing or attempting to commit a felony;
- attempted suicide, while sane or insane;
- being under the influence of narcotics or any other controlled chemical substance unless administered upon the advice of a physician;
- participation in any form of aeronautics, except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
- alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.

BENEFIT INFORMATION

INITIAL CRITICAL ILLNESS BENEFIT

We pay the benefits, as described below, subject to the conditions described below and all other provisions of the policy. The policy provides coverage only for the critical illnesses indicated. It does not cover any other disease, sickness or incapacity, unless specifically stated.

Claims for benefits under the policy not satisfying all the criteria for diagnosis may be subject to review by an independent physician consultant. All covered critical illnesses must be diagnosed by a physician. Emergency situations that occur while the covered person is outside the United States may be reviewed and considered for approval by a physician on foreign soil or when the covered person returns to the United States.

At the time you elect coverage under the policy you and your eligible dependents, you must choose a basic benefit option as described in the most recent version of the Associate's Benefit Book. The amount payable for each critical illness is the percentage next to that critical illness multiplied by the basic benefit amount applicable to each covered person. Benefits are payable only once for each initial occurrence of a critical illness per covered person.

ALZHEIMER'S DISEASE

We will pay a benefit for the following Alzheimer's Disease critical illness if a covered person is diagnosed with the critical illness, provided that:

- the date of diagnosis is after the effective date of coverage;
- the date of diagnosis is while insured;
- the critical illness is not excluded by name or specific description; and
- we have not paid an initial critical illness benefit for this critical illness before.

Alzheimer's Disease means a clinically established diagnosis of the disease by a psychiatrist or neurologist, resulting in the inability to perform, independently, 3 or more of the activities of daily living.

For purposes of this benefit, the date of diagnosis for Alzheimer's Disease means the date diagnosis is established by the psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the covered person's medical records.

Alzheimer's Disease that is diagnosed prior to the effective date of coverage is never covered under the policy.

Critical Illness	**Percentage of Basic Benefit Amount**
Alzheimer's Disease	100%

BENIGN BRAIN TUMOR

We will pay a benefit for the following critical illness if a covered person is diagnosed with the critical illness, provided that:

- the date of diagnosis is after the effective date of coverage;
- the date of diagnosis is while insured;
- the critical illness is not excluded by name or specific description; and
- we have not paid an initial critical illness benefit for this critical illness before.

Benign brain tumor means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and resulting in persistent neurological deficits including, but not limited to, loss of vision, loss of hearing, or balance disruption.

Benign brain tumor does not include tumors of the skull, pituitary adenomas, or germinomas.

For purposes of this benefit, the date of diagnosis for a benign brain tumor means the date neurological symptoms and deficiencies were documented by a physician to have first occurred after the covered person's effective date of coverage.

Critical Illness	**Percentage of Basic Benefit Amount**
Benign Brain Tumor	100%

INITIAL CRITICAL ILLNESS BENEFIT (Continued)

CANCER

We will pay a benefit for the following cancer critical illnesses if a covered person is diagnosed with the critical illness, provided that:

- the date of diagnosis is while insured;
- the cancer is not excluded by name or specific description; and
- we have not paid an initial critical illness benefit for this particular form of cancer before.

Positive diagnosis of cancer means a diagnosis by a licensed Doctor of Medicine certified by the American Board of Pathology to practice Pathological Anatomy, or an Osteopathic Pathologist. Diagnosis is based on a microscopic examination of fixed tissue, or preparations from the hemic system (except for skin cancer). We accept clinical diagnosis of cancer as evidence that cancer existed in a covered person when a pathological diagnosis cannot be made, provided medical evidence substantially documents the diagnosis and the covered person received definitive treatment for the cancer.

For purposes of this benefit, the date of diagnosis for invasive cancer or carcinoma in situ means the date a diagnosis is established by the physician based on clinical and/or laboratory findings as supported by the covered person's medical records. Clear and definitive diagnosis must be made by either a pathological or clinical method.

Critical Illness	Percentage of Basic Benefit Amount
Invasive Cancer	100%
Carcinoma in situ	25%

COMA

We will pay a benefit for the following critical illness if a covered person is diagnosed with the critical illness, provided that:

- the date of diagnosis is after the effective date of coverage;
- the date of diagnosis is while insured;
- the critical illness is not excluded by name or specific description; and
- we have not paid an initial critical illness benefit for this critical illness before.

Coma means a continuous profound state of unconsciousness lasting 7 or more consecutive days due to an underlying sickness or traumatic brain injury. It is associated with severe neurologic dysfunction and unresponsiveness of a prolonged nature requiring significant medical intervention and life support measures. Such state must begin within 31 days of the illness.

Coma does not include a medically induced coma.

For purposes of this benefit, the date of diagnosis for a coma means the first day of the period for which a physician confirms a coma has lasted for 7 consecutive days.

Critical Illness	Percentage of Basic Benefit Amount
Coma	100%

INITIAL CRITICAL ILLNESS BENEFIT (Continued)

COMPLETE LOSS OF HEARING

We will pay a benefit for the following critical illness if a covered person is diagnosed with the critical illness, provided that:

- the date of diagnosis is after the effective date of coverage;
- the date of diagnosis is while insured;
- the critical illness is not excluded by name or specific description; and
- we have not paid an initial critical illness benefit for this critical illness before.

Complete loss of hearing means the total and irreversible loss of hearing in both ears continuing for 6 consecutive months following the illness that caused it.

Complete loss of hearing does not include loss of hearing that can be corrected by the use of any hearing aid or device.

For purposes of this benefit, the date of diagnosis for complete loss of hearing means the date the audiologist makes an accurate certification of total and permanent hearing loss in both ears.

Complete loss of hearing that is diagnosed prior to the effective date of coverage is never covered under the policy.

Critical Illness	Percentage of Basic Benefit Amount
Complete Loss of Hearing	100%

COMPLETE LOSS OF SIGHT

We will pay a benefit for the following critical illness if a covered person is diagnosed with the critical illness, provided that:

- the date of diagnosis is after the effective date of coverage;
- the date of diagnosis is while insured;
- the critical illness is not excluded by name or specific description; and
- we have not paid an initial critical illness benefit for this critical illness before.

Complete loss of sight means the permanent and uncorrectable loss of sight in both eyes due to sickness and certified by an ophthalmologist with:

- sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-chart Acuity); or
- visual field restriction to 20 degrees or less in both eyes.

For purposes of this benefit, the date of diagnosis for complete loss of sight means the date the ophthalmologist makes an accurate certification of total and permanent loss of sight in both eyes.

Complete loss of sight that is diagnosed prior to the effective date of coverage is excluded and is never covered under the policy.

Critical Illness	Percentage of Basic Benefit Amount
Loss of sight in both eyes	100%
Loss of sight in one eye	100%

INITIAL CRITICAL ILLNESS BENEFIT. (Continued)

CORONARY ARTERY BY-PASS SURGERY

We will pay a benefit for the following coronary artery by-pass surgery critical illness if a covered person is diagnosed with the critical illness, provided that:

- the date of diagnosis is after the effective date of coverage;
- the date of diagnosis is while insured;
- the critical illness is not excluded by name or specific description; and
- we have not paid an initial critical illness benefit for this critical illness before.

Coronary artery by-pass surgery means the undergoing of a surgical operation to correct narrowing or blockage of one or more coronary arteries with bypass grafts on the advice of a cardiologist registered in the United States.

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

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

For purposes of this benefit, the date of diagnosis for a coronary artery by-pass surgery means the date the actual coronary artery by-pass surgery occurs.

Critical Illness	Percentage of Basic Benefit Amount
Coronary Artery By-Pass Surgery	100%

DISMEMBERMENT

We will pay a benefit for the following critical illness if a covered person is diagnosed with the critical illness, provided that:

- the date of diagnosis is after the effective date of coverage;
- the date of diagnosis is while insured;
- the critical illness is not excluded by name or specific description; and
- we have not paid an initial critical illness benefit for this critical illness before.

Dismemberment means the loss of hand or hands, or foot or feet, when there is total and permanent severance at or above the wrist or ankle joint. For the loss of arm or arms or leg or legs, means severance at or above the elbow joint or knee joint. For the loss of eye or eyes means the entire and irrecoverable loss of sight. For the loss of finger means the severance through or above metacarpophalangeal joints.

For purposes of this benefit, the date of diagnosis for dismemberment means the date the actual dismemberment for the covered person occurs.

Dismemberment that is diagnosed prior to the effective date of coverage is excluded and is never covered under the policy.

Critical Illness	Percentage of Basic Benefit Amount
Both arms and both legs	100%
Both feet, hands, arms or legs	100%
One foot, hand, arm or leg	100%
One or more fingers and/or one or more toes	25%

INITIAL CRITICAL ILLNESS BENEFIT. (Continued)

END STAGE RENAL FAILURE

We will pay a benefit for the following end stage renal failure critical illness if a covered person is diagnosed with the critical illness, provided that:

- the date of diagnosis is after the effective date of coverage;
- the date of diagnosis is while insured;
- the critical illness is not excluded by name or specific description; and
- we have not paid an initial critical illness benefit for this critical illness before.

End stage renal failure means failure of both kidneys to perform their essential functions, with the covered person undergoing peritoneal dialysis or hemodialysis or a renal transplant.

For purposes of this benefit, the date of diagnosis for end stage renal failure means the date that the covered person begins renal dialysis.

Critical Illness	Percentage of Basic Benefit Amount
End Stage Renal Failure	100%

HEART ATTACK, STROKE, AND TRANSIENT ISCHEMIC ATTACK (TIA)

We will pay a benefit for the following heart attack, stroke, and TIA critical illnesses if a covered person is diagnosed with the critical illness provided that:

- the date of diagnosis is after the effective date of coverage;
- the date of diagnosis is while insured;
- the critical illness is not excluded by name or specific description; and
- we have not paid an initial critical illness benefit for the critical illness before.

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

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

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

For purposes of this benefit, date of diagnosis for a heart attack means the date of death (infarction) of a portion of the heart muscle.

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

For purposes of this benefit, date of diagnosis for a stroke is the date a stroke occurred based on documented neurological deficits and neuroimaging studies.

Transient Ischemic Attack (TIA) mean episodes of stroke like symptoms related to central nervous system ischemia in which there are no residual neurologic complications or sequelae. Stroke, head injury, peripheral neurologic disorders are excluded.

For purposes of this benefit, date of diagnosis for a TIA is the date a TIA occurred based on documented neurological deficits and neuroimaging studies.

Critical Illness	Percentage of Basic Benefit Amount
Heart Attack	100%
Stroke	100%
Transient Ischemic Attack (TIA)	25%

INITIAL CRITICAL ILLNESS BENEFIT. (Continued)

PARALYSIS

We will pay a benefit for the following critical illness if a covered person is diagnosed with the critical illness, provided that:

- the date of diagnosis is after the effective date of coverage;
- the date of diagnosis is while insured;
- the critical illness is not excluded by name or specific description; and
- we have not paid an initial critical illness benefit for this critical illness before.

Paralysis means the loss of the use of a limb, without severance, that is diagnosed by a physician to be permanent, complete and irreversible.

For purposes of this benefit, the date of diagnosis for paralysis means the date a physician establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.

Paralysis that is diagnosed prior to the effective date of coverage is never covered under the policy.

Critical Illness	Percentage of Basic Benefit Amount
Quadriplegia (Paralysis of 4 limbs)	100%
Paraplegia (Paralysis of 2 limbs)	100%

PARKINSON'S DISEASE

We will pay a benefit for the following critical illness if a covered person is diagnosed with the critical illness, provided that:

- the date of diagnosis is after the effective date of coverage;
- the date of diagnosis is while insured;
- the critical illness is not excluded by name or specific description; and
- we have not paid an initial critical illness benefit for this critical illness before.

Parkinson's Disease means a brain disorder that is diagnosed by a physiatrist or neurologist, resulting in the inability to perform, independently, 2 or more of the activities of daily living.

For purposes of this benefit, the date of diagnosis for Parkinson's Disease means the date the diagnosis is established by a physiatrist or neurologist based on clinical and/or diagnostic findings as supported by the covered person's medical records.

Parkinson's Disease that is diagnosed prior to the effective date of coverage is excluded and is never covered under the policy.

Critical Illness	Percentage of Basic Benefit Amount
Parkinson's Disease	100%

RUPTURED OR DISSECTING ANEURYSM

We will pay a benefit for a ruptured or dissecting aneurysm if a covered person is diagnosed with the critical illness and undergoes surgery, provided that:

- the date of diagnosis is after the effective date of coverage;
- the date of diagnosis is while insured;
- the critical illness is not excluded by name or specific description; and
- we have not paid an initial critical illness benefit for the critical illness before.

Aneurysm means a balloon-like bulge or weakening in the walls of an artery.

An aneurysm does not include a bruise or an aneurysm that resulted from an accident.

INITIAL CRITICAL ILLNESS BENEFIT (Continued)

RUPTURED OR DISSECTING ANEURYSM (Continued)

Dissecting aneurysm means a condition in which a tear or split develops in a layer of an artery wall causing bleeding into and along the layers of the artery wall.

A dissecting aneurysm does not include a bruise or an aneurysm that resulted from an accident.

Ruptured aneurysm means a condition in which the aneurysm bursts and causes bleeding inside the body.

A ruptured aneurysm does not include a bruise or an aneurysm that resulted from an accident.

For purposes of this benefit, the date of diagnosis for a ruptured or dissecting aneurysm means the date of the rupture or dissection as determined by ultrasound, CT Scan, Angiogram or MRI.

A ruptured or dissecting aneurysm that is diagnosed prior to the effective date of coverage is excluded and is never covered under the policy.

Critical Illness	Percentage of Basic Benefit Amount
Ruptured or Dissecting Aneurysm	25%

SPECIFIED DISEASE

We will pay a benefit for the following specified disease critical illnesses if a covered person is diagnosed with the critical illness, provided that:

- the date of diagnosis is after the effective date of coverage;
- the date of diagnosis is while insured;
- the critical illness is not excluded by name or specific description; and
- we have not paid an initial critical illness benefit for the critical illness before.

Positive diagnosis of a specified disease means a diagnosis by a qualified physician based on generally accepted diagnostic procedures and criteria.

For purposes of this benefit, the date of diagnosis for a specified disease means the earliest of the date of: tentative diagnosis; or clinical diagnosis; or the day the tissue specimen, culture(s) and/or titer(s) are taken, upon which the positive or tentative diagnosis of a specified disease is made.

Any specified disease listed below that is diagnosed prior to the effective date of coverage is never covered under the policy.

Specified Diseases	Percentage of Basic Benefit Amount	Specified Diseases (Continued)	Percentage of Basic Benefit Amount
Addison's Disease	50%	Multiple Sclerosis	50%
Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	50%	Muscular Dystrophy	50%
		Myasthenia Gravis	50%
Cerebrospinal Meningitis (bacterial)	50%	Necrotizing fasciitis	50%
Cerebral Palsy	50%	Osteomyelitis	50%
Cystic Fibrosis	50%	Poliomyelitis	50%
Diphtheria	50%	Rabies	50%
Encephalitis	50%	Sickle Cell Anemia	100%
Huntington's Chorea	50%	Systemic Lupus	100%
Legionnaire's Disease (confirmation by culture or sputum)	50%	Systemic Sclerosis (Scleroderma)	50%
		Tetanus	50%
Malaria	50%	Tuberculosis	100%

BENEFIT INFORMATION (Continued)

SUBSEQUENT EVENT CRITICAL ILLNESS BENEFIT

We pay this benefit for another occurrence of a covered critical illness paid under the Initial Critical Illness Benefit for a Benign Brain Tumor, Carcinoma in situ, Coma, Coronary Artery By-Pass Surgery, Heart Attack, Invasive Cancer, Ruptured or Dissecting Aneurysm, Rabies, and Stroke. Benefits will be paid at 100% of the Initial Critical Illness Benefit for another occurrence of the same condition, subject to all of the following:

- the same condition is excluded for 180 days after the prior occurrence;
- a subsequent diagnosis of a related cancer for which a benefit was previously paid is not excluded, provided the covered person is symptom and treatment-free during the 180 days after the prior occurrence; and
- a diagnosis of an unrelated cancer is not excluded.

AMBULANCE

We pay $400 for ground ambulance or $4,000 for air ambulance if a covered person requires ambulance transportation to a hospital or emergency center as a result of a covered illness. Service must be provided by a licensed professional ambulance company.

LODGING BENEFIT

We pay $60 per day when a covered person receives treatment for a critical illness on an outpatient basis. The benefit is for lodging at a motel, hotel, or other accommodations acceptable to us. This benefit is limited to 60 days per calendar year. This benefit is not payable for lodging occurring more than 24 hours prior to treatment or for lodging occurring more than 24 hours following treatment. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

NATIONAL CANCER INSTITUTE (NCI) EVALUATION

We pay the following benefit when a covered person receives an evaluation or consultation at an NCI-sponsored center or any Walmart Center of Excellence as defined in the policyholder's Health and Welfare Plan as a result of a previous diagnosis of a covered critical illness:

- $500 for the evaluation or consultation; and
- $250 for the transportation and lodging of the covered person if the NCI-sponsored center or Walmart Center of Excellence is more than 100 miles from the covered person's home.

The reason for such evaluation or consultation at an NCI-sponsored center or Walmart Center of Excellence must be to determine the appropriate treatment for a critical illness. This benefit is paid once per initial and subsequent event diagnosis of a critical illness.

POST TRAUMATIC STRESS DISORDER (PTSD)

We pay $100 for each day a covered person receives counseling for PTSD, as defined, subject to all of the following:
- the covered person has been diagnosed with PTSD by a physician or a licensed mental health professional; and
- the covered person is receiving counseling by group and/or individual therapy.

This benefit is payable only once per day per covered person and is limited to 6 days per calendar year.

Post-Traumatic Stress Disorder (PTSD) means a mental health condition that is triggered by a terrifying event. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event.

Positive Diagnosis of Post-Traumatic Stress Disorder (PTSD) means a diagnosis by a physician based on a psychological evaluation and generally accepted criteria of signs and symptoms. Diagnosis of PTSD is also based on the following:
- The covered person experienced or witnessed an event that involved death or serious injury, or the threat of death or serious injury;
- The covered person's response to the event involved intense fear, horror or a sense of helplessness;
- The covered person relives experiences of the event;
- The covered person tries try to avoid situations or things that remind them of the traumatic event;
- Symptoms last longer than one month; and
- Symptoms cause significant distress in the covered person's life or interferes with their ability to go about their normal daily tasks.

SKIN CANCER BENEFIT

We pay $500 if a covered person is diagnosed with skin cancer if:
- the date of diagnosis is after the effective date of coverage;
- the date of diagnosis is while insured; and
- it is not excluded by name or specific description.

This benefit is payable only once per covered person per calendar year.

Skin cancer means basal cell carcinoma and squamous cell carcinoma. For the purposes of this policy, skin cancer does not include malignant melanoma. It also does not include any conditions which may be considered pre-cancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; non-malignant melanoma; moles; or similar diseases or lesions.

Positive Diagnosis of skin cancer means a diagnosis by a licensed Doctor of Medicine certified by the American Board of Pathology to practice Pathological Anatomy, or an Osteopathic Pathologist. Diagnosis is based on microscopic examination of skin biopsy samples.

TRANSPORTATION BENEFIT

We pay the actual cost, up to $1,500, for round trip transportation coach fare on a common carrier or a personal vehicle allowance of $0.50 per mile, up to $1,500, that is required for treatment of a covered critical illness at a hospital (inpatient or outpatient); or radiation therapy center; or chemotherapy or oncology clinic; or any other specialized free-standing treatment center. Mileage is measured from the covered person's home to the treatment facility as described above. The benefit will not be paid if the covered person lives within 100 miles one-way of the treatment facility. We do not pay for: transportation for someone to accompany or visit the covered person receiving treatment; visits to a physician's office or clinic; or for other services. If the treatment is for a covered child and common carrier travel is necessary, we will pay this benefit for up to 2 adults to accompany the child.

CLAIM INFORMATION

NOTICE OF CLAIM

We encourage covered persons to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim must be given to us within 60 days after the occurrence or commencement of any benefit covered by the policy, or as soon as reasonably possible. Notice given by, or on behalf of, a covered person or the beneficiary to us at PO Box 41488, Jacksonville FL 32203-1488 with your name and certificate number, is notice to us.

A claim form can be requested from us. If it is not received within 15 days of the request, notice of the claim may be sent to us by providing us a statement of the nature and extent of the loss.

FILING A CLAIM

When a covered person submits a claim and the claim is denied, a notice will be sent within a reasonable time period but not longer than 30 days from receipt of the claim. If we determine that an extension is necessary due to matters beyond our control, this time may be extended 15 days. The covered person will receive notice before the extension that indicates the circumstances requiring the extension and the date by which we expect to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and the covered person will be given at least 45 days to submit the covered person's information. Then we will make our determination within 15 days from the date we receive the information, or, if earlier, the deadline to submit the information.

Notice of Determination: If a claim is filed properly, and the claim is in part or wholly denied, the covered person will receive notice of an adverse benefit determination that will:

- state the specific reason(s) for the adverse benefit determination;
- reference the specific policy provisions on which the determination is based;
- describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary;
- describe the policy's claims review procedures and the time limits applicable to such procedures, including a statement of the covered person's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- disclose any internal rule, guideline, or protocol relied on in making the adverse determination (or state that such information is available free of charge upon request); and
- if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

PROOF OF CLAIM

Written proof must be given to us within 90 days of each covered critical illness. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 15 months from the time specified unless the covered person is legally incapacitated.

COOPERATION OF BENEFICIARY

The beneficiary must reasonably cooperate during any investigation and/or adjudication of a claim. This includes the authorization for the release of medical records and other information.

PHYSICAL EXAMINATION AND AUTOPSY

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

PAYMENT OF CLAIMS

After receiving written proof of claim, we will pay all benefits then due under the policy and will make payment to you unless you have assigned the benefit to someone else. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or as described in the “Beneficiary; Change of Beneficiary” provision.

CLAIM INFORMATION (Continued)

ASSIGNMENT

An assignment of the coverage under the policy is not binding on us, unless:

- it is a written request; and
- it is received and recorded by us at our home office.

We are not responsible for the validity of any assignment. An assignment is subject to any payment we make or other action we take before we record the assignment. An assignment may not change the owner or beneficiary.

OVERPAID CLAIM

We have the right to recover any overpayments due to:

- fraud; or
- any error we make in processing a claim.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid.

CLAIM REVIEW

A covered person will have 180 days from the receipt of an adverse benefit determination to file an appeal. Requests for appeals should be sent to Allstate Benefits, Wal-Mart Claims Unit, PO Box 41488, Jacksonville FL 32203-1488, Attention: Appeals.

The covered person will have the opportunity to submit written comments, documents, or other information in support of the appeal and the covered person will have access to all documents that are relevant to the claim. The appeal will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination.

If the claim involves a medical judgment question, we will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, we will provide the covered person with the identification of any medical expert whose advice we obtained in connection with the appeal.

A final decision on appeal will be made within a reasonable period of time, but no later than 60 days from the date the request is received.

Notice of appeals determination: If a claim is in part or wholly denied, the covered person will receive notice of an adverse benefit determination that will:

- state specific reason(s) of the adverse determination;
- reference specific plan provision(s) on which the benefit determination is based;
- state that the covered person are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- describe any voluntary appeal procedures offered by the policy and the covered person's right to obtain information about such procedures;
- disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request); and
- include a statement regarding the covered person's right to bring an action under section 502(a) of ERISA.

A covered person will also receive a notice if the claim on appeal is approved.

GLOSSARY

Active employment means that you are working for the employer for earnings that are paid regularly and are performing the material and substantial duties as assigned by the employer. You will be deemed to be in active employment on a day which is not one of the employer's scheduled workdays only if actively employed on the preceding scheduled workday. Temporary and seasonal workers are excluded from coverage.

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

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment.

Activities of daily living means activities used to measure the ability of a person to care for themselves independently. These activities include the following:
- bathing;
- dressing;
- toileting;
- eating; or
- taking medication.

Associate means a person who is: a citizen, expatriate, or resident of the United States or one of its territories; and in active employment with the employer named as the policyholder.

Associate and Child(ren) Coverage means coverage that includes only you, as defined, and eligible children.

Associate and Spouse Coverage means coverage that includes only you, as defined, and your spouse or domestic partner.

Associate-Only Coverage means coverage that includes only you, as defined.

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

Cancer means a disease manifested by the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells in any part of the body. This includes: Hodgkin's Disease; leukemia; lymphoma; carcinoma; sarcoma; or malignant tumor. It does not include any conditions which may be considered pre-cancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; non-malignant melanoma; moles; or similar diseases or lesions.

Carcinoma in situ means a diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Carcinoma in situ includes:
- early prostate cancer diagnosed as stage A or equivalent staging; and
- melanoma not invading the dermis.

Carcinoma in situ does not include:
- other skin malignancies;
- pre-malignant lesions (such as intraepithelial neoplasia); or
- benign tumors or polyps.

Carcinoma in situ must be identified pursuant to a pathological or clinical diagnosis, as defined.

Certificate year means a consecutive 12-month period beginning on the effective date of insurance for each insured associate.

GLOSSARY (Continued)

Clinical diagnosis means a clinical identification of cancer based on history, laboratory study and symptoms. We will pay benefits for a clinical diagnosis only if:

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

Common carrier means the following: commercial airlines; passenger trains; inter-city bus lines; trolleys; or boats. It does not include taxis; intra-city bus lines; or private charter planes.

Covered person means any of the following:

- any eligible family member (including you) named in the enrollment and acceptable for coverage by us;
- any eligible family member added after the effective date; or
- a newborn child or adopted child subject to the "Eligibility of Dependents" provision.

Critical Illness means one of the illnesses listed under the Initial Critical Illness Benefit.

Domestic partner means your same-sex or opposite-sex partner who is eligible for coverage provided that:

- both you and your same-sex or opposite-sex partner are considered domestic partners according to the law of your state of residence; or
- if your state of residence has no domestic partnership law, you must satisfy the definition of domestic partner as defined by the policyholder.

Employer means the individual, company or corporation where you are in active employment, and includes any division, subsidiary, or affiliated company named in the policy.

Family Coverage means coverage that includes you, as defined, and your eligible dependents.

Grace period means a period of 60 days following the premium due date during which premium payment may be made. While you are employed with the policyholder, the premiums will be paid by the policyholder through payroll deductions. The grace period only applies to you during any portability period, when you will be required to pay the premiums directly to us.

Initial enrollment period means one of the following periods during which you may first apply for coverage under the policy:

- if you are eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the employer; or
- if you become eligible for coverage after the policy effective date, the period as determined by the policyholder's Health and Welfare Plan after the date you are first eligible to apply for coverage.

Injury means accidental bodily injury sustained by a covered person while coverage under the policy is in force.

Insured associate means an associate who has: fulfilled all eligibility requirements set forth in the policy and the policyholder's Health and Welfare Plan; and properly completed and signed the enrollment, provided that the enrollment has been received by us.

GLOSSARY (Continued)

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

The following are not considered invasive cancer for purposes of the policy: carcinoma in situ; tumors in the presence of any human immuno-deficiency virus; skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic; and early prostate (stage A) cancer.

Leave of absence means you are absent from active employment for a period of time that has been agreed to in advance in writing by your current employer.

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

Oncologist means a legally licensed Doctor of Medicine or Doctor of Osteopathic Medicine certified to practice in the field of Oncology.

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

Pathologist means a legally licensed Doctor of Medicine or Doctor of Osteopathic Medicine certified by the American Board of Pathology to practice Pathological Anatomy.

Payable claim means a claim for which we are liable under the terms of the policy.

Physician means:

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

We will not recognize you, your spouse or domestic partner, children, parents or siblings as a physician for a claim.

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

Sickness means an illness that must begin while a person is insured under the policy.

Symptom and treatment-Free means free of any symptoms (the subjective evidence of disease or physical disturbance observed by a medical professional or the patient) and treatment (medical care, prevention and management of illnesses or injuries by a physician, including the professional services of a radiologist, pathologist or other medical specialist acting within the scope of his or her medical license). For the purposes of the policy, the following are not considered treatment: maintenance drug therapy and routine follow-up office visits to verify if the critical illness has returned.

Tentative diagnosis means a diagnosis by a qualified physician based on generally accepted diagnostic procedures and criteria.

Tobacco-free means that you have never used tobacco products, or, if you have previously used them, you have not used tobacco products 30 days before the date you enrolled for this coverage AND pledge to remain tobacco-free.

Under the influence means a condition as determined by the laws of the state in which the loss occurred.

We, us, or **our** means American Heritage Life Insurance Company.

You, your, or **yours** means the insured associate, as defined, who meets the eligibility requirements.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (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, such as division offices, 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 the Pension and Welfare Benefit Administration.

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

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

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 Plan. These 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 the Employer or any other person, may fire 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 materials for the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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. Generally, you must complete the appeals process before filing a law suit against the Plan. However, you should consult with your own legal counsel in determining when it is proper to file a law suit against the Plan.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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 these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest regional office of the Employee Benefits Security Administration, 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 Employee Benefits Security Administration publications hotline at (866) 444-3272 or by logging on to the Internet at www.dol.gov/ebsa.

ADMINISTRATIVE INFORMATION

Plan Year: January 1 through December 31

Plan Number: 501

Type of Plan: Welfare benefit plan

Type of Administration: The Plan allocates discretionary authority among Committees (or their delegates) concerning the administration, interpretation, and application of the Plan. The Plan also provides that discretionary authority over claims for benefits and appeals may be allocated to, among others, an insurance carrier of an insured benefit.

Plan Sponsor:
Walmart Inc.
702 SW 8th Street
Bentonville, AR 72716

Plan Administrator/Named Fiduciary:
The Administrative Committee
Associates' Health and Welfare Plan
922 West Walnut, Ste. A
Rogers, AR 72756-3540
(479) 621-2058

Agent for Service of Legal Process:
Corporation Trust Company
1209 Orange Street
Corporation Trust Center
Wilmington, DE 19801
Legal process may also be served on the Plan Administrator
or Trustee.

Plan Sponsor's EIN: 71-0415188

Funding: Contributions to the Plan may be made by Walmart Inc. out of its general assets or through the Associates' Health and Welfare Plan Master Trust. Contributions also may be required by employees, in an amount determined by Walmart Inc. in its discretion. All assets of the Plan, including Associate contributions and any dividends or earnings thereon, shall be available to pay any benefits provided under the Plan or expenses of the Plan, including insurance premiums.

Plan Trustee: JP Morgan Chase Bank, N.A.

Plan Documents: This document, together with the current version of the Associate Benefits Book, constitutes the summary plan description (SPD) for the critical illness coverage portion of the Plan. The SPD, together with the Walmart Inc. Associates' Health and Welfare Plan Wrap Document, are the Plan documents for the Plan.

Plan Amendment or Termination: Walmart Inc. reserves the right to amend or terminate at any time and to any extent the SPD, including the Associate Benefits Book, and the Associates' Health and Welfare Plan Wrap Document. None of the benefits described in this Document can be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by the Plan Administrator, by a management Associate of the Company, or by any member of the applicable committees of the Plan. Only written statements by the applicable committee of the Plan shall bind the Plan.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

This Rider is made part of the Certificate to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Certificate, not inconsistent with this Rider.

MAJOR ORGAN TRANSPLANT RIDER

This rider is issued in consideration of the rider premium and the request for this rider. Benefits are subject to all of the terms, conditions and provisions of the policy and the certificate. All terms defined and used in the policy and certificate apply to this rider unless otherwise provided in this rider. This rider provides coverage only for the procedures stated. It does not cover any other disease, sickness or incapacity.

DEFINITIONS

Certificate. The certificate to which this rider is attached.

Date of Loss. Means the date a covered person:
1. is placed on the National Transplant List, as an active or an inactive candidate, for a major organ transplant; or
2. undergoes the actual surgery for a major organ transplant.

Major Organ. Means human bone marrow, heart, lungs, liver, pancreas, or stem cells. Major organ includes kidneys when transplanted due to end stage renal failure. Lungs and kidneys are each one major organ, regardless of whether one or both lungs, or one or both kidneys, are transplanted.

Major Organ Transplant. Means the surgical transplant, by a physician, of a major organ. The transplanted major organ must come from a human donor. Each major organ transplanted is a major organ transplant eligible for the Surgery Benefit, even if multiple major organ transplants are performed in one surgical procedure.

National Transplant List. Means the database containing information on all people in the United States and Puerto Rico who are waiting for one or more major organ transplants, as mandated by the National Organ Transplant Act.

Rider Effective Date. The effective date of coverage under this rider is the same as the certificate effective date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider effective date is determined as described in the certificate provision titled “Effective Date of Coverage”.

BENEFITS

We pay the benefits described below, subject to all of the following:
1. the date of loss is after the rider effective date, or after the covered person’s effective date of coverage under previous versions of this rider; and
2. the date of loss is while this rider, or previous versions of this rider, is in force; and
3. the covered person has been continuously covered by this rider and previous versions of this rider since the date of loss; and
4. a recommendation for a major organ transplant for the same major organ was not made by a physician prior to the covered person’s effective date of coverage under this rider or previous versions of this rider; and
5. coverage for the benefit is not excluded by name or specific description.

Candidate Benefit. We pay the basic benefit amount for this rider if a covered person is placed on the National Transplant List as an active or an inactive candidate for a major organ transplant. This benefit is payable only once, per covered person.

Surgery Benefit. We pay the basic benefit amount for this rider if a covered person undergoes a major organ transplant, performed by a physician. Emergency situations that occur while the covered person is outside the United States may be reviewed and considered for approval by a United States physician on foreign soil or when the covered person returns to the United States.

Claims under this rider may be subject to review by an independent physician consultant.

LIMITATIONS AND EXCLUSIONS

The Candidate Benefit is not payable if we have previously paid:
1. the Candidate Benefit on the covered person, for any reason; or
2. the Surgery Benefit on the covered person for the same major organ.

The Surgery Benefit is not payable if we have previously paid the Candidate Benefit on the covered person for the same major organ. If we paid the Candidate Benefit for a covered person listed as a candidate for multiple major organ transplants, only the first one of those major organs transplanted will be considered the same major organ.

No benefit is payable for major organ transplants using mechanical or non-human organs.

The Limitations and Exclusions provision of the certificate applies to this rider.

TERMINATION

This rider terminates at the earliest of:
1. the end of the grace period for the payment of the premium for your certificate and this rider; or
2. the date your certificate terminates; or
3. the date the policy terminates.

A covered person's coverage under this rider terminates at the earliest of:
1. the date the covered person is no longer eligible as defined in the certificate; or
2. the date the insured employee is no longer eligible based upon the policyholder's Health and Welfare Plan.

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office.

Secretary

President

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687

CERTIFICATE ENDORSEMENT

This endorsement is attached to and made a part of the certificate as of July 1, 2022, or the effective date, whichever is later. All definitions, exclusions, limitations, terms, conditions, and provisions of the group policy and certificate apply to this endorsement. If there is a conflict between this endorsement and the group policy or certificate, this endorsement will control.

- The TERMINATION OF COVERAGE provision under the GENERAL PROVISIONS section is deleted in its entirety and replaced with the following:

  TERMINATION OF COVERAGE

  Your coverage under the policy ends, subject to the "Portability Coverage" provision of this certificate, on the earliest of:
  - the date the policy is canceled by the policyholder;
  - the last day of coverage for which premiums were paid, if you fail to pay your premiums within 30 days of the date your premium is due;
  - the last day you are in active employment, except as provided under the "Leave of Absence" provision;
  - the date you are no longer in an eligible class; or
  - the date your class is no longer eligible.

  We will provide coverage for a payable claim that occurs while you are covered under the policy.

  If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death, or when you move to an eligible class that does not provide spouse coverage.

  If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death, or when you move to an eligible class that does not provide domestic partner coverage.

  Coverage for a dependent child ends on the date the child is no longer eligible for coverage under the terms of the policyholder's Health and Welfare Plan. Coverage does not terminate for an unmarried child who:
  - is incapable of self-sustaining employment by reason of mental or physical incapacity;
  - became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
  - is chiefly dependent upon you for support and maintenance.

  The child's coverage continues as long as your coverage remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished to us, at our expense, when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

  If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims incurred after termination will not be paid. There may be no refund due if you have Associate and Child(ren) Coverage or Family Coverage and there are other dependent children insured under the policy.

  Coverage may be eligible for continuation as outlined in the "Portability Coverage" provision.

All other requirements of the policy and certificate not specifically stated within this endorsement still apply.

Signed for American Heritage Life Insurance Company at its home office in Jacksonville, Florida.

Secretary

GCICWMEND5

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

THIS IS A GROUP CRITICAL ILLNESS CERTIFICATE WHICH ONLY PROVIDES STATED BENEFITS FOR SPECIFIED ILLNESSES OR OTHER BENEFITS THAT MAY BE ADDED. THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

Important Privacy Policy Notice

At Allstate Benefits ("AB"), we value you as a customer. We also share your concerns about privacy. We are sending this notice to explain how we treat personal information ("customer information") that is not public. This is information that we obtain from you or other sources when we provide you with products and services.

We want you to know that: we respect your privacy; and we protect your information.

- We do not sell customer information.
- We do not share your information with: persons; companies; or organizations outside of AB that would use that information to contact you about their products and services.
- We expect persons or organizations that provide services on our behalf to keep your information confidential. We also expect them to use your information only to provide the services we've asked them to perform.
- We communicate to our employees about the need to protect your information. We have established safeguards (these are physical, electronic and procedural) to protect this information.

Below are answers to questions that you might have about privacy. You may be wondering...

What do we do with your information?

AB does not sell your customer or medical information to anyone. We do not share it with companies or organizations outside of AB that would use that information to contact you about their own products and services. If this were to change, we would offer you the option to opt out of this type of information sharing. Also, we would obtain your consent before we share medical information for marketing purposes.

Your agent or broker may use your information to help you with your insurance needs. We may also communicate with you about products, features, and options in which you have expressed an interest. Without your consent, we may provide your information to persons or organizations in and out of AB. This would be done as permitted or required by law. We may do this to:

- Fulfill a transaction you have requested.
- Service your policy.
- Market our products to you.
- Investigate or handle claims.
- Detect or prevent fraud.
- Participate in insurance support organizations (Information from a report by an insurance support organization may be retained by that organization and distributed to other persons.).
- Comply with lawful requests from regulatory and law enforcement authorities.

These persons or organizations may include:

- Our affiliated companies.
- Companies that perform services, including marketing, on our behalf.
- Other financial institutions with which we have an agreement for the sale of financial products.
- Other insurance companies to perform their role in an insurance transaction involving you.
- Businesses that conduct actuarial or research studies.
- Persons requesting information pursuant to a subpoena or court order.
- Your agent or broker.
- An employer, if your premiums are payroll deducted.
- The creditor who sold you insurance, if your policy is credit insurance.

What kind of customer information do we have, and where did we get it?
Much of the information that we have about you comes from you. When you perform certain transactions, you may give us information such as your name, address, and Social Security number. These transactions include when you submit: an application for insurance; a request for insurance; a request for products and services we offer; or a request for an insurance quote. We may have contacted you by telephone or mail for additional information. We keep information about the types of services you purchase from us and our affiliates. Examples of this include premiums, fund values, and payment history. We may collect information from outside sources such as consumer reporting agencies and health care providers. The information we collect may include the following:

- Motor vehicle reports.
- Credit reports.
- Medical information.

How do we protect your customer information?
We expect any company with whom we share your information to use it only to provide the service we have asked them to perform. Information about you is also available within AB to those individuals who may need to use it to fulfill and service the needs of our customers. We communicate the need to protect your information to all employees and agents. We especially communicate this need to individuals who have access to it. Plus, we have established physical, electronic, and procedural safeguards to protect your information. Note that if your relationship with us ends, your information will remain protected. This protection will be provided according to our privacy practices outlined in this Important Notice.

How can you find out what information we have about you?
You may request to see, or obtain by mail, the information about you in our records. If you believe that our information is incomplete or inaccurate, you may request that we correct, add to, or delete from the disputed information. In order to fulfill your request, we may make arrangements to copy and disclose your information to you on our behalf. This may be done with an insurance support organization or a consumer reporting agency. You may also request a more complete description of the entities to which we disclose your information, or the conditions that might warrant such disclosures. Please send any of the requests listed above in writing to:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

If you are an Internet user …
Our website, www.allstatebenefits.com, provides information about AB, our products, and the agencies and brokers that represent us. You may also perform certain transactions on the website. When accessing www.allstatebenefits.com, please be sure to read the Privacy Statement that appears there. To learn more, the www.allstatebenefits.com Privacy Statement provides information relating to your use of the website. This includes, for example:

1) our use of online collecting devices known as “cookies”;
2) how we collect information such as IP address (the number assigned to your computer when you use the Internet), browser and platform types, domain names, access times, referral data, and your activity while using our site;
3) who should use our website;
4) the security of information over the Internet;
5) links and co-branded sites.

We hope you have found this notice helpful. If you have any questions or would like more information, please don’t hesitate to contact your agent or write us at:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

This notice is being provided on behalf of the following companies:

American Heritage Life Insurance Company
Bluegrass Life Insurance Company
Acme United Insurance Company
SMA Life Assurance Company
Holiday Life Insurance Company
Kentucky Home Mutual
Keystone State Life
National Guardian Life

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE APRIL 14, 2003

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of our Plan's customers' Protected Health Information, to provide those customers with notice of our legal duties and privacy practices with respect to Protected Health Information, and to send notification to affected customers if there is a breach of unsecured Protected Health Information. If your state provides privacy protections that are more stringent than those provided by HIPAA, we will maintain your Protected Health Information in accordance with the more stringent state standard.

This Notice applies to "Protected Health Information" associated with "Health Plans" issued by American Heritage Life Insurance Company.

This Notice describes how we may use and disclose Protected Health Information to perform claims handling, payment, general insurance operations, and for other purposes that are permitted or required by law. Use or disclosure of your Protected Health Information for the purposes described in this Notice may be made in writing, orally, or by electronic means.

We are required to abide by the terms of this Notice. However, we may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all of your Protected Health Information that we maintain, including any information we created or received prior to issuing the new notice. If we make a material revision to our Privacy Notice, copies will be sent to you if you are then currently insured under our Plan.

Protected Health Information means information about you that is created or received by us and during the administration of coverage under the Plan, which identifies you or for which there is a reasonable basis to believe the information can be used to identify you and that relates to:

1) the past, present or future physical or mental health condition of the individual; or
2) the provision of health care to the individual; or
3) the past, present or future payment for the provision of health care to the individual.

Uses and Disclosures of Protected Health Information With Your Written Authorization

Except as described in the next section of this Notice, we will not use or disclose your Protected Health Information for any purpose unless you have signed a form authorizing the use or disclosure. For example, most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes, and disclosures that constitute a sale of Protected Health Information will be made only with your authorization. You have the right to revoke that authorization in writing at any time, except to the extent that we have already taken action in reliance on the authorization; or the authorization was obtained as a condition of obtaining coverage, to the extent that other law allows the insurer to contest a claim under the policy or the policy itself.

Uses and Disclosures of Protected Health Information Without Your Written Authorization

For Payment. We may make use of and disclose your Protected Health Information without your written authorization as may be necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims or certify these services are covered under your Plan.

For Plan Administrative Operations. We may make use of and disclose your Protected Health Information without your written authorization as necessary for our Plan administrative operations. Plan administrative operations include our usual business activities, examples of which are management, licensing, peer review, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, claims handling, complaint handling and other functions related to your Plan. We are prohibited from using or disclosing genetic information for underwriting purposes.

To Individuals Involved In Your Care. We may, without your written authorization, for the purposes of treatment, payment or Plan administrative operations, disclose the fact that you are covered under a Plan or that payment has been processed to a family member, other relative, your close personal friend or any other person you may identify. In these circumstances, we would not disclose any Protected Health Information which is not directly relevant to that person's involvement with your care or with payment for your care.

If you have designated a person to receive information regarding payment of the premium or pay premium via credit card, we may inform that person or credit card facility when your premium has not been paid or received by us.

We may also disclose limited Protected Health Information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

To Our Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these may include, but are not limited to our duly appointed insurance agents, financial auditors, reinsurers, legal services, enrollment and billing services, claim payment and medical management services. We may provide access to your Protected Health Information without your written authorization to one or more of these outside persons or organizations who assist us with payment or Plan administrative operations. We require these business associates to appropriately safeguard the privacy of your information.

To Plan Sponsors. If you are enrolled in a group health plan, we may share summary health information with your employer, union, or other employee organization that sponsors and maintains the group health plan, for purposes of obtaining premium bids; or modifying, amending, or terminating the group health plan; or enrollment and disenrollment information. Summary health information excludes genetic information.

For Other Products and Services. We may contact you without your written authorization to provide information regarding Plan upgrades or additional benefits that may be of interest to you. For example, we may use the fact that you currently are insured under a Plan for the purpose of communicating to you about changes to our Plan or products that could enhance or add value to existing coverage.

For Disclosure With Authorization. Unless otherwise excluded in this notice, we will not disclose any other Protected Health Information to any person or entity not specifically mentioned elsewhere in this Notice without your express written authorization.

For Other Uses and Disclosures. We are permitted or required by law to make some other uses and disclosures of your Protected Health Information without your authorization. We may release your Protected Health Information:

- if required by law to a government authorized health oversight agency or company conducting audits, investigations, or civil or criminal proceedings.

- if required to do so by a court or administrative ordered subpoena or discovery request. In most cases you will have notice of such a release.

- for public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.

- as required by law if we suspect child abuse or neglect or if we believe you to be a victim of abuse, neglect or domestic violence.

- to the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls.

- to law enforcement officials as required by law to report wounds, injuries or crimes.

- to coroners, medical examiners and/or funeral directors consistent with law.

- for a national security or intelligence activity or, if you are a member of the military, as required by the armed forces.

- to workers' compensation agencies or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Your Rights

Right to Inspect and Copy Your Protected Health Information. You may have access to our records that contain your Protected Health Information in order to inspect and obtain copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from our Privacy Officer and submit the completed form to our Privacy Office. If you request copies, we may charge you copying and mailing costs. If you request a copy of your Protected Health Information in electronic form, we will provide it to you electronically only if the record is readily producible in electronic form.

Right to Amend Your Protected Health Information. You have the right to request that we amend your Protected Health Information maintained in our enrollment, payment, claims adjudication and case or medical management records, or other records we use to make decisions about you. If you desire to amend these records, please obtain an amendment request form from our Privacy Officer and submit the completed form to our Privacy Office. We will comply with your request unless special circumstances apply. If your physician or other health care provider created the information that you desire to amend, you should contact the provider to amend the information.

Right to an Accounting of the Disclosures of Your Protected Health Information. Upon request, you may obtain an accounting of certain disclosures of your Protected Health Information made by us on or after April 14, 2003, excluding disclosures made earlier than six years before the date of your request. If you request an accounting more than once during any 12 month period, we will charge you a reasonable fee for the subsequent accounting statements.

Right to Request Confidential Communications. We will accommodate your reasonable request to receive communications of your Protected Health Information from us by alternative means of communication or at alternative locations if the request clearly states that disclosure of that information could endanger you.

Right to Request Restrictions on Use and Disclosure of Your Protected Health Information. You have the right to request restrictions on some of our uses and disclosures of your Protected Health Information to family members and others involved in your care or payment for care; or some of our uses and disclosures used to carry out treatment, payment, or Plan administrative operations, by notifying us of your request for a restriction in writing mailed to the contact identified at the end of this Notice. Your request must describe in detail the restriction you are requesting. We are not required to agree to your restriction request but will attempt to accommodate your requests. We retain the right to terminate an agreed-to restriction. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination, but the termination will only be effective for Protected Health Information we receive after we have notified you of the termination. You also have the right to terminate any agreed-to restriction by contacting us using the "Contact Information" provided at the end of this Notice.

Personal Representatives. You may exercise your rights through a personal representative who will be required to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or if you are the parent of a minor child. We reserve the right to deny access to your personal representative.

Right to Receive Paper Copy of this Notice. You may obtain a copy of this Notice. You may obtain a paper copy of this Notice even if you agreed to receive such notice electronically. Please contact us and we will mail it to you.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, send it in writing to the "Contact Information" at the address listed at the end of this Notice. There will be no retaliation for filing a complaint.

You may obtain a copy of this Notice by writing to us at the contact address below.

Contact Information

If you have questions or need further assistance regarding this Notice, you may contact:

Allstate Benefits
Attn: HIPAA Privacy Officer
1776 American Heritage Life Drive
Jacksonville, Florida 32224

Or, you may telephone the Customer Care Center at 1-800-521-3535.

IMPORTANT NOTICE

To obtain information or to make a complaint:

You may call or write us at:

American Heritage Life Insurance Company
1776 American Heritage Life Drive
Jacksonville, Florida 32224

1-800-514-9525

You may also contact your agent by calling or writing:

Wal-Mart Benefits Customer Service
1-800-421-1362

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

ATTACH THIS NOTICE TO YOUR CERTIFICATE:

This notice is for information only and does not become a part of the certificate.

LIMITATIONS AND EXCLUSIONS UNDER THE
ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy and contract owners who live in this state and, in some cases, to keep coverage in force. Please note that the valuable extra protection provided by the member insurers through the Guaranty Association is limited. This protection is not a substitute for a consumers' careful consideration in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") provides coverage of claims under some types of policies or contracts if the insurer or health maintenance organization becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in the state of Arkansas. Other conditions may also preclude coverage.

The Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer or health maintenance organization and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy or health maintenance organization coverage.

You should not rely on availability of coverage under the Guaranty Association when selecting an insurer or health maintenance organization.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol Avenue
Little Rock, Arkansas 72201

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

The state law that provides for this safety net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"), which is codified at Ark. Code Ann. §§ 23-96-101, *et seq*. Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act, nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state; or
- Their policy or contract was issued by a hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends, voting rights, and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to or in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC"), regardless of whether the FPBC is yet liable;
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by state or federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, claims for policy misrepresentation, and extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustee(s).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 in life insurance death benefits without regard to the number of policies and contracts there were with the same company, even if they provided different types of coverages. The Guaranty Association will pay a maximum of $500,000 in health benefits, provided that coverage for disability insurance benefits and long- term care insurance benefits shall not exceed $300,000. The Guaranty Association will pay $300,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits. These are limitations under which the Guaranty Association is obligated to operate prior to considering either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

Consumer Complaint Notice

If you are a resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding a claim, premium, or other matters relating to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:

https://www.osi.state.nm.us/ConsumerAssistance/index.aspx

ATTACH THIS NOTICE TO YOUR CERTIFICATE:

This notice is for information only and does not become a part of the certificate.

NMCN