

SERFF Tracking Number: ALST-126250591 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 43089
 Company Tracking Number: GCIPWM
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: /GCIPWM

Filing at a Glance

Company: American Heritage Life Insurance Company

Product Name: Group Critical Illness SERFF Tr Num: ALST-126250591 State: Arkansas
 TOI: H07G Group Health - Specified Disease - SERFF Status: Closed-Approved- State Tr Num: 43089
 Limited Benefit Closed
 Sub-TOI: H07G.001 Critical Illness Co Tr Num: GCIPWM State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor
 Authors: Angie Redden, Lynn Disposition Date: 09/16/2009
 Bautista, Patti Hicks
 Date Submitted: 07/31/2009 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Not Filed
 Project Number: GCIPWM Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments: This is a case
 Specific filing for policyholder situated in
 Arkansas
 Explanation for Combination/Other: Market Type: Group
 Submission Type: Resubmission Previous Filing Number: ALST-126167624
 Group Market Size: Large Overall Rate Impact:
 Group Market Type: Employer Filing Status Changed: 09/16/2009
 Explanation for Other Group Market Type:
 State Status Changed: 09/16/2009 Deemer Date:
 Created By: Lynn Bautista Submitted By: Lynn Bautista
 Corresponding Filing Tracking Number:
 Filing Description:
 These forms were previously approved under filing number ALST-126167624 (State Tracking Number 42770) on July 1, 2009. As before, these forms are being submitted as a single case filing to provide group voluntary coverage as requested by Walmart Stores Inc., to provide benefits to their employees beginning January 1, 2010. Walmart's 2009 open enrollment for their 2010 benefits will begin in October of this year. The benefits and many of the administrative

SERFF Tracking Number: ALST-126250591 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 43089
 Company Tracking Number: GCIPWM
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: /GCIPWM

provisions have been designed and worded specifically at the request of the policyholder. The policyholder has requested a change to the forms since they were last approved, which is to include language for Employee and Spouse Coverage. This is the only change to the forms. A red-line version of the forms is included for your convenience. As these forms have not yet been implemented and the change is minor, we have not revised the form number on these forms.

Company and Contact

Filing Contact Information

Lynn Bautista, Compliance Analyst CBautista@allstate.com
 Attn: Legal/Compliance 904-992-3046 [Phone]
 1776 American Heritage Life Drive 904-992-2975 [FAX]
 Jacksonville, FL 32224-9983

Filing Company Information

American Heritage Life Insurance Company	CoCode: 60534	State of Domicile: Florida
ATTN: Legal/Compliance	Group Code: 8	Company Type: Life and Health
1776 American Heritage Life Drive	Group Name: Allstate	State ID Number:
Jacksonville, FL 32224-9983	FEIN Number: 59-0781901	
(904) 992-1776 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	\$50 per filing
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Heritage Life Insurance Company	\$50.00	07/31/2009	29563001

SERFF Tracking Number: ALST-126250591 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 43089
 Company Tracking Number: GCIPWM
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: /GCIPWM

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/16/2009	09/16/2009
Approved-Closed	Rosalind Minor	08/05/2009	08/05/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Evidence of Insurability and Enrollment Form	Lynn Bautista	09/09/2009	09/16/2009
Form	Evidence of Insurability and Enrollment Form	Lynn Bautista	09/09/2009	09/16/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Revision to Evidence of Insurability and Enrollment Form	Note To Reviewer	Lynn Bautista	09/15/2009	09/15/2009

SERFF Tracking Number: ALST-126250591 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 43089
 Company Tracking Number: GCIPWM
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: /GCIPWM

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Red-line version of forms	Approved-Closed	Yes
Form	Group Critical Illness Insurance Policy	Approved-Closed	Yes
Form	Group Critical Illness Certificate of Insurance	Approved-Closed	Yes
Form	Evidence of Insurability and Enrollment Form	Approved-Closed	Yes
Form	Evidence of Insurability and Enrollment Form	Approved-Closed	Yes

SERFF Tracking Number: ALST-126250591 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 43089
 Company Tracking Number: GCIPWM
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: /GCIPWM

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Red-line version of forms	Approved-Closed	Yes
Form	Group Critical Illness Insurance Policy	Approved-Closed	Yes
Form	Group Critical Illness Certificate of Insurance	Approved-Closed	Yes
Form	Evidence of Insurability and Enrollment Form	Approved-Closed	Yes
Form	Evidence of Insurability and Enrollment Form	Approved-Closed	Yes

SERFF Tracking Number: ALST-126250591 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 43089
 Company Tracking Number: GCIPWM
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: /GCIPWM

Amendment Letter

Submitted Date: 09/16/2009

Comments:

Some formatting changes were made to the Evidence of Insurability forms AWD4528WM and AWD4528WMESP. The medical questions have not been changed since their last approval. Since these forms have not been used in the state yet, the form number has not been changed. A copy of both forms has been added to the Schedule Tab. If there are any questions, please let me know.

Thank you!

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
AWD4528WM	Application/Enrollment Form	Evidence of Insurability and Enrollment Form	Revised		ALST-126167624	AWD4528WM	M	Walmart Enrollment and EOI Form.pdf
AWD4528WMESP	Application/Enrollment Form	Evidence of Insurability and Enrollment Form	Revised		ALST-126167624	AWD4528WM	M	Walmart Enrollment and EOI Form Spanish.pdf

SERFF Tracking Number: ALST-126250591 State: Arkansas
Filing Company: American Heritage Life Insurance Company State Tracking Number: 43089
Company Tracking Number: GCIPWM
TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
Limited Benefit
Product Name: Group Critical Illness
Project Name/Number: /GCIPWM

Note To Reviewer

Created By:

Lynn Bautista on 09/15/2009 10:34 AM

Last Edited By:

Lynn Bautista

Submitted On:

09/15/2009 10:35 AM

Subject:

Revision to Evidence of Insurability and Enrollment Form

Comments:

Added "[If you elect child(ren) coverage, please list all children in the dependent section and answer the child(ren) medical questions if required based on all of your children, even if you have not enrolled them in other products.]" to page 2 of the form. This is the last change to these forms for Walmart. Thank you.

SERFF Tracking Number: ALST-126250591 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 43089
 Company Tracking Number: GCIPWM
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: /GCIPWM

Form Schedule

Lead Form Number: GCIPWM

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/05/2009	GCIPWM	Policy/Contract	Group Critical Illness Insurance Policy Certificate	Revised	Replaced Form #: GCIPWM Previous Filing #: ALST-126167624	50.000	GCIPWM Policy.pdf
Approved-Closed 08/05/2009	GVCICWM	Certificate	Group Critical Illness Certificate of Insurance	Revised	Replaced Form #: GVCICWM Previous Filing #: ALST-126167624	51.000	GVCICWM Certificate.pdf
Approved-Closed 09/16/2009	AWD4528 WM	Application/Enrollment Form	Evidence of Insurability and Enrollment Form	Revised	Replaced Form #: AWD4528WM Previous Filing #: ALST-126167624		Walmart Enrollment and EOI Form.pdf
Approved-Closed 09/16/2009	AWD4528 WMESP	Application/Enrollment Form	Evidence of Insurability and Enrollment Form	Revised	Replaced Form #: AWD4528WM Previous Filing #: ALST-126167624		Walmart Enrollment and EOI Form Spanish.pdf



[Workplace Division]

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

A Stock Company

1

GROUP CRITICAL ILLNESS INSURANCE POLICY NON-PARTICIPATING

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this policy carefully and contact us promptly with any questions. This 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 consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the policyholder's signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

2

[]

Secretary

[]

President

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

TABLE OF CONTENTS

POLICY SPECIFICATIONS	3
POLICYHOLDER PROVISIONS	4
GENERAL PROVISIONS.....	[5 – 8]
PORTABILITY COVERAGE	[9]
LIMITATIONS AND EXCLUSIONS	[10]
BENEFIT INFORMATION.....	[11 – 15]
CLAIM INFORMATION.....	[16 – 17]
GLOSSARY.....	[18 – 21]

3

**GROUP CRITICAL ILLNESS
POLICY SPECIFICATIONS**

- 4 **POLICYHOLDER:** [WALMART STORES, INC.]
- 5 **POLICY NUMBER:** [GROUP123]
- 6 **POLICY EFFECTIVE DATE:** [January 1, 2010]
- 7 **POLICY ANNIVERSARY DATE:** [January 1, 2011] and the [first day] of [January] each calendar year thereafter.
- GOVERNING JURISDICTION:** The state of Arkansas and subject to the laws of that jurisdiction.
- 8 **ELIGIBLE CLASS(ES):** [The classes of employees eligible for insurance are those classes defined in the policyholder's Health and Welfare Plan.]
- 9 **ELIGIBILITY WAITING PERIOD:** [The waiting period for eligible employees is as defined in the policyholder's Health and Welfare Plan]
- 10 **BASIC BENEFIT AMOUNT:** [\$5,000-50,000 for insured employee
100% of the insured employee's basic benefit amount for covered spouse (not available to spouses of part-time employees)
100% of the insured employee's basic benefit amount for covered children]
- 11 **GUARANTEED ISSUE LIMIT:** [\$15,000]
- 12 **OPTIONAL RIDER:** [Major Organ Transplant Rider – same amount as basic benefit amount **(Not available to employees participating in the Policyholder's Freedom Medical plan.)**]
- 13 **INITIAL RATE:** [Bi-weekly rate of \$XX.XX per employee for Employee-Only Coverage; or \$XX.XX per employee for Employee and Child(ren) Coverage; or \$XX.XX per employee for Employee and Spouse Coverage \$XX.XX per employee for Family Coverage]
- 14 **RATE GUARANTEE DATE:** [12/31/2016 for active employees]
- 15 **PREMIUM DUE:** [01/01/2010 and bi-weekly thereafter.] The policyholder must send all premiums on or before the premium due date to us. The premium must be paid in United States dollars.

Premium payments are required while the employee is receiving benefits except as provided in the Waiver of Premium benefit.
- 16 **COST OF COVERAGE:** [The employee pays the cost of coverage pre-tax through the policyholder's Flexible Benefit Plan.]
- 17 **[DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES:**

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

Name

[None]

Location (City and State)]

POLICYHOLDER PROVISIONS

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date shown on page 3 except for the following reasons:

1. a change occurs in this plan design (including any material change in the eligibility rules) that is requested by the policyholder; or
- 18 2. the number of insured eligible employees decreases by [50%] or more due to corporate restructuring; or
3. a new law or a change in any existing law is enacted which applies to this policy that would materially change the cost of the policy.

We will notify the policyholder in writing at least [180 days] before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect any time subject to the "Rate Guarantee" provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The policyholder must provide us with the following on a regular basis:

1. information about employees:
 - a. who are eligible to become insured; and
 - b. whose coverage changes; and/or
 - c. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required to administer this policy.

CANCELING POLICY

This policy can be canceled:

1. by us; or
2. by the policyholder.

19 We may terminate or offer to modify this policy after the Rate Guarantee Date with at least [365 days] written notice to the policyholder, if:

1. the policyholder fails to perform any of its material obligations that relate to this policy; or
2. fewer than [50 employees] are insured.

With regards to the policyholder's failure to perform any of its material obligations that relate to this policy, before we give the policyholder [365 days] written notice of our intent to terminate or modify this policy, we must first give the policyholder [30 days] written notice of the breach and the opportunity to cure the breach during that [30 day] period. Only after giving such notice may we provide the policyholder with the [365 days] written notice of our intent to terminate or modify this policy.

The policyholder must pay us all premiums due for the full period this policy is in force. If the premium is not paid before the grace period ends, we may terminate this policy with at least [30 days] written notice to the policyholder. If the policyholder pays all past due premiums before the conclusion of the [30 day] notice period, the policy will not terminate.

The policyholder may cancel this policy by written notice delivered to us at least [180 days] prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

GENERAL PROVISIONS

ELIGIBILITY OF DEPENDENTS

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

Dependents of an employee cannot be covered as both a dependent and as an employee with their own coverage. If a dependent is or becomes covered as an employee with their own coverage, we will terminate their coverage as a dependent and refund any premium that may have been paid for the dependent coverage for the period of time that they were covered as a dependent while having their own coverage.

A child born to the employee or spouse, while Employee 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 policy.

20

If the insured employee has Employee-Only Coverage [or Employee and Spouse Coverage], newborn children are automatically covered from the moment of birth for a period of [60 days]. If the insured employee desires uninterrupted coverage for a newborn child, the insured employee must notify the employer within [60 days] of that child's birth. Upon notification to us, we will convert the insured employee's Employee-Only Coverage to Employee and Child(ren) Coverage [or Employee and Spouse Coverage to Family Coverage] and provide notification of the additional premium due. If the insured employee does not notify the employer within [60 days] of the birth of the child, the temporary automatic coverage ends.

If the insured employee has Employee-Only Coverage or Employee and Child(ren) Coverage and marries and desires coverage for his or her spouse, the insured employee must notify the employer of the marriage within [60 days] of the marriage. We will convert the coverage to Family Coverage and provide notification of the additional premium due.

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

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by the insured employee has been entered within [60 days] after the date of birth.
2. If adoption proceedings have been instituted by the insured employee within [60 days] after the date of birth and the insured employee has temporary custody, coverage is provided from the moment of birth.
3. For 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 the insured employee has custody of the child pursuant to decree of the court and required premiums are paid.

If the insured employee has Employee-Only Coverage [or Employee and Spouse Coverage], we will convert the Employee-Only Coverage to Employee and Child(ren) Coverage [or Employee and Spouse Coverage to Family Coverage] and provide notification of the additional premium due.

ELIGIBILITY DATE

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

1. this policy's effective date; or
2. the date that the employee becomes eligible for coverage under the terms of the policyholder's Health and Welfare Plan.

WHEN AN ELIGIBLE EMPLOYEE CAN ENROLL OR CHANGE COVERAGE

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

GENERAL PROVISIONS (Continued)

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if:

1. the employee:
 - a. voluntarily canceled coverage under this policy and is reapplying; or
 - b. is applying for an amount of coverage over the Guaranteed Issue Limit; or
 - c. is applying for the coverage, or an increase in the amount of coverage, after his or her initial enrollment period.
- 21 2. the eligible dependent:
 - a. did not enroll within [60 days] of eligibility; or
 - b. is applying for an amount over the Guaranteed Issue Limit.

EFFECTIVE DATE OF COVERAGE

Coverage for employees who enroll during the initial enrollment will be effective on the effective date of this policy. For employees who enroll subsequent to the effective date of this policy, coverage will be effective in accordance with the terms of the policyholder's Health and Welfare Plan.

For any change in an employee's coverage that is subject to evidence of insurability, the change in coverage is effective in accordance with the terms of the policyholder's Health and Welfare Plan.

CERTIFICATES OF INSURANCE

We will furnish to the policyholder a certificate of insurance for delivery to each insured employee. The certificate will provide a description of the insurance provided by this policy and will state:

1. the essential features of the insurance coverage; and
2. to whom benefits are payable.

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

TERMINATION OF COVERAGE

The insured employee's coverage under this policy ends, subject to the "Portability Coverage" provision of this policy, on the earliest of:

1. the date this policy is canceled by the policyholder; or
2. the last day of the period for which such insured employee made any required premium payments; or
3. the last day such insured employee is in active employment, except as provided under the "Leave of Absence" provision; or
4. the date such insured employee is no longer in an eligible class; or
5. the date such insured employee's class is no longer eligible.

We will provide coverage for a payable claim that occurs while the insured employee is covered under this policy.

If the insured employee's spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or death of the insured employee, or when an insured employee moves to an eligible class that does not provide spouse 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:

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

GENERAL PROVISIONS (Continued)

TERMINATION OF COVERAGE (Continued)

The child's coverage continues as long as the insured employee's 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 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 the insured employee has Employee and Child(ren) Coverage or Family Coverage and there are other dependent children insured under this policy.

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

AGENCY

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

LEAVE OF ABSENCE

If an insured employee ceases active employment because of a leave of absence while coverage is in force, he or she will have the opportunity to continue coverage while he or she is 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.

GRACE PERIOD

22 The policyholder is entitled to a grace period of [60 days] for the payment of any premium due. This policy continues in force during the grace period, unless the policyholder gives us written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of this policy. The policyholder is liable to us for the payment of any pro-rata premium for the time this policy is in force during the grace period.

ENTIRE CONTRACT

The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the application and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or the covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his or her beneficiary, if any, if a claim is denied based upon such a statement.

INCONTESTABILITY

After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void this policy. 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.

GENERAL PROVISIONS (Continued)

23 [DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of this 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 this 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 this policy, such determinations shall be final and conclusive.]

LEGAL ACTION

No legal action may be brought to obtain benefits under this policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 180 days from the time a decision on appeal regarding a claim for benefits under this policy has been rendered. A lawsuit may not be filed after this 180 day period expires.

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 there is no named beneficiary, we will pay any benefits due at a covered person's death in the following order:

- 24
1. [to the insured employee, if living; otherwise
 2. to the insured employee's spouse, if living; otherwise
 3. to the covered person's children, in equal shares, if living; otherwise
 4. to the covered person's parents, in equal shares, if living; otherwise
 5. to the covered person's siblings, in equal shares, if living; otherwise
 6. to the covered person's estate].

Any change of beneficiary must be filed with the policyholder or at our home office. It will not take effect unless so filed, but if so filed, will take effect on the date signed. This will be true whether or not the covered person is 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.

25 [UNPAID PREMIUM; EXCESS PREMIUM

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

(This space intentionally left blank.)

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:

1. coverage under the policy terminates as described in the General Provision entitled "Termination of Coverage"; and
2. 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 this 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 this policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under this policy. Any change made to this 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 a covered person's coverage under this 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 for the first [36 months] of portability coverage is the rate in effect under this policy for active employees who have the same coverage. After the first [36 months], the premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least [31 days] before any change is to take effect.

GRACE PERIOD

The grace period, as defined in this policy, 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:

1. the date the person again becomes eligible for insurance under this policy; or
2. 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
3. with respect to insurance for dependents:
 - a. the date the employee's insurance terminates; or
 - b. the date the dependent ceases to be an eligible dependent as defined.

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

TERMINATION OF THE POLICY

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

LIMITATIONS AND EXCLUSIONS

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

1. any act of war, whether or not declared, participation in a riot, insurrection or rebellion; or
2. intentionally self-inflicted injuries; or
3. engaging in an illegal occupation or committing or attempting to commit a felony; or
4. attempted suicide, while sane or insane; or
5. being under the influence of narcotics or any other controlled chemical substance unless administered upon the advice of a physician; or
6. 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
7. alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.

(This space intentionally left blank.)

BENEFIT INFORMATION

A. INITIAL CRITICAL ILLNESS BENEFIT. We pay the benefits, as described below, subject to the conditions described below and all other provisions of this policy. This 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 this 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 United States physician on foreign soil or when the covered person returns to the United States.

At the time an employee elects coverage under this policy for the employee and his or her eligible dependents, the employee 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. We will continue to pay benefits until the maximum total percentage of 200% of the basic benefit amount is reached for each covered person.

For purposes of the benefits available in this policy, date of diagnosis means the date the following diagnoses are made:

- **For Heart Attack:** The date of death (infarction) of a portion of the heart muscle.
- **For Stroke:** The date a stroke occurred based on documented neurological deficits and neuroimaging studies.
- **For Coronary Artery By-Pass Surgery:** The date the actual coronary artery by-pass surgery occurs.
- **For Invasive Cancer or Carcinoma in situ:** The date the 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.
- **For End-Stage Renal Failure:** The date that the covered person begins renal dialysis.
- **For Alzheimer's Disease:** The date the diagnosis is established by the psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the covered person's medical records.
- **For a Specified Disease:** 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.

Pre-existing Condition Definition and Limitation

27 Pre-existing Condition Definition. For purposes of the benefits available under this policy, a pre-existing condition means any critical illness for which the covered person has sought medical advice or treatment in the [12 months] immediately before the effective date of their coverage. A pre-existing condition may exist even though a diagnosis has not yet been made. Preventative care and maintenance treatment are not treatment of a critical illness, even if such care and maintenance would not have occurred but for the covered person being diagnosed previously with the critical illness.

Pre-existing Condition Limitation. Some critical illness benefits described below indicate that they are subject to the pre-existing condition limitation. For those benefits, unless the benefit for the particular critical illness states otherwise, if a covered person has a critical illness that meets the definition of pre-existing condition as defined above, benefits under this policy will be payable for that critical illness only after the covered person has been symptom and treatment free of such critical illness for any [12] consecutive months after the effective date of their coverage.

Some critical illnesses described below indicate they are never paid if the critical illness is diagnosed prior to the effective date or meets the definition of pre-existing condition as defined above. For those benefits, unless the benefit for the particular critical illness states otherwise, if a covered person has a critical illness that has been diagnosed prior to the covered person's effective date of coverage or if the critical illness meets the definition of pre-existing condition as defined above, that critical illness is excluded from coverage for that covered person.

BENEFIT INFORMATION

A. INITIAL CRITICAL ILLNESS BENEFIT (Continued)

- 1. Heart Attack and Stroke.** We will pay a benefit for the following heart attack and stroke critical illnesses if a covered person is diagnosed with the critical illness provided that:
- a. the date of diagnosis is after the effective date of coverage; and
 - b. the date of diagnosis is while insured; and
 - c. the critical illness is not excluded by name or specific description; and
 - d. we have not paid an initial critical illness benefit for the critical illness before.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Heart Attack	100%
Stroke	100%

- 2. Coronary Artery By-Pass Surgery.** Subject to the pre-existing condition limitation, 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:
- a. the date of diagnosis is after the effective date of coverage; and
 - b. the date of diagnosis is while insured; and
 - c. the critical illness is not excluded by name or specific description; and
 - d. we have not paid an initial critical illness benefit for this critical illness before.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Coronary Artery By-Pass Surgery	100%

- 3. Cancer.** Subject to the pre-existing condition limitation, we will pay a benefit for the following cancer critical illnesses if a covered person is diagnosed with the critical illness, provided that:
- a. the date of diagnosis is while insured; and
 - b. the cancer is not excluded by name or specific description; and
 - c. we have not paid an initial critical illness benefit for this particular form of cancer before.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Invasive Cancer	100%
Carcinoma in situ	25%

- 4. End Stage Renal Failure.** Subject to the pre-existing condition limitation, 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:
- a. the date of diagnosis is after the effective date of coverage; and
 - b. the date of diagnosis is while insured; and
 - c. the critical illness is not excluded by name or specific description; and
 - d. we have not paid an initial critical illness benefit for this critical illness before.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
End Stage Renal Failure	100%

BENEFIT INFORMATION (Continued)

A. INITIAL CRITICAL ILLNESS BENEFIT (Continued)

- 5. 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; and
 - the date of diagnosis is while insured; and
 - the critical illness is not a pre-existing condition as defined; and
 - 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 that is diagnosed prior to the effective date of coverage or that meets the definition of pre-existing condition is excluded and is never covered under this policy.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Alzheimer’s Disease	100%

- 6. 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; and
 - the date of diagnosis is while insured; and
 - the critical illness is not a pre-existing condition as defined; and
 - 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.

Any specified disease listed below that is diagnosed prior to the effective date of coverage or that meets the definition of pre-existing condition is excluded and is never covered under this policy.

28

Specified Diseases	Percentage of Basic Benefit Amount	Specified Diseases (continued)	Percentage of Basic Benefit Amount
[Addison’s Disease	25%	Multiple Sclerosis	25%
Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease)	25%	Muscular Dystrophy	25%
		Myasthenia Gravis	25%
Cerebrospinal Meningitis (bacterial)	25%	Necrotizing fasciitis	25%
Cerebral Palsy	25%	Osteomyelitis	25%
Cystic Fibrosis	25%	Poliomyelitis	25%
Diphtheria	25%	Rabies	25%
Encephalitis	25%	Sickle Cell Anemia	25%
Huntington’s Chorea	25%	Systemic Lupus	25%
Legionnaire’s Disease (confirmation by culture or sputum)	25%	Systemic Sclerosis (Scleroderma)	25%
		Tetanus	25%
Malaria	25%	Tuberculosis	25%]

- B. RECURRENCE BENEFIT.** We pay this benefit for another occurrence of a covered critical illness paid under the Initial Critical Illness Benefit for a Heart Attack, Stroke, Coronary Artery By-Pass Surgery, Invasive Cancer, Carcinoma in situ and Rabies. Benefits will be paid at 50% 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; and
 - for the cancer related benefits, the covered person must be symptom and treatment-free during the 180 days after the prior occurrence; and
 - benefits paid for a recurrence contribute toward the maximum total of benefits, which is 200% of the basic benefit amount per covered person.

BENEFIT INFORMATION (Continued)

C. WAIVER OF PREMIUM. We pay this benefit if, while this coverage is in force, the insured employee becomes disabled due to a critical illness for which an Initial Critical Illness Benefit has been paid and remains disabled for 90 days. We pay premiums due after such 90 days for as long as the insured employee remains disabled. If the insured employee is employed at the time of disability, we will pay premiums for the first 365 days if he or she is unable to work at his or her own occupation; and then after 365 days if unable to work at any occupation. If unemployed at the time of disability, the insured employee must be unable to perform 2 or more activities of daily living for 90 consecutive days. An insured employee must not be working at any job for pay or benefits while premiums are waived.

D. NATIONAL CANCER INSTITUTE (NCI) EVALUATION. We pay the following benefit when a covered person receives an evaluation or consultation at an NCI-sponsored cancer center as a result of a previous diagnosis of a covered internal cancer:

1. \$500 for the evaluation or consultation; and
2. \$250 for the transportation and lodging of the covered person if the NCI-sponsored cancer center is more than 100 miles from the covered person's home.

The reason for such evaluation or consultation at an NCI-sponsored cancer center must be to determine the appropriate treatment for a covered cancer. This benefit is paid once per initial and recurrence diagnosis of invasive or carcinoma in situ cancer.

E. 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.

F. 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.

(This space intentionally left blank.)

BENEFIT INFORMATION (Continued)

29

G. WELLNESS BENEFIT. We pay [\$75] per certificate year, per covered person, when an eligible test or vaccination is performed, after the insured employee's coverage has been in force for 12 months. The test or vaccination must be performed under the supervision of or recommended by a physician, while coverage is in force, and a charge must be incurred. We will pay this benefit regardless of the result of the test.

Eligible tests are as follows:

1. [Biopsies for cancer; and
2. Blood tests for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3 – blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for cancer; and
10. Echocardiogram; and
11. Electrocardiogram; and
12. Endoscopy; and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. Human Papillomavirus (HPV) vaccination; and
16. Lipid Panel; and
17. Mammography; and
18. Pap Smear, including Thin Prep Pap Test; and
19. Serum Protein Electrophoresis; and
20. Stress Tests; and
21. Thermography; and
22. Ultrasounds for cancer detection].

[If the insured employee was covered by the prior cancer policy offered through the policyholder's Health and Welfare Plan, the length of time his or her coverage was in effect will reduce the waiting period for receiving benefits under this wellness benefit.]

(This space intentionally left blank.)

CLAIM INFORMATION

NOTICE OF CLAIM

30

We encourage a covered person 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 this 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 the covered person's 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

31

[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:

1. state the specific reason(s) for the adverse benefit determination; and
2. reference the specific policy provisions on which the determination is based; and
3. describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary; and
4. 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; and
5. 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
6. 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.

CLAIM INFORMATION (Continued)

PAYMENT OF CLAIMS

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

ASSIGNMENT

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

1. it is a written request; and
2. 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:

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

The insured employee must reimburse us in full. We will work with such insured employee to develop a reasonable method of repayment if he or she is financially unable to repay us in a lump sum.

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

CLAIM REVIEW

32

[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 Workplace Division, Wal-Mart Claims Unit, PO Box 41488, Jacksonville FL 32203-1488], Attention: Appeals.

A 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:

1. state specific reason(s) of the adverse determination; and
2. reference specific plan provision(s) on which the benefit determination is based; and
3. state that the covered person is 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; and
4. describe any voluntary appeal procedures offered by the policy and the covered person's right to obtain information about such procedures; and
5. 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); and
6. 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
7. include a statement regarding the covered person's right to bring an action under section 502(a) of ERISA.

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

GLOSSARY

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

The location at which the employee performs work must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires such employee 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:

1. bathing; or
2. dressing; or
3. toileting; or
4. eating; or
5. taking medication.

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.

Any Occupation. Means any gainful occupation for which the employee is suited by education, training or experience.

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:

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

Carcinoma in situ does not include:

1. other skin malignancies; or
2. pre-malignant lesions (such as intraepithelial neoplasia); or
3. 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 employee.

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:

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

GLOSSARY (Continued)

Common Carrier. Means the following: commercial airlines; passenger trains; inter-city buslines; trolleys; or boats. It does not include taxis; intra-city buslines; or private charter planes.

Coronary Artery By-Pass Surgery. Means the undergoing of a surgical operation to correct narrowing or blockage of 1 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.

Covered Person. Means any of the following:

1. any eligible family member (including the employee) named in the enrollment or evidence of insurability form and acceptable for coverage by us; or
2. any eligible dependent added after the effective date; or
3. 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.

Disabled. Means that the employee is:

1. unable to work; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of a covered critical illness.

Eligibility Waiting Period. Means the continuous period of time that the employee must be in active employment in an eligible class before he or she is eligible for coverage.

Employee. Means a person who is: (1) a citizen or resident of the United States or one of its territories; and (2) in active employment with the employer named as the policyholder.

Employee and Child(ren) Coverage. Means coverage that includes only the insured employee, as defined, and eligible children.

[Employee and Spouse Coverage. Means coverage that includes only the insured employee, as defined, and his or her spouse.]

Employee-Only Coverage. Means coverage that includes only the insured employee, as defined.

Employer. Means the individual, company or corporation where the employee is in active employment, and includes any division, subsidiary, or affiliated company named in this policy.

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.

Evidence of Insurability. Means a statement of the employee's or a dependent's medical history which we will use to determine if he or she is approved for coverage.

Family Coverage. Means coverage that includes the insured employee, as defined, and his or her eligible dependents.

33 Grace Period. Means a period of [60 days] following the premium due date during which premium payment may be made. While the insured employee is employed with the policyholder, the premiums will be paid by the policyholder through payroll deductions. The grace period only applies to the insured employee during any portability period, when insured employees will be required to pay the premiums directly to us.

33 Guaranteed Issue Limit. Means the maximum basic benefit amount of [\$15,000] for which the insured employee and his or her eligible dependents may enroll without requiring evidence of insurability.

GLOSSARY (Continued)

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:

1. new electrocardiographic changes; and
2. 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.

Initial Enrollment Period. Means one of the following periods during which the employee may first apply for coverage under this policy:

1. if the employee is eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if the employee becomes eligible for coverage after the policy effective date, the period, as determined by the policyholder's Health and Welfare Plan, after the date the employee is first eligible to apply for coverage.

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

Insured Employee. Means an employee who has: (1) fulfilled all eligibility requirements set forth in this policy and the policyholder's Health and Welfare Plan; and (2) properly completed and signed the enrollment, provided that the enrollment has been received by us and any required evidence of insurability has been approved by us.

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

The following are not considered invasive cancer for purposes of this 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 the employee is absent from active employment for a period of time that has been agreed to in advance in writing by the current employer.

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

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

Own Occupation. Means the occupation the employee is performing when a period of total disability begins.

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 this policy.

Physician. Means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. 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 the insured employee, his or her spouse, children, parents or siblings as a physician for a claim.

GLOSSARY (Continued)

Policyholder. Means the legal entity to whom this policy is issued.

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.

Positive Diagnosis (of a specified disease). Means a diagnosis by a qualified physician based on generally accepted diagnostic procedures and criteria.

Sickness. Means an illness that must begin while a person is insured under this policy.

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

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 this 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.

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

We, Us and Our. Means American Heritage Life Insurance Company.

(This space intentionally left blank.)



Allstate[®]

Workplace Division

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 POLICY WHICH ONLY PROVIDES
STATED BENEFITS FOR SPECIFIED CRITICAL ILLNESSES OR OTHER BENEFITS THAT MAY BE ADDED.
THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**



Allstate

[Workplace Division]

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

A Stock Company

1

(called "we", "our" or "us")

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 the Wal-Mart Stores, 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.

2

[

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.

TABLE OF CONTENTS

3

GENERAL PROVISIONS.....[3 – 5]

PORTABILITY COVERAGE.....[6]

LIMITATIONS AND EXCLUSIONS[7]

BENEFIT INFORMATION.....[8 – 12]

CLAIM INFORMATION.....[13 – 14]

GLOSSARY.....[15 – 18]

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.

Your dependents cannot be covered as both a dependent and as an associate with their own coverage. If your dependent is or becomes covered as an associate with their own coverage, we will terminate their coverage as a dependent and refund any premium that may have been paid for the dependent coverage for the period of time that they were covered as a dependent while having their own coverage.

A child born to you or your spouse, 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.

4

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 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 Family Coverage and provide notification of the additional premium due.

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

1. 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.
2. 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.
3. For 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 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:

1. the policy's effective date; or
2. 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)

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if:

1. you:
 - a. voluntarily cancel coverage under this certificate and reapply; or
 - b. apply for an amount of coverage over the Guaranteed Issue Limit; or
 - c. apply for the coverage, or an increase in the amount of coverage, after your initial enrollment period.
- 5 2. the eligible dependent:
 - a. does not enroll within [60 days] of eligibility; or
 - b. applies for an amount over the Guaranteed Issue Limit.

EFFECTIVE DATE OF COVERAGE

6 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 anytime 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:

1. the date the policy is canceled by the policyholder; or
2. the last day of the period for which you made any required premium payments; or
3. the last day you are in active employment, except as provided under the "Leave of Absence" provision; or
4. the date you are no longer in an eligible class; or
5. 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.

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:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. 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 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.

7 [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

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 180 days from the time a decision on appeal regarding a claim for benefits under this certificate has been rendered. A lawsuit may not be filed after this 180 day period expires.

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, we will pay any benefits due at the covered person's death in the following order:

1. [to you, if living; otherwise
2. to your spouse, if living; otherwise
3. to the covered person's children, in equal shares, if living; otherwise
4. to the covered person's parents, in equal shares, if living; otherwise
5. to the covered person's siblings, in equal shares, if living; otherwise
6. to the covered person's estate].

Any change of beneficiary must be filed with the policyholder or at our home office. It will not take effect unless so filed, but if so filed, will take effect on the date you signed it. This will be true whether or not the covered person is 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.

9 [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 or one of your eligible dependents. 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:

1. coverage under the policy terminates as described in the General Provision entitled "Termination of Coverage"; and
2. 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 for the first [36 months] of portability coverage is the rate in effect under the policy for active associates who have the same coverage. After the first [36 months], the premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. 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:

1. the date you again become eligible for insurance under the policy; or
2. 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
3. with respect to insurance for dependents:
 - a. the date your insurance terminates; or
 - b. 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):

1. any act of war, whether or not declared, participation in a riot, insurrection or rebellion; or
2. intentionally self-inflicted injuries; or
3. engaging in an illegal occupation or committing or attempting to commit a felony; or
4. attempted suicide, while sane or insane; or
5. being under the influence of narcotics or any other controlled chemical substance unless administered upon the advice of a physician; or
6. 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
7. alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.

(This space intentionally left blank.)

BENEFIT INFORMATION

A. 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 United States physician on foreign soil or when the covered person returns to the United States.

At the time you elect coverage under the policy for 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. We will continue to pay benefits until the maximum total percentage of 200% of the basic benefit amount is reached for each covered person.

For purposes of the benefits available in the policy, date of diagnosis means the date the following diagnoses are made:

- **For Heart Attack:** The date of death (infarction) of a portion of the heart muscle.
- **For Stroke:** The date a stroke occurred based on documented neurological deficits and neuroimaging studies.
- **For Coronary Artery By-Pass Surgery:** The date the actual coronary artery by-pass surgery occurs.
- **For Invasive Cancer or Carcinoma in situ:** The date the 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.
- **For End-Stage Renal Failure:** The date that the covered person begins renal dialysis.
- **For Alzheimer's Disease:** The date the diagnosis is established by the psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the covered person's medical records.
- **For a Specified Disease:** 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.

Pre-existing Condition Definition and Limitation

11 Pre-existing Condition Definition. For purposes of the benefits available under the policy, a pre-existing condition means any critical illness for which the covered person has sought medical advice or treatment in the [12 months] immediately before the effective date of their coverage. A pre-existing condition may exist even though a diagnosis has not yet been made. Preventative care and maintenance treatment are not treatment of a critical illness, even if such care and maintenance would not have occurred but for the covered person being diagnosed previously with the critical illness.

Pre-existing Condition Limitation. Some critical illness benefits described below indicate that they are subject to the pre-existing condition limitation. For those benefits, unless the benefit for the particular critical illness states otherwise, if a covered person has a critical illness that meets the definition of pre-existing condition as defined above, benefits under the policy will be payable for that critical illness only after the covered person has been symptom and treatment free of such critical illness for any [12 consecutive months] after the effective date of their coverage.

Some critical illnesses described below indicate they are never paid if the critical illness is diagnosed prior to the effective date or meets the definition of pre-existing condition as defined above. For those benefits, unless the benefit for the particular critical illness states otherwise, if a covered person has a critical illness that has been diagnosed prior to the covered person's effective date of coverage or if the critical illness meets the definition of pre-existing condition as defined above, that critical illness is excluded from coverage for that covered person.

BENEFIT INFORMATION

A. INITIAL CRITICAL ILLNESS BENEFIT (Continued)

1. **Heart Attack and Stroke.** We will pay a benefit for the following heart attack and stroke critical illnesses if a covered person is diagnosed with the critical illness provided that:
- a. the date of diagnosis is after the effective date of coverage; and
 - b. the date of diagnosis is while insured; and
 - c. the critical illness is not excluded by name or specific description; and
 - d. we have not paid an initial critical illness benefit for the critical illness before.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Heart Attack	100%
Stroke	100%

2. **Coronary Artery By-Pass Surgery.** Subject to the pre-existing condition limitation, 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:
- a. the date of diagnosis is after the effective date of coverage; and
 - b. the date of diagnosis is while insured; and
 - c. the critical illness is not excluded by name or specific description; and
 - d. we have not paid an initial critical illness benefit for this critical illness before.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Coronary Artery By-Pass Surgery	100%

3. **Cancer.** Subject to the pre-existing condition limitation, we will pay a benefit for the following cancer critical illnesses if a covered person is diagnosed with the critical illness, provided that:
- a. the date of diagnosis is while insured; and
 - b. the cancer is not excluded by name or specific description; and
 - c. we have not paid an initial critical illness benefit for this particular form of cancer before.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Invasive Cancer	100%
Carcinoma in situ	25%

4. **End Stage Renal Failure.** Subject to the pre-existing condition limitation, 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:
- a. the date of diagnosis is after the effective date of coverage; and
 - b. the date of diagnosis is while insured; and
 - c. the critical illness is not excluded by name or specific description; and
 - d. we have not paid an initial critical illness benefit for this critical illness before.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
End Stage Renal Failure	100%

BENEFIT INFORMATION (Continued)

A. INITIAL CRITICAL ILLNESS BENEFIT (Continued)

- 5. 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; and
 - the date of diagnosis is while insured; and
 - the critical illness is not a pre-existing condition as defined; and
 - 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 that is diagnosed prior to the effective date of coverage or that meets the definition of pre-existing condition is excluded and is never covered under the policy.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Alzheimer’s Disease	100%

- 6. 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; and
 - the date of diagnosis is while insured; and
 - the critical illness is not a pre-existing condition as defined; and
 - 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.

Any specified disease listed below that is diagnosed prior to the effective date of coverage or that meets the definition of pre-existing condition is excluded and is never covered under the policy.

12

Specified Diseases	Percentage of Basic Benefit Amount	Specified Diseases (continued)	Percentage of Basic Benefit Amount
Addison’s Disease	25%	Multiple Sclerosis	25%
Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease)	25%	Muscular Dystrophy	25%
		Myasthenia Gravis	25%
Cerebrospinal Meningitis (bacterial)	25%	Necrotizing fasciitis	25%
Cerebral Palsy	25%	Osteomyelitis	25%
Cystic Fibrosis	25%	Poliomyelitis	25%
Diphtheria	25%	Rabies	25%
Encephalitis	25%	Sickle Cell Anemia	25%
Huntington’s Chorea	25%	Systemic Lupus	25%
Legionnaire’s Disease (confirmation by culture or sputum)	25%	Systemic Sclerosis (Scleroderma)	25%
		Tetanus	25%
Malaria	25%	Tuberculosis	25%

- B. RECURRENCE BENEFIT.** We pay this benefit for another occurrence of a covered critical illness paid under the Initial Critical Illness Benefit for a Heart Attack, Stroke, Coronary Artery By-Pass Surgery, Invasive Cancer, Carcinoma in situ and Rabies. Benefits will be paid at 50% 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; and
 - for the cancer related benefits, the covered person must be symptom and treatment-free during the 180 days after the prior occurrence; and
 - benefits paid for a recurrence contribute toward the maximum total of benefits, which is 200% of the basic benefit amount per covered person.

BENEFIT INFORMATION (Continued)

- C. WAIVER OF PREMIUM.** We pay this benefit if, while this coverage is in force, you become disabled due to a critical illness for which an Initial Critical Illness Benefit has been paid and remain disabled for 90 days. We pay premiums due after such 90 days for as long as you remain disabled. If you are employed at the time of disability, we will pay premiums for the first 365 days if you are unable to work at your own occupation; and then after 365 days if unable to work at any occupation. If unemployed at the time of disability, you must be unable to perform 2 or more activities of daily living for 90 consecutive days. You must not be working at any job for pay or benefits while premiums are waived.
- D. NATIONAL CANCER INSTITUTE (NCI) EVALUATION.** We pay the following benefit when a covered person receives an evaluation or consultation at an NCI-sponsored cancer center as a result of a previous diagnosis of a covered internal cancer:
1. \$500 for the evaluation or consultation; and
 2. \$250 for the transportation and lodging of the covered person if the NCI-sponsored cancer center is more than 100 miles from the covered person's home.
- The reason for such evaluation or consultation at an NCI-sponsored cancer center must be to determine the appropriate treatment for a covered cancer. This benefit is paid once per initial and recurrence diagnosis of invasive or carcinoma in situ cancer.
- E. 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.
- F. 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.

(This space intentionally left blank.)

BENEFIT INFORMATION (Continued)

13

G. WELLNESS BENEFIT. We pay [\$75] per certificate year, per covered person, when an eligible test or vaccination is performed, after your coverage has been in force for 12 months. The test or vaccination must be performed under the supervision of or recommended by a physician, while coverage is in force, and a charge must be incurred. We will pay this benefit regardless of the result of the test.

Eligible tests are as follows:

1. [Biopsies for cancer; and
2. Blood tests for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3 – blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for cancer; and
10. Echocardiogram; and
11. Electrocardiogram; and
12. Endoscopy; and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. Human Papillomavirus (HPV) vaccination; and
16. Lipid Panel; and
17. Mammography; and
18. Pap Smear, including Thin Prep Pap Test; and
19. Serum Protein Electrophoresis; and
20. Stress Tests; and
21. Thermography; and
22. Ultrasounds for cancer detection].

[If you were covered by the prior cancer policy offered through the policyholder's Health and Welfare Plan, the length of time your prior coverage was in effect will reduce the waiting period for receiving benefits under this wellness benefit.]

(This space intentionally left blank.)

CLAIM INFORMATION

NOTICE OF CLAIM

14 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

15 [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:

1. state the specific reason(s) for the adverse benefit determination; and
2. reference the specific policy provisions on which the determination is based; and
3. describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary; and
4. 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; and
5. 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
6. 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:

1. it is a written request; and
2. 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:

1. fraud; or
2. 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

16

[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 Workplace Division, 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:

1. state specific reason(s) of the adverse determination; and
2. reference specific plan provision(s) on which the benefit determination is based; and
3. 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; and
4. describe any voluntary appeal procedures offered by the policy and the covered person's right to obtain information about such procedures; and
5. 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); and
6. 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
7. 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 work days only if actively employed on the preceding scheduled work day. Temporary and seasonal workers are excluded from coverage.

The location at which you perform work must be:

1. your employer's usual place of business; or
2. an alternative work site at the direction of your employer; or
3. 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:

1. bathing; or
2. dressing; or
3. toileting; or
4. eating; or
5. taking medication.

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.

Any Occupation. Means any gainful occupation for which you are suited by education, training or experience.

Associate. Means a person who is: (1) a citizen or resident of the United States or one of its territories; and (2) in active employment with the employer named as the policyholder.

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

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.]

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:

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

Carcinoma in situ does not include:

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

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

GLOSSARY (Continued)

Certificate Year. Means a consecutive 12 month period beginning on the effective date of insurance for each insured associate.

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:

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

Common Carrier. Means the following: commercial airlines; passenger trains; inter-city buslines; trolleys; or boats. It does not include taxis; intra-city buslines; or private charter planes.

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.

Covered Person. Means any of the following:

1. any eligible family member (including you) named in the enrollment or evidence of insurability form and acceptable for coverage by us; or
2. any eligible family member added after the effective date; or
3. 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.

Disabled. Means that you are:

1. unable to work; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of a covered critical illness.

Eligibility Waiting Period. Means the continuous period of time that you must be in active employment in an eligible class before you are eligible for coverage.

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.

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.

Evidence of Insurability. Means a statement of your medical history or your dependent's medical history which we will use to determine if he or she is approved for coverage.

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 the associate is employed with the policyholder, the premiums will be paid by the policyholder through payroll deductions. The grace period only applies to the Associate during any portability period, when Associates will be required to pay the premiums directly to us.

17 **Guaranteed Issue Limit.** Means the maximum basic benefit amount of [\$15,000] for which you and your eligible dependents may enroll without requiring evidence of insurability.

GLOSSARY (Continued)

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:

1. new electrocardiographic changes; and
2. 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.

Initial Enrollment Period. Means one of the following periods during which you may first apply for coverage under the policy:

1. 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
2. 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: (1) fulfilled all eligibility requirements set forth in the policy and the policyholder's Health and Welfare Plan; and (2) properly completed and signed the enrollment, provided that the enrollment has been received by us and any required evidence of insurability has been approved by us.

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.

Own Occupation. Means the occupation you are performing when a period of total disability begins.

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:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. 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, children, parents or siblings as a physician for a claim.

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

GLOSSARY (Continued)

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.

Positive Diagnosis (of a specified disease). Means a diagnosis by a qualified physician based on generally accepted diagnostic procedures and criteria.

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

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

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.

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

We, Us and Our. Means American Heritage Life Insurance Company.

You, Your or Yours. Means the insured associate, as defined, who meets the eligibility requirements.

(This space intentionally left blank.)

[STATEMENT OF ERISA RIGHTS

18

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:

Wal-Mart Stores, 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 Wal-Mart Stores, 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 Wal-Mart Stores, 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 Wal-Mart Stores, Inc. Associates' Health and Welfare Plan Wrap Document, are the Plan documents for the Plan.

Plan Amendment or Termination: Wal-Mart 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.]



Allstate[®]

Workplace Division

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.**



AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Workplace Division

WALMART [EVIDENCE OF INSURABILITY (PROOF OF GOOD HEALTH) AND] ENROLLMENT FORM

This box for AHL Home Office use only

GENERAL INFORMATION SECTION
(Please complete entire section)

Please print with black ink

ASSOCIATE'S NAME Last (Sr, Jr, etc.)	First	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER	HEIGHT	WEIGHT	<input type="checkbox"/> Married <input type="checkbox"/> Single
RESIDENCE ADDRESS (Street or P.O. Box)				CITY	STATE	ZIP	
BIRTHDATE (MM/DD/YEAR)	RESIDENCE PHONE NUMBER	EMPLOYER CASE NUMBER WMART			DATE HIRED (MM/DD/YEAR)		
OCCUPATION N/A	SITUS STATE AR	PLANT OR DIVISION N/A	ASSOCIATE'S [WIN] ID NUMBER N/A				

SELECTION OF COVERAGE SECTION

Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Associate Only	<input type="checkbox"/> New Election
	<input type="checkbox"/> Associate+Spouse	<input type="checkbox"/> Status Change Election _____ Reason for Change _____ Date of Event _____
	<input type="checkbox"/> Associate+Child(ren)	
	<input type="checkbox"/> Family]	

Critical Illness <input type="checkbox"/> Yes <input type="checkbox"/> No Basic Benefit Amount \$ _____	<input type="checkbox"/> Associate Only	<input type="checkbox"/> New Election
	<input type="checkbox"/> Associate+Spouse	<input type="checkbox"/> Status Change Election _____ Reason for Change _____ Date of Event _____
[Guarantee Issue Amount of \$5,000, \$10,000, or \$15,000. Amounts of \$20,000, \$25,000, \$30,000, \$40,000 or \$50,000 can be elected subject to proof of good health.]	<input type="checkbox"/> Associate+Child(ren)	
	<input type="checkbox"/> Family]	

[DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Choose Plan(s):		Dependent's Name(s) (Last, First, M.I.)	Relationship	Gender	Date of Birth (MM/DD/YEAR)
Accident	Critical Illness				

[BENEFICIARY SECTION

(Please select your beneficiary. Use additional paper if needed.)

For Plan(s):		Name of Beneficiary (Last, First, M.I.)	Relationship	Age	Primary, Secondary or Tertiary	Allocation
Accident	Critical Illness					
						%
						%
						%
						%

*Allocations for Primary, Secondary and Tertiary Beneficiaries should equal 100%.

**WALMART [EVIDENCE OF INSURABILITY (PROOF OF GOOD HEALTH)
AND] ENROLLMENT FORM
[PROOF OF GOOD HEALTH SECTION FOR CRITICAL ILLNESS**

Initial Enrollment. Please answer each question if you are requesting a Basic Benefit Amount of [\$20,000] or more.

Increase And Post Initial Enrollment. Please answer each question if you are applying for an increase in coverage or if you are applying any time after your initial enrollment period.

Non-Medical Question			
1. Is the proposed insured actively at work now and has he/she worked each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, normal pregnancy or other leaves of absence that are not related to his/her own illness or injury?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	N/A
Medical Questions			
2. Has any person proposed for coverage been diagnosed, treated, or anticipate being treated for any of the following: Sickle Cell Anemia; Lupus; Tuberculosis; HIV Acquired Immune Deficiency Syndrome ("AIDS"); AIDS Related Complex ("ARC"); Alzheimer's Disease; Kidney Failure; Emphysema; Circulatory Disorders; Diabetes; Epilepsy; any form of Hepatitis; Liver Disorders; or any disorder of the Kidneys, Prostate, Lungs, and/or Pancreas?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has any person proposed for coverage had or been recommended to have an Organ Transplant?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any person proposed for coverage been diagnosed, treated for or counseled in the last 5 years for: Alcohol; Drug Abuse; Asthma; any Cancer (except basal cell skin cancer) or any Malignancy; any Heart Conditions, Heart Attack, Stroke, Transient Ischemic Attack (TIA), or any other abnormality of the Heart including High Blood Pressure with readings of 150 systolic or 100 diastolic more than once in the last year?	Associate	Spouse	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Initial Enrollment. If the associate answers "no" to Question 1 or "yes" to Questions 2, 3, or 4, we will issue the guaranteed issue amount of [\$15,000]. If the spouse answers "yes" to Questions 2, 3, or 4, the spouse's Basic Benefit Amount is [\$15,000]. If any dependent child answers "yes" to Questions 2, 3, or 4, all children are issued a Basic Benefit Amount of [\$15,000].

Increase And Post Initial Enrollment. If you answer "no" to Question 1 or "yes" to Questions 2, 3, or 4, you are not eligible for the requested coverage.]

[If you elect child(ren) coverage, please list all children in the dependent section and answer the child(ren) medical questions if required based on all of your children, even if you have not enrolled them in other products.]

[DELIVERY NOTICE: Your certificate of insurance will be made available to you by your employer in electronic form. Included with the certificate will be privacy and other legal notices. To access your certificate and these legal notices, you will need a personal computer with internet access and appropriate browser software, and Adobe® Acrobat® Reader® software. Unless you decline below, you agree to receive these legal notices with the certificate of insurance in electronic form provided by your employer. At any time, you may withdraw your consent and receive a paper copy of these legal notices by calling 1-800-514-9525; or by writing to American Heritage Life Insurance Company, PO BOX 41488, Jacksonville, FL 32203-1488.

I decline electronic delivery of the certificate and the legal notices. Please mail them to me.]

[CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

I CERTIFY that the statements and answers provided are made by me, are complete and true, are correctly and fully recorded and that no important circumstance or information has been withheld or omitted. These statements and answers are offered to AHL as an inducement to grant insurance, and I understand that AHL may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this Evidence of Insurability (Proof of Good Health) and Enrollment Form. · **I AUTHORIZE** my employer to deduct from my salary or wages the necessary premium for the coverage(s) requested. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.]

FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Associate's Signature _____ Signed at _____ Date Signed _____
(City and State)



Workplace Division

**AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224**

**WALMART [EVIDENCIA DE ASEGURABILIDAD (PRUEBA DE BUEN ESTADO DE SALUD)
Y] FORMULARIO DE INSCRIPCIÓN**

This box for AHL Home Office use only (Esta casilla es solo para uso de la oficina central de AHL)

Sírvase escribir en letra de imprenta con tinta negra

SECCIÓN DE INFORMACIÓN GENERAL
(Llene la sección completa)

NOMBRE DEL ASOCIADO Apellido (Sr., Jr., etc.) Nombre Inicial del segundo nombre		<input type="checkbox"/> H <input type="checkbox"/> M	NÚMERO DE SEGURO SOCIAL	ESTATURA	PESO	<input type="checkbox"/> Casado(a) <input type="checkbox"/> Soltero(a)
DIRECCIÓN PARTICULAR (Calle o casilla de correo)			CIUDAD	ESTADO	CÓDIGO POSTAL	
FECHA DE NACIMIENTO (MM/DD/AÑO)	NÚMERO DE TELÉFONO PARTICULAR	EMPLEADOR NÚMERO DE CASO WMART		FECHA DE CONTRATACIÓN (MM/DD/AÑO)		
OCUPACIÓN N/A	ESTADO SEDE AR	PLANTA O DIVISIÓN N/A	NÚMERO DE DOCUMENTO DE [WIN] IDENTIDAD DEL ASOCIADO			

SECCIÓN DE SELECCIÓN DE COBERTURA

Accidente <input type="checkbox"/> Sí <input type="checkbox"/> No	[<input type="checkbox"/> Asociado solamente <input type="checkbox"/> Asociado + Cónyuge <input type="checkbox"/> Asociado + Hijo(s) <input type="checkbox"/> Familiar]	<input type="checkbox"/> Elección nuevo <input type="checkbox"/> El cambio de elección de estatus _____ Razón del cambio _____ Fecha del evento _____
		<input type="checkbox"/> Sí <input type="checkbox"/> No Monto de beneficio básico \$ _____ <small>[Monto de emisión de garantía de \$5,000, \$10,000 o \$15,000. Se pueden elegir montos de \$20,000, \$25,000, \$30,000, \$40,000 o \$50,000, sujeto a prueba de buen estado de salud.]</small>

[SECCIÓN DE COBERTURA DE DEPENDIENTES

(Completar si se elige cobertura de dependientes. Use hojas adicionales de ser necesario).

Elija los planes:		Nombres de los dependientes (Apellido, nombre, inicial del segundo nombre)	Parentesco	Género	Fecha de nacimiento (MM/DD/AÑO)
Accidente	Enfermedad grave				

[SECCIÓN DEL BENEFICIARIO

(Seleccione su beneficiario. Use hojas adicionales de ser necesario).

Para los planes:		Nombre del beneficiario (Apellido, nombre, inicial del segundo nombre)	Parentesco	Edad	Primario, secundario o terciario	Asignación
Accidente	Enfermedad grave					
						%
						%
						%
						%

*Las asignaciones para beneficiarios primarios, secundario o terciario deben ser equivalentes al 100%.

**WALMART [EVIDENCIA DE ASEGURABILIDAD (PRUEBA DE BUEN ESTADO DE SALUD)
Y] FORMULARIO DE INSCRIPCIÓN**

[SECCIÓN DE PRUEBA DE BUEN ESTADO DE SALUD PARA ENFERMEDAD GRAVE

Inscripción inicial. Responda a cada pregunta en caso de solicitar un monto de beneficio básico de [\$20,000] o más.

Inscripción de incremento y posterior a la inicial Responda a cada pregunta en caso de solicitar un incremento de cobertura o en caso de solicitar la inscripción en algún momento posterior a su período inicial de inscripción.

Pregunta no médica			
1. ¿Se encuentra el asegurado propuesto trabajando activamente en la actualidad y ha trabajado cada semana realizando todas las actividades en su ocupación regular y en su lugar de empleo regular durante los últimos 3 meses, a excepción de enfermedades o lesiones menores con una duración de 1 semana o menos, licencia por un embarazo normal u otras licencias no relacionadas con su propia enfermedad o lesión?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	N/D	N/D
Preguntas médicas			
2. ¿A alguna persona propuesta para cobertura se le ha diagnosticado, tratado o se anticipa que será tratada por cualquiera de las siguientes: anemia drepanocítica; lupus; tuberculosis; síndrome de inmunodeficiencia adquirida por VIH (“SIDA”); complejo relacionado con el SIDA (AIDS related complex, “ARC”); enfermedad de Alzheimer; insuficiencia renal; enfisema; trastornos circulatorios; diabetes; epilepsia; cualquier forma de hepatitis; trastornos hepáticos; o cualquier trastorno de los riñones, la próstata, los pulmones y/o el páncreas?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
3. ¿A alguna persona propuesta para cobertura se ha sometido o se le ha aconsejado realizarse un trasplante de órgano?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
4. ¿A alguna persona propuesta para cobertura se le ha diagnosticado, tratado o aconsejado en los últimos 5 años por alguno de los siguientes: alcohol; drogadicción; asma; cualquier cáncer (excepto cáncer de piel de células basales) o cualquier otro tumor; cualquier afección cardíaca, ataque al corazón, accidente cerebrovascular, ataque isquémico transitorio (transient ischemic attack, TIA) o cualquier otra anomalía del corazón, incluida presión arterial alta con lecturas de 150 sistólica o 100 diastólica más de una vez durante el último año?	Asociado	Cónyuge	Hijo(s)
	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No

Inscripción inicial. Si el asociado responde “no” a la pregunta 1 o “sí” a las preguntas 2, 3 ó 4, emitiremos el monto de emisión garantizada de [\$15,000]. Si el cónyuge responde “sí” a las preguntas 2, 3 ó 4, el monto de beneficio básico del cónyuge es de [\$15,000]. Si cualquier hijo dependiente responde “sí” a las preguntas 2, 3 ó 4, a todos los hijos se les emite un monto de beneficio básico de [\$15,000].

Inscripción de incremento y posterior a la inicial Si usted responde “no” a la pregunta 1 o “sí” a las preguntas 2, 3 ó 4, usted no es elegible para la cobertura solicitada].

Si elige cobertura para hijo(s), enumere todos sus hijos en la sección de dependientes y responda a las preguntas médicas correspondientes a su(s) hijo(s), si así se requiere, en base a todos ellos, aun cuando no los haya inscrito en otros productos.

[NOTIFICACIÓN DE ENTREGA: Su certificado de seguro será puesto a disposición suya por parte de su empleador en forma electrónica. Junto con el certificado, habrá notificaciones legales y sobre privacidad. Para acceder a su certificado y a estas notificaciones legales, necesitará una computadora personal con conexión a Internet y un programa de navegación apropiado, y también el programa Adobe® Acrobat® Reader®. A menos que usted manifieste lo contrario a continuación, acepta recibir estas notificaciones legales con el certificado de seguro en forma electrónica por parte de su empleador. En cualquier momento, puede retirar su consentimiento y recibir una copia impresa de estas notificaciones legales llamando al 1-800-937-7039 o escribiendo a Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, FL 32224.

No acepto la entrega de las notificaciones legales por medios electrónicos. Sírvanse enviármelas por correo.]

[CERTIFICACIÓN, ENTENDIMIENTO Y AUTORIZACIONES

CERTIFICO que los enunciados y las respuestas provistos son efectuados por mí, son completos y verdaderos, han sido registrados correcta e íntegramente y que ninguna circunstancia o información importante ha sido retenida u omitida. Estos enunciados y respuestas se ofrecen a AHL a modo de inducción para la concesión de seguro, y entiendo que AHL podrá usar cualquier enunciado o declaración falsos para disputar la validez de cualquier cobertura provista sobre la base de esta Evidencia de Asegurabilidad (prueba de buen estado de salud) y Formulario de inscripción. • **AUTORIZO** a mi empleador a deducir de mi salario o sueldo la prima necesaria para las coberturas solicitadas. Entiendo que si rechazo cualquier cobertura para la cual soy elegible, se puede requerir prueba de asegurabilidad satisfactoria, por mi cuenta y cargo, en caso de que desee solicitarla en una fecha futura. Tal solicitud podría ser denegada sobre la base de dicha prueba.]

NOTIFICACIÓN SOBRE FRAUDE: Cualquier persona que, a sabiendas, presente un reclamación falsa o fraudulenta por el pago de una pérdida o beneficio o que, a sabiendas, presente información falsa en una solicitud de seguro será culpable de un crimen y podrá estar sujeta a multas y encarcelamiento.

Firma del asociado _____ Firmado en _____ Fecha de la firma _____
(Ciudad y estado)

SERFF Tracking Number: ALST-126250591 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 43089
 Company Tracking Number: GCIPWM
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: /GCIPWM

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	08/05/2009
Bypass Reason:	Certification provided with previous approved filing.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	08/05/2009
Bypass Reason:	GCIAPPAR; AWD4528WM and AWD4528WMESP were filed and approved on 7/1/2009		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Red-line version of forms	Approved-Closed	08/05/2009
Comments:			
Attachments:	GCIPWM Policy red-line version.pdf GCICWM Certificate red-line version.pdf		



[Workplace Division]

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

A Stock Company

1

**GROUP CRITICAL ILLNESS INSURANCE POLICY
NON-PARTICIPATING**

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this policy carefully and contact us promptly with any questions. This 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 consists of:

- 1. all policy provisions and any amendments and/or attachments issued; and
- 2. the policyholder's signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

2

[*Gay S. Steu*]

Secretary

[*David A. Beard*]

President

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

TABLE OF CONTENTS

POLICY SPECIFICATIONS 3

POLICYHOLDER PROVISIONS 4

GENERAL PROVISIONS.....[5 – 8]

PORTABILITY COVERAGE[9]

LIMITATIONS AND EXCLUSIONS[10]

BENEFIT INFORMATION.....[11 – 15]

CLAIM INFORMATION.....[16 – 17]

GLOSSARY.....[18 – 21]

3

**GROUP CRITICAL ILLNESS
POLICY SPECIFICATIONS**

- 4 **POLICYHOLDER:** [WALMART STORES, INC.]
- 5 **POLICY NUMBER:** [GROUP123]
- 6 **POLICY EFFECTIVE DATE:** [January 1, 2010]
- 7 **POLICY ANNIVERSARY DATE:** [January 1, 2011] and the [first day] of [January] each calendar year thereafter.
- GOVERNING JURISDICTION:** The state of Arkansas and subject to the laws of that jurisdiction.
- 8 **ELIGIBLE CLASS(ES):** [The classes of employees eligible for insurance are those classes defined in the policyholder's Health and Welfare Plan.]
- 9 **ELIGIBILITY WAITING PERIOD:** [The waiting period for eligible employees is as defined in the policyholder's Health and Welfare Plan]
- 10 **BASIC BENEFIT AMOUNT:** [\$5,000-50,000 for insured employee
100% of the insured employee's basic benefit amount for covered spouse (not available to spouses of part-time employees)
100% of the insured employee's basic benefit amount for covered children]
- 11 **GUARANTEED ISSUE LIMIT:** [\$15,000]
- 12 **OPTIONAL RIDER:** [Major Organ Transplant Rider – same amount as basic benefit amount **(Not available to employees participating in the Policyholder's Freedom Medical plan.)**]
- 13 **INITIAL RATE:** [Bi-weekly rate of \$XX.XX per employee for Employee-Only Coverage; or \$XX.XX per employee for Employee and Child(ren) Coverage; or **\$XX.XX per employee for Employee and Spouse Coverage**
\$XX.XX per employee for Family Coverage]
- 14 **RATE GUARANTEE DATE:** [12/31/2016 for active employees]
- 15 **PREMIUM DUE:** [01/01/2010 and bi-weekly thereafter.] The policyholder must send all premiums on or before the premium due date to us. The premium must be paid in United States dollars.

Premium payments are required while the employee is receiving benefits except as provided in the Waiver of Premium benefit.
- 16 **COST OF COVERAGE:** [The employee pays the cost of coverage pre-tax through the policyholder's Flexible Benefit Plan.]

17 **[DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES:**

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

Name

[None]

Location (City and State)]

POLICYHOLDER PROVISIONS

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date shown on page 3 except for the following reasons:

1. a change occurs in this plan design (including any material change in the eligibility rules) that is requested by the policyholder; or
- 18 2. the number of insured eligible employees decreases by [50%] or more due to corporate restructuring; or
3. a new law or a change in any existing law is enacted which applies to this policy that would materially change the cost of the policy.

We will notify the policyholder in writing at least [180 days] before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect any time subject to the "Rate Guarantee" provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The policyholder must provide us with the following on a regular basis:

1. information about employees:
 - a. who are eligible to become insured; and
 - b. whose coverage changes; and/or
 - c. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required to administer this policy.

CANCELING POLICY

This policy can be canceled:

1. by us; or
2. by the policyholder.

19 We may terminate or offer to modify this policy after the Rate Guarantee Date with at least [365 days] written notice to the policyholder, if:

1. the policyholder fails to perform any of its material obligations that relate to this policy; or
2. fewer than [50 employees] are insured.

With regards to the policyholder's failure to perform any of its material obligations that relate to this policy, before we give the policyholder [365 days] written notice of our intent to terminate or modify this policy, we must first give the policyholder [30 days] written notice of the breach and the opportunity to cure the breach during that [30 day] period. Only after giving such notice may we provide the policyholder with the [365 days] written notice of our intent to terminate or modify this policy.

The policyholder must pay us all premiums due for the full period this policy is in force. If the premium is not paid before the grace period ends, we may terminate this policy with at least [30 days] written notice to the policyholder. If the policyholder pays all past due premiums before the conclusion of the [30 day] notice period, the policy will not terminate.

The policyholder may cancel this policy by written notice delivered to us at least [180 days] prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

GENERAL PROVISIONS

ELIGIBILITY OF DEPENDENTS

Eligible dependents are the individuals defined as “Eligible Dependents” under the policyholder’s Health and Welfare Plan.

Dependents of an employee cannot be covered as both a dependent and as an employee with their own coverage. If a dependent is or becomes covered as an employee with their own coverage, we will terminate their coverage as a dependent and refund any premium that may have been paid for the dependent coverage for the period of time that they were covered as a dependent while having their own coverage.

A child born to the employee or spouse, while Employee 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 policy.

20

If the insured employee has Employee-Only Coverage [or Employee and Spouse Coverage], newborn children are automatically covered from the moment of birth for a period of [60 days]. If the insured employee desires uninterrupted coverage for a newborn child, the insured employee must notify the employer within [60 days] of that child’s birth. Upon notification to us, we will convert the insured employee’s Employee-Only Coverage to Employee and Child(ren) Coverage [or Employee and Spouse Coverage to Family Coverage] and provide notification of the additional premium due. If the insured employee does not notify the employer within [60 days] of the birth of the child, the temporary automatic coverage ends.

If the insured employee has Employee-Only Coverage or Employee and Child(ren) Coverage and marries and desires coverage for his or her spouse, the insured employee must notify the employer of the marriage within [60 days] of the marriage. We will convert the coverage to Family Coverage and provide notification of the additional premium due.

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

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by the insured employee has been entered within [60 days] after the date of birth.
2. If adoption proceedings have been instituted by the insured employee within [60 days] after the date of birth and the insured employee has temporary custody, coverage is provided from the moment of birth.
3. For 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 the insured employee has custody of the child pursuant to decree of the court and required premiums are paid.

If the insured employee has Employee-Only Coverage [or Employee and Spouse Coverage], we will convert the Employee-Only Coverage to Employee and Child(ren) Coverage [or Employee and Spouse Coverage to Family Coverage] and provide notification of the additional premium due.

ELIGIBILITY DATE

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

1. this policy’s effective date; or
2. the date that the employee becomes eligible for coverage under the terms of the policyholder’s Health and Welfare Plan.

WHEN AN ELIGIBLE EMPLOYEE CAN ENROLL OR CHANGE COVERAGE

The employee may apply for or change coverage as permitted under the terms of the policyholder’s Health and Welfare Plan.

GENERAL PROVISIONS (Continued)

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if:

1. the employee:
 - a. voluntarily canceled coverage under this policy and is reapplying; or
 - b. is applying for an amount of coverage over the Guaranteed Issue Limit; or
 - c. is applying for the coverage, or an increase in the amount of coverage, after his or her initial enrollment period.
- 21 2. the eligible dependent:
 - a. did not enroll within [60 days] of eligibility; or
 - b. is applying for an amount over the Guaranteed Issue Limit.

EFFECTIVE DATE OF COVERAGE

Coverage for employees who enroll during the initial enrollment will be effective on the effective date of this policy. For employees who enroll subsequent to the effective date of this policy, coverage will be effective in accordance with the terms of the policyholder's Health and Welfare Plan.

For any change in an employee's coverage that is subject to evidence of insurability, the change in coverage is effective in accordance with the terms of the policyholder's Health and Welfare Plan.

CERTIFICATES OF INSURANCE

We will furnish to the policyholder a certificate of insurance for delivery to each insured employee. The certificate will provide a description of the insurance provided by this policy and will state:

1. the essential features of the insurance coverage; and
2. to whom benefits are payable.

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

TERMINATION OF COVERAGE

The insured employee's coverage under this policy ends, subject to the "Portability Coverage" provision of this policy, on the earliest of:

1. the date this policy is canceled by the policyholder; or
2. the last day of the period for which such insured employee made any required premium payments; or
3. the last day such insured employee is in active employment, except as provided under the "Leave of Absence" provision; or
4. the date such insured employee is no longer in an eligible class; or
5. the date such insured employee's class is no longer eligible.

We will provide coverage for a payable claim that occurs while the insured employee is covered under this policy.

If the insured employee's spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or death of the insured employee, or when an insured employee moves to an eligible class that does not provide spouse 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:

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

GENERAL PROVISIONS (Continued)

TERMINATION OF COVERAGE (Continued)

The child's coverage continues as long as the insured employee's 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 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 the insured employee has Employee and Child(ren) Coverage or Family Coverage and there are other dependent children insured under this policy.

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

AGENCY

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

LEAVE OF ABSENCE

If an insured employee ceases active employment because of a leave of absence while coverage is in force, he or she will have the opportunity to continue coverage while he or she is 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.

GRACE PERIOD

22

The policyholder is entitled to a grace period of [60 days] for the payment of any premium due. This policy continues in force during the grace period, unless the policyholder gives us written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of this policy. The policyholder is liable to us for the payment of any pro-rata premium for the time this policy is in force during the grace period.

ENTIRE CONTRACT

The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the application and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or the covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his or her beneficiary, if any, if a claim is denied based upon such a statement.

INCONTESTABILITY

After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void this policy. 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.

GENERAL PROVISIONS (Continued)

23 [DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of this 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 this 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 this policy, such determinations shall be final and conclusive.]

LEGAL ACTION

No legal action may be brought to obtain benefits under this policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 180 days from the time a decision on appeal regarding a claim for benefits under this policy has been rendered. A lawsuit may not be filed after this 180 day period expires.

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 there is no named beneficiary, we will pay any benefits due at a covered person's death in the following order:

- 24
1. [to the insured employee, if living; otherwise
 2. to the insured employee's spouse, if living; otherwise
 3. to the covered person's children, in equal shares, if living; otherwise
 4. to the covered person's parents, in equal shares, if living; otherwise
 5. to the covered person's siblings, in equal shares, if living; otherwise
 6. to the covered person's estate].

Any change of beneficiary must be filed with the policyholder or at our home office. It will not take effect unless so filed, but if so filed, will take effect on the date signed. This will be true whether or not the covered person is 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.

25 [UNPAID PREMIUM; EXCESS PREMIUM

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

(This space intentionally left blank.)

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:

1. coverage under the policy terminates as described in the General Provision entitled "Termination of Coverage"; and
2. 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 this 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 this policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under this policy. Any change made to this 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 a covered person's coverage under this 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 for the first [36 months] of portability coverage is the rate in effect under this policy for active employees who have the same coverage. After the first [36 months], the premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least [31 days] before any change is to take effect.

GRACE PERIOD

The grace period, as defined in this policy, 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:

1. the date the person again becomes eligible for insurance under this policy; or
2. 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
3. with respect to insurance for dependents:
 - a. the date the employee's insurance terminates; or
 - b. the date the dependent ceases to be an eligible dependent as defined.

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

TERMINATION OF THE POLICY

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

LIMITATIONS AND EXCLUSIONS

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

1. any act of war, whether or not declared, participation in a riot, insurrection or rebellion; or
2. intentionally self-inflicted injuries; or
3. engaging in an illegal occupation or committing or attempting to commit a felony; or
4. attempted suicide, while sane or insane; or
5. being under the influence of narcotics or any other controlled chemical substance unless administered upon the advice of a physician; or
6. 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
7. alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.

(This space intentionally left blank.)

BENEFIT INFORMATION

A. INITIAL CRITICAL ILLNESS BENEFIT. We pay the benefits, as described below, subject to the conditions described below and all other provisions of this policy. This 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 this 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 United States physician on foreign soil or when the covered person returns to the United States.

At the time an employee elects coverage under this policy for the employee and his or her eligible dependents, the employee 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. We will continue to pay benefits until the maximum total percentage of 200% of the basic benefit amount is reached for each covered person.

For purposes of the benefits available in this policy, date of diagnosis means the date the following diagnoses are made:

- **For Heart Attack:** The date of death (infarction) of a portion of the heart muscle.
- **For Stroke:** The date a stroke occurred based on documented neurological deficits and neuroimaging studies.
- **For Coronary Artery By-Pass Surgery:** The date the actual coronary artery by-pass surgery occurs.
- **For Invasive Cancer or Carcinoma in situ:** The date the 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.
- **For End-Stage Renal Failure:** The date that the covered person begins renal dialysis.
- **For Alzheimer's Disease:** The date the diagnosis is established by the psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the covered person's medical records.
- **For a Specified Disease:** 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.

Pre-existing Condition Definition and Limitation

27

Pre-existing Condition Definition. For purposes of the benefits available under this policy, a pre-existing condition means any critical illness for which the covered person has sought medical advice or treatment in the [12 months] immediately before the effective date of their coverage. A pre-existing condition may exist even though a diagnosis has not yet been made. Preventative care and maintenance treatment are not treatment of a critical illness, even if such care and maintenance would not have occurred but for the covered person being diagnosed previously with the critical illness.

Pre-existing Condition Limitation. Some critical illness benefits described below indicate that they are subject to the pre-existing condition limitation. For those benefits, unless the benefit for the particular critical illness states otherwise, if a covered person has a critical illness that meets the definition of pre-existing condition as defined above, benefits under this policy will be payable for that critical illness only after the covered person has been symptom and treatment free of such critical illness for any [12] consecutive months after the effective date of their coverage.

Some critical illnesses described below indicate they are never paid if the critical illness is diagnosed prior to the effective date or meets the definition of pre-existing condition as defined above. For those benefits, unless the benefit for the particular critical illness states otherwise, if a covered person has a critical illness that has been diagnosed prior to the covered person's effective date of coverage or if the critical illness meets the definition of pre-existing condition as defined above, that critical illness is excluded from coverage for that covered person.

BENEFIT INFORMATION

A. INITIAL CRITICAL ILLNESS BENEFIT (Continued)

- 1. Heart Attack and Stroke.** We will pay a benefit for the following heart attack and stroke critical illnesses if a covered person is diagnosed with the critical illness provided that:
- a. the date of diagnosis is after the effective date of coverage; and
 - b. the date of diagnosis is while insured; and
 - c. the critical illness is not excluded by name or specific description; and
 - d. we have not paid an initial critical illness benefit for the critical illness before.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Heart Attack	100%
Stroke	100%

- 2. Coronary Artery By-Pass Surgery.** Subject to the pre-existing condition limitation, 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:
- a. the date of diagnosis is after the effective date of coverage; and
 - b. the date of diagnosis is while insured; and
 - c. the critical illness is not excluded by name or specific description; and
 - d. we have not paid an initial critical illness benefit for this critical illness before.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Coronary Artery By-Pass Surgery	100%

- 3. Cancer.** Subject to the pre-existing condition limitation, we will pay a benefit for the following cancer critical illnesses if a covered person is diagnosed with the critical illness, provided that:
- a. the date of diagnosis is while insured; and
 - b. the cancer is not excluded by name or specific description; and
 - c. we have not paid an initial critical illness benefit for this particular form of cancer before.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Invasive Cancer	100%
Carcinoma in situ	25%

- 4. End Stage Renal Failure.** Subject to the pre-existing condition limitation, 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:
- a. the date of diagnosis is after the effective date of coverage; and
 - b. the date of diagnosis is while insured; and
 - c. the critical illness is not excluded by name or specific description; and
 - d. we have not paid an initial critical illness benefit for this critical illness before.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
End Stage Renal Failure	100%

BENEFIT INFORMATION (Continued)

A. INITIAL CRITICAL ILLNESS BENEFIT (Continued)

5. 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:

- a. the date of diagnosis is after the effective date of coverage; and
- b. the date of diagnosis is while insured; and
- c. the critical illness is not a pre-existing condition as defined; and
- d. the critical illness is not excluded by name or specific description; and
- e. we have not paid an initial critical illness benefit for this critical illness before.

Alzheimer's Disease that is diagnosed prior to the effective date of coverage or that meets the definition of pre-existing condition is excluded and is never covered under this policy.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Alzheimer's Disease	100%

6. 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:

- a. the date of diagnosis is after the effective date of coverage; and
- b. the date of diagnosis is while insured; and
- c. the critical illness is not a pre-existing condition as defined; and
- d. the critical illness is not excluded by name or specific description; and
- e. we have not paid an initial critical illness benefit for the critical illness before.

Any specified disease listed below that is diagnosed prior to the effective date of coverage or that meets the definition of pre-existing condition is excluded and is never covered under this policy.

28

Specified Diseases	Percentage of Basic Benefit Amount	Specified Diseases (continued)	Percentage of Basic Benefit Amount
Addison's Disease	25%	Multiple Sclerosis	25%
Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	25%	Muscular Dystrophy	25%
		Myasthenia Gravis	25%
Cerebrospinal Meningitis (bacterial)	25%	Necrotizing fasciitis	25%
Cerebral Palsy	25%	Osteomyelitis	25%
Cystic Fibrosis	25%	Poliomyelitis	25%
Diphtheria	25%	Rabies	25%
Encephalitis	25%	Sickle Cell Anemia	25%
Huntington's Chorea	25%	Systemic Lupus	25%
Legionnaire's Disease (confirmation by culture or sputum)	25%	Systemic Sclerosis (Scleroderma)	25%
		Tetanus	25%
Malaria	25%	Tuberculosis	25%]

B. RECURRENCE BENEFIT. We pay this benefit for another occurrence of a covered critical illness paid under the Initial Critical Illness Benefit for a Heart Attack, Stroke, Coronary Artery By-Pass Surgery, Invasive Cancer, Carcinoma in situ and Rabies. Benefits will be paid at 50% of the Initial Critical Illness Benefit for another occurrence of the same condition, subject to all of the following:

1. the same condition is excluded for 180 days after the prior occurrence; and
2. for the cancer related benefits, the covered person must be symptom and treatment-free during the 180 days after the prior occurrence; and
3. benefits paid for a recurrence contribute toward the maximum total of benefits, which is 200% of the basic benefit amount per covered person.

BENEFIT INFORMATION (Continued)

C. WAIVER OF PREMIUM. We pay this benefit if, while this coverage is in force, the insured employee becomes disabled due to a critical illness for which an Initial Critical Illness Benefit has been paid and remains disabled for 90 days. We pay premiums due after such 90 days for as long as the insured employee remains disabled. If the insured employee is employed at the time of disability, we will pay premiums for the first 365 days if he or she is unable to work at his or her own occupation; and then after 365 days if unable to work at any occupation. If unemployed at the time of disability, the insured employee must be unable to perform 2 or more activities of daily living for 90 consecutive days. An insured employee must not be working at any job for pay or benefits while premiums are waived.

D. NATIONAL CANCER INSTITUTE (NCI) EVALUATION. We pay the following benefit when a covered person receives an evaluation or consultation at an NCI-sponsored cancer center as a result of a previous diagnosis of a covered internal cancer:

1. \$500 for the evaluation or consultation; and
2. \$250 for the transportation and lodging of the covered person if the NCI-sponsored cancer center is more than 100 miles from the covered person's home.

The reason for such evaluation or consultation at an NCI-sponsored cancer center must be to determine the appropriate treatment for a covered cancer. This benefit is paid once per initial and recurrence diagnosis of invasive or carcinoma in situ cancer.

E. 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.

F. 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.

(This space intentionally left blank.)

BENEFIT INFORMATION (Continued)

29

G. WELLNESS BENEFIT. We pay [\$75] per certificate year, per covered person, when an eligible test or vaccination is performed, after the insured employee's coverage has been in force for 12 months. The test or vaccination must be performed under the supervision of or recommended by a physician, while coverage is in force, and a charge must be incurred. We will pay this benefit regardless of the result of the test.

Eligible tests are as follows:

1. [Biopsies for cancer; and
2. Blood tests for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3 – blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for cancer; and
10. Echocardiogram; and
11. Electrocardiogram; and
12. Endoscopy; and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. Human Papillomavirus (HPV) vaccination; and
16. Lipid Panel; and
17. Mammography; and
18. Pap Smear, including Thin Prep Pap Test; and
19. Serum Protein Electrophoresis; and
20. Stress Tests; and
21. Thermography; and
22. Ultrasounds for cancer detection].

[If the insured employee was covered by the prior cancer policy offered through the policyholder's Health and Welfare Plan, the length of time his or her coverage was in effect will reduce the waiting period for receiving benefits under this wellness benefit.]

(This space intentionally left blank.)

CLAIM INFORMATION

NOTICE OF CLAIM

30

We encourage a covered person 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 this 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 the covered person's 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

31

[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:

1. state the specific reason(s) for the adverse benefit determination; and
2. reference the specific policy provisions on which the determination is based; and
3. describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary; and
4. 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; and
5. 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
6. 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.

CLAIM INFORMATION (Continued)

PAYMENT OF CLAIMS

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

ASSIGNMENT

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

1. it is a written request; and
2. 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:

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

The insured employee must reimburse us in full. We will work with such insured employee to develop a reasonable method of repayment if he or she is financially unable to repay us in a lump sum.

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

CLAIM REVIEW

32

[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 Workplace Division, Wal-Mart Claims Unit, PO Box 41488, Jacksonville FL 32203-1488], Attention: Appeals.

A 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:

1. state specific reason(s) of the adverse determination; and
2. reference specific plan provision(s) on which the benefit determination is based; and
3. state that the covered person is 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; and
4. describe any voluntary appeal procedures offered by the policy and the covered person's right to obtain information about such procedures; and
5. 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); and
6. 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
7. include a statement regarding the covered person's right to bring an action under section 502(a) of ERISA.

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

GLOSSARY

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

The location at which the employee performs work must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires such employee 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:

1. bathing; or
2. dressing; or
3. toileting; or
4. eating; or
5. taking medication.

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.

Any Occupation. Means any gainful occupation for which the employee is suited by education, training or experience.

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:

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

Carcinoma in situ does not include:

1. other skin malignancies; or
2. pre-malignant lesions (such as intraepithelial neoplasia); or
3. 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 employee.

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:

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

GLOSSARY (Continued)

Common Carrier. Means the following: commercial airlines; passenger trains; inter-city buslines; trolleys; or boats. It does not include taxis; intra-city buslines; or private charter planes.

Coronary Artery By-Pass Surgery. Means the undergoing of a surgical operation to correct narrowing or blockage of 1 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.

Covered Person. Means any of the following:

1. any eligible family member (including the employee) named in the enrollment or evidence of insurability form and acceptable for coverage by us; or
2. any eligible dependent added after the effective date; or
3. 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.

Disabled. Means that the employee is:

1. unable to work; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of a covered critical illness.

Eligibility Waiting Period. Means the continuous period of time that the employee must be in active employment in an eligible class before he or she is eligible for coverage.

Employee. Means a person who is: (1) a citizen or resident of the United States or one of its territories; and (2) in active employment with the employer named as the policyholder.

Employee and Child(ren) Coverage. Means coverage that includes only the insured employee, as defined, and eligible children.

[Employee and Spouse Coverage. Means coverage that includes only the insured employee, as defined, and his or her spouse.]

Employee-Only Coverage. Means coverage that includes only the insured employee, as defined.

Employer. Means the individual, company or corporation where the employee is in active employment, and includes any division, subsidiary, or affiliated company named in this policy.

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.

Evidence of Insurability. Means a statement of the employee's or a dependent's medical history which we will use to determine if he or she is approved for coverage.

Family Coverage. Means coverage that includes the insured employee, as defined, and his or her eligible dependents.

33 **Grace Period.** Means a period of [60 days] following the premium due date during which premium payment may be made. While the insured employee is employed with the policyholder, the premiums will be paid by the policyholder through payroll deductions. The grace period only applies to the insured employee during any portability period, when insured employees will be required to pay the premiums directly to us.

33 **Guaranteed Issue Limit.** Means the maximum basic benefit amount of [\$15,000] for which the insured employee and his or her eligible dependents may enroll without requiring evidence of insurability.

GLOSSARY (Continued)

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:

1. new electrocardiographic changes; and
2. 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.

Initial Enrollment Period. Means one of the following periods during which the employee may first apply for coverage under this policy:

1. if the employee is eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if the employee becomes eligible for coverage after the policy effective date, the period, as determined by the policyholder's Health and Welfare Plan, after the date the employee is first eligible to apply for coverage.

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

Insured Employee. Means an employee who has: (1) fulfilled all eligibility requirements set forth in this policy and the policyholder's Health and Welfare Plan; and (2) properly completed and signed the enrollment, provided that the enrollment has been received by us and any required evidence of insurability has been approved by us.

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

The following are not considered invasive cancer for purposes of this 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 the employee is absent from active employment for a period of time that has been agreed to in advance in writing by the current employer.

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

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

Own Occupation. Means the occupation the employee is performing when a period of total disability begins.

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 this policy.

Physician. Means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. 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 the insured employee, his or her spouse, children, parents or siblings as a physician for a claim.

GLOSSARY (Continued)

Policyholder. Means the legal entity to whom this policy is issued.

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.

Positive Diagnosis (of a specified disease). Means a diagnosis by a qualified physician based on generally accepted diagnostic procedures and criteria.

Sickness. Means an illness that must begin while a person is insured under this policy.

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

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 this 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.

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

We, Us and Our. Means American Heritage Life Insurance Company.

(This space intentionally left blank.)



Allstate[®]

Workplace Division

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 POLICY WHICH ONLY PROVIDES
STATED BENEFITS FOR SPECIFIED CRITICAL ILLNESSES OR OTHER BENEFITS THAT MAY BE ADDED.
THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**



Allstate

[Workplace Division]

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

A Stock Company

1

(called "we", "our" or "us")

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 the Wal-Mart Stores, 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.

2

[

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.

TABLE OF CONTENTS

3

GENERAL PROVISIONS.....[3 – 5]

PORTABILITY COVERAGE.....[6]

LIMITATIONS AND EXCLUSIONS[7]

BENEFIT INFORMATION.....[8 – 12]

CLAIM INFORMATION.....[13 – 14]

GLOSSARY.....[15 – 18]

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.

Your dependents cannot be covered as both a dependent and as an associate with their own coverage. If your dependent is or becomes covered as an associate with their own coverage, we will terminate their coverage as a dependent and refund any premium that may have been paid for the dependent coverage for the period of time that they were covered as a dependent while having their own coverage.

A child born to you or your spouse, 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.

4

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 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 Family Coverage and provide notification of the additional premium due.

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

1. 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.
2. 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.
3. For 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 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:

1. the policy's effective date; or
2. 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)

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if:

1. you:
 - a. voluntarily cancel coverage under this certificate and reapply; or
 - b. apply for an amount of coverage over the Guaranteed Issue Limit; or
 - c. apply for the coverage, or an increase in the amount of coverage, after your initial enrollment period.
5. the eligible dependent:
 - a. does not enroll within [60 days] of eligibility; or
 - b. applies for an amount over the Guaranteed Issue Limit.

EFFECTIVE DATE OF COVERAGE

6. 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 anytime 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:

1. the date the policy is canceled by the policyholder; or
2. the last day of the period for which you made any required premium payments; or
3. the last day you are in active employment, except as provided under the "Leave of Absence" provision; or
4. the date you are no longer in an eligible class; or
5. 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.

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:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. 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 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.

7 [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

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 180 days from the time a decision on appeal regarding a claim for benefits under this certificate has been rendered. A lawsuit may not be filed after this 180 day period expires.

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, we will pay any benefits due at the covered person's death in the following order:

1. [to you, if living; otherwise
2. to your spouse, if living; otherwise
3. to the covered person's children, in equal shares, if living; otherwise
4. to the covered person's parents, in equal shares, if living; otherwise
5. to the covered person's siblings, in equal shares, if living; otherwise
6. to the covered person's estate].

Any change of beneficiary must be filed with the policyholder or at our home office. It will not take effect unless so filed, but if so filed, will take effect on the date you signed it. This will be true whether or not the covered person is 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.

9 [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 or one of your eligible dependents. 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:

1. coverage under the policy terminates as described in the General Provision entitled "Termination of Coverage"; and
2. 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 for the first [36 months] of portability coverage is the rate in effect under the policy for active associates who have the same coverage. After the first [36 months], the premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. 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:

1. the date you again become eligible for insurance under the policy; or
2. 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
3. with respect to insurance for dependents:
 - a. the date your insurance terminates; or
 - b. 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):

1. any act of war, whether or not declared, participation in a riot, insurrection or rebellion; or
2. intentionally self-inflicted injuries; or
3. engaging in an illegal occupation or committing or attempting to commit a felony; or
4. attempted suicide, while sane or insane; or
5. being under the influence of narcotics or any other controlled chemical substance unless administered upon the advice of a physician; or
6. 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
7. alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.

(This space intentionally left blank.)

BENEFIT INFORMATION

A. 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 United States physician on foreign soil or when the covered person returns to the United States.

At the time you elect coverage under the policy for 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. We will continue to pay benefits until the maximum total percentage of 200% of the basic benefit amount is reached for each covered person.

For purposes of the benefits available in the policy, date of diagnosis means the date the following diagnoses are made:

- **For Heart Attack:** The date of death (infarction) of a portion of the heart muscle.
- **For Stroke:** The date a stroke occurred based on documented neurological deficits and neuroimaging studies.
- **For Coronary Artery By-Pass Surgery:** The date the actual coronary artery by-pass surgery occurs.
- **For Invasive Cancer or Carcinoma in situ:** The date the 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.
- **For End-Stage Renal Failure:** The date that the covered person begins renal dialysis.
- **For Alzheimer's Disease:** The date the diagnosis is established by the psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the covered person's medical records.
- **For a Specified Disease:** 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.

Pre-existing Condition Definition and Limitation

11 Pre-existing Condition Definition. For purposes of the benefits available under the policy, a pre-existing condition means any critical illness for which the covered person has sought medical advice or treatment in the [12 months] immediately before the effective date of their coverage. A pre-existing condition may exist even though a diagnosis has not yet been made. Preventative care and maintenance treatment are not treatment of a critical illness, even if such care and maintenance would not have occurred but for the covered person being diagnosed previously with the critical illness.

Pre-existing Condition Limitation. Some critical illness benefits described below indicate that they are subject to the pre-existing condition limitation. For those benefits, unless the benefit for the particular critical illness states otherwise, if a covered person has a critical illness that meets the definition of pre-existing condition as defined above, benefits under the policy will be payable for that critical illness only after the covered person has been symptom and treatment free of such critical illness for any [12 consecutive months] after the effective date of their coverage.

Some critical illnesses described below indicate they are never paid if the critical illness is diagnosed prior to the effective date or meets the definition of pre-existing condition as defined above. For those benefits, unless the benefit for the particular critical illness states otherwise, if a covered person has a critical illness that has been diagnosed prior to the covered person's effective date of coverage or if the critical illness meets the definition of pre-existing condition as defined above, that critical illness is excluded from coverage for that covered person.

BENEFIT INFORMATION

A. INITIAL CRITICAL ILLNESS BENEFIT (Continued)

1. **Heart Attack and Stroke.** We will pay a benefit for the following heart attack and stroke 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; and
 - the date of diagnosis is while insured; and
 - 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.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Heart Attack	100%
Stroke	100%

2. **Coronary Artery By-Pass Surgery.** Subject to the pre-existing condition limitation, 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; and
 - the date of diagnosis is while insured; and
 - 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.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Coronary Artery By-Pass Surgery	100%

3. **Cancer.** Subject to the pre-existing condition limitation, 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; and
 - 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.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Invasive Cancer	100%
Carcinoma in situ	25%

4. **End Stage Renal Failure.** Subject to the pre-existing condition limitation, 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; and
 - the date of diagnosis is while insured; and
 - 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.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
End Stage Renal Failure	100%

BENEFIT INFORMATION (Continued)

A. INITIAL CRITICAL ILLNESS BENEFIT (Continued)

- 5. 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; and
 - the date of diagnosis is while insured; and
 - the critical illness is not a pre-existing condition as defined; and
 - 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 that is diagnosed prior to the effective date of coverage or that meets the definition of pre-existing condition is excluded and is never covered under the policy.

<u>Critical Illness</u>	<u>Percentage of Basic Benefit Amount</u>
Alzheimer’s Disease	100%

- 6. 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; and
 - the date of diagnosis is while insured; and
 - the critical illness is not a pre-existing condition as defined; and
 - 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.

Any specified disease listed below that is diagnosed prior to the effective date of coverage or that meets the definition of pre-existing condition is excluded and is never covered under the policy.

12

Specified Diseases	Percentage of Basic Benefit Amount	Specified Diseases (continued)	Percentage of Basic Benefit Amount
[Addison’s Disease	25%	Multiple Sclerosis	25%
Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease)	25%	Muscular Dystrophy	25%
Cerebrospinal Meningitis (bacterial)	25%	Myasthenia Gravis	25%
Cerebral Palsy	25%	Necrotizing fasciitis	25%
Cystic Fibrosis	25%	Osteomyelitis	25%
Diphtheria	25%	Poliomyelitis	25%
Encephalitis	25%	Rabies	25%
Huntington’s Chorea	25%	Sickle Cell Anemia	25%
Legionnaire’s Disease (confirmation by culture or sputum)	25%	Systemic Lupus	25%
Malaria	25%	Systemic Sclerosis (Scleroderma)	25%
		Tetanus	25%
		Tuberculosis	25%]

- B. RECURRENCE BENEFIT.** We pay this benefit for another occurrence of a covered critical illness paid under the Initial Critical Illness Benefit for a Heart Attack, Stroke, Coronary Artery By-Pass Surgery, Invasive Cancer, Carcinoma in situ and Rabies. Benefits will be paid at 50% 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; and
 - for the cancer related benefits, the covered person must be symptom and treatment-free during the 180 days after the prior occurrence; and
 - benefits paid for a recurrence contribute toward the maximum total of benefits, which is 200% of the basic benefit amount per covered person.

BENEFIT INFORMATION (Continued)

- C. WAIVER OF PREMIUM.** We pay this benefit if, while this coverage is in force, you become disabled due to a critical illness for which an Initial Critical Illness Benefit has been paid and remain disabled for 90 days. We pay premiums due after such 90 days for as long as you remain disabled. If you are employed at the time of disability, we will pay premiums for the first 365 days if you are unable to work at your own occupation; and then after 365 days if unable to work at any occupation. If unemployed at the time of disability, you must be unable to perform 2 or more activities of daily living for 90 consecutive days. You must not be working at any job for pay or benefits while premiums are waived.
- D. NATIONAL CANCER INSTITUTE (NCI) EVALUATION.** We pay the following benefit when a covered person receives an evaluation or consultation at an NCI-sponsored cancer center as a result of a previous diagnosis of a covered internal cancer:
1. \$500 for the evaluation or consultation; and
 2. \$250 for the transportation and lodging of the covered person if the NCI-sponsored cancer center is more than 100 miles from the covered person's home.
- The reason for such evaluation or consultation at an NCI-sponsored cancer center must be to determine the appropriate treatment for a covered cancer. This benefit is paid once per initial and recurrence diagnosis of invasive or carcinoma in situ cancer.
- E. 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.
- F. 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.

(This space intentionally left blank.)

BENEFIT INFORMATION (Continued)

13

G. WELLNESS BENEFIT. We pay [\$75] per certificate year, per covered person, when an eligible test or vaccination is performed, after your coverage has been in force for 12 months. The test or vaccination must be performed under the supervision of or recommended by a physician, while coverage is in force, and a charge must be incurred. We will pay this benefit regardless of the result of the test.

Eligible tests are as follows:

1. [Biopsies for cancer; and
2. Blood tests for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3 – blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for cancer; and
10. Echocardiogram; and
11. Electrocardiogram; and
12. Endoscopy; and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. Human Papillomavirus (HPV) vaccination; and
16. Lipid Panel; and
17. Mammography; and
18. Pap Smear, including Thin Prep Pap Test; and
19. Serum Protein Electrophoresis; and
20. Stress Tests; and
21. Thermography; and
22. Ultrasounds for cancer detection].

[If you were covered by the prior cancer policy offered through the policyholder's Health and Welfare Plan, the length of time your prior coverage was in effect will reduce the waiting period for receiving benefits under this wellness benefit.]

(This space intentionally left blank.)

CLAIM INFORMATION

NOTICE OF CLAIM

14 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

15 [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:

1. state the specific reason(s) for the adverse benefit determination; and
2. reference the specific policy provisions on which the determination is based; and
3. describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary; and
4. 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; and
5. 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
6. 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:

1. it is a written request; and
2. 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:

1. fraud; or
2. 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

16

[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 Workplace Division, 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:

1. state specific reason(s) of the adverse determination; and
2. reference specific plan provision(s) on which the benefit determination is based; and
3. 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; and
4. describe any voluntary appeal procedures offered by the policy and the covered person's right to obtain information about such procedures; and
5. 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); and
6. 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
7. 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 work days only if actively employed on the preceding scheduled work day. Temporary and seasonal workers are excluded from coverage.

The location at which you perform work must be:

1. your employer's usual place of business; or
2. an alternative work site at the direction of your employer; or
3. 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:

1. bathing; or
2. dressing; or
3. toileting; or
4. eating; or
5. taking medication.

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.

Any Occupation. Means any gainful occupation for which you are suited by education, training or experience.

Associate. Means a person who is: (1) a citizen or resident of the United States or one of its territories; and (2) in active employment with the employer named as the policyholder.

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

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.]

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:

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

Carcinoma in situ does not include:

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

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

GLOSSARY (Continued)

Certificate Year. Means a consecutive 12 month period beginning on the effective date of insurance for each insured associate.

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:

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

Common Carrier. Means the following: commercial airlines; passenger trains; inter-city buslines; trolleys; or boats. It does not include taxis; intra-city buslines; or private charter planes.

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.

Covered Person. Means any of the following:

1. any eligible family member (including you) named in the enrollment or evidence of insurability form and acceptable for coverage by us; or
2. any eligible family member added after the effective date; or
3. 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.

Disabled. Means that you are:

1. unable to work; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of a covered critical illness.

Eligibility Waiting Period. Means the continuous period of time that you must be in active employment in an eligible class before you are eligible for coverage.

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.

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.

Evidence of Insurability. Means a statement of your medical history or your dependent's medical history which we will use to determine if he or she is approved for coverage.

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 the associate is employed with the policyholder, the premiums will be paid by the policyholder through payroll deductions. The grace period only applies to the Associate during any portability period, when Associates will be required to pay the premiums directly to us.

17 **Guaranteed Issue Limit.** Means the maximum basic benefit amount of [\$15,000] for which you and your eligible dependents may enroll without requiring evidence of insurability.

GLOSSARY (Continued)

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:

1. new electrocardiographic changes; and
2. 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.

Initial Enrollment Period. Means one of the following periods during which you may first apply for coverage under the policy:

1. 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
2. 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: (1) fulfilled all eligibility requirements set forth in the policy and the policyholder's Health and Welfare Plan; and (2) properly completed and signed the enrollment, provided that the enrollment has been received by us and any required evidence of insurability has been approved by us.

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.

Own Occupation. Means the occupation you are performing when a period of total disability begins.

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:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. 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, children, parents or siblings as a physician for a claim.

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

GLOSSARY (Continued)

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.

Positive Diagnosis (of a specified disease). Means a diagnosis by a qualified physician based on generally accepted diagnostic procedures and criteria.

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

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

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.

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

We, Us and Our. Means American Heritage Life Insurance Company.

You, Your or Yours. Means the insured associate, as defined, who meets the eligibility requirements.

(This space intentionally left blank.)

[STATEMENT OF ERISA RIGHTS

18

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:

Wal-Mart Stores, 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 Wal-Mart Stores, 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 Wal-Mart Stores, 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 Wal-Mart Stores, Inc. Associates' Health and Welfare Plan Wrap Document, are the Plan documents for the Plan.

Plan Amendment or Termination: Wal-Mart 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.]



Allstate[®]

Workplace Division

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.**