GROUP
solutions

Benefit coverage for

Walmart Associates

An apple a day might not protect you from critical illnesses, but our coverage can help.

GCIPWM

CRITICAL ILLNESS INSURANCE

the right coverage • your future • great choice

Walmart
Save money. Live better.

your coverage—your choice!

You have probably heard the old saying, "An apple a day keeps the doctor away." But, an apple won't help cover the bills when you are diagnosed with a critical illness and need medical attention. Our Critical Illness policy can help supplement your existing medical insurance, and help pay for non-medical expenses not usually covered. Take the bite out of medical insurance by protecting yourself today.

meeting your needs

Our group critical illness coverage helps offer financial peace of mind, should a covered critical illness be diagnosed.

- Choose a basic benefit option in $5,000 increments, from $5,000 - $15,000; Guaranteed Issue.*
- Benefits payable for critical illness, specified diseases, plus wellness.
- Premiums are affordable
- Benefits paid directly to you unless you choose to sign them over to someone else
- Coverage options include: you, you and your spouse, you and your child(ren), or family. Coverage for spouse and child(ren) is only available if you enroll.
- Spouse and child(ren) receive the same basic benefit option as you.**
- Section 125 qualified, so you can pay your premiums with pre-tax dollars. There could be tax consequences, please consult with your tax advisor.

*If you enroll after your initial enrollment period or desire a basic benefit option that is higher than $15,000, you will be required to provide proof of good health. **Only if Guaranteed Issue limit selected or employee and dependent(s) pass underwriting if requesting amount over the Guaranteed Issue limit.

Our Critical Illness coverage can help secure your financial future.

EASY

on you & your savings

Check out the details.

benefit coverage highlights

Group Critical Illness insurance pays you a lump-sum benefit upon diagnosis of a covered critical illness or condition. Having supplemental Critical Illness insurance can help lessen the financial impact to your wallet. Most traditional health insurance plans are valuable, but often set limits on what will be covered. Our coverage helps you to concentrate on getting better, rather than spend your time and energy worrying about paying the bills.

The lump-sum benefit you receive when you are diagnosed with a critical illness, for each category of coverage, can help you:

Pay for treatments not covered under your medical insurance

Spend precious time with your family and friends

Pay your mortgage and other expenses

Because medical treatments and technology are advancing daily, people are living longer with major illnesses or diseases. This can be very costly. Financial hardship can happen, due to indirect medical expenses that health and disability insurance doesn't cover. Group Critical Illness insurance is a strong supplement to your current health or disability insurance coverage.

Think about this...if your medical or disability coverage did not cover all treatments, would you have enough money set aside to pay out of pocket? The best way to determine the need is to understand how your finances would be affected tomorrow if you or a family member suffered a critical illness today.

What if you or a family member couldn't work because of a critical illness? Your paycheck would be reduced or stop and life as you know it would still continue. You would still owe bills and need money for your daily living necessities. The simple items you take for granted when you are employed, such as, food, gas, electricity, child care, and your child's education, would still continue. How would you pay for them?

your benefit coverage

Benefits for critical illness coverage will be provided to you, your spouse, and child(ren), where applicable. Terms and conditions for each benefit will vary. Payment of benefits is subject to policy provisions. Please review your coverage carefully.

About every 25 seconds, an American will suffer a coronary event, and about every minute someone will die from one.[1]

HOW TO GET STARTED

Choose your benefit amount in $5,000 increments, from $5,000 to $15,000 and Guaranteed Issue up to $15,000. No proof of good health is required, if you enroll when you are first eligible. Higher benefit amounts are available.

Make sure to select coverage for you, you and your spouse, you and your child(ren), or your entire family.

Initial Critical Illness Benefit - A benefit will be paid for heart attack, stroke, transient ischemic attack, coronary artery by-pass surgery, invasive cancer or carcinoma in situ, end stage renal failure, Alzheimer's disease, or a specified disease **(see descriptions for all benefits; this page).**

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, provided: the date of diagnosis is after the effective date of coverage; and while you are insured; and, if applicable, is not a pre-existing condition as defined; and meets the definition in the policy; and is not excluded by name or specific description; and we have not paid an initial critical illness benefit for it before.

We will continue to pay benefits until the maximum total percentage of 200% of the basic benefit amount is reached for each covered person.

Heart Attack and Stroke (100%) - **The benefit amount you have chosen will be paid** for you or a covered family member if diagnosed with a heart attack or stroke critical illness. Heart Attack diagnosis must be based on electrocardiograph proof and lab reports showing elevated cardiac enzymes or biochemical markers. Stroke must include evidence of medical record documentation or permanent neurological deficit.

Transient Ischemic Attacks (TIA's) (25%) - **The benefit amount you have chosen will be paid** for you or a covered family member if diagnosed with a TIA critical illness. TIA diagnosis must be based on documented neurological deficits and neuroimaging studies.

Coronary Artery By-Pass Surgery* (100%) - **The benefit amount you have chosen will be paid** for coronary artery by-pass surgery critical illness if you or a covered family member is diagnosed with the critical illness.

Cancer* (Invasive 100% or Carcinoma in situ 25%) - **The benefit amount you have chosen will be paid** for cancer critical illnesses if you or a covered family member is diagnosed with the critical illness. **Carcinoma in situ** means a diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Carcinoma in situ includes: early prostate cancer diagnosed as stage A or equivalent staging; and melanoma not invading the dermis. Carcinoma in situ does not include: other skin malignancies; or pre-malignant lesions (such as intraepithelial neoplasia); or benign tumors or polyps. Carcinoma in situ must be identified pursuant to a pathological or clinical diagnosis, as defined.

End Stage Renal Failure* (100%) - **The benefit amount you have chosen will be paid** for end stage renal failure critical illness if you or a covered family member is diagnosed with the critical illness.

Alzheimer's Disease* (100%) - **The benefit amount you have chosen will be paid** for Alzheimer's Disease critical illness if you or a covered family member is diagnosed with the critical illness. If you or a covered family member were diagnosed with Alzheimer's Disease prior to the effective date of coverage, or had a pre-existing condition, it will be excluded and never covered under the policy.

Specified Disease* (25%) - **The benefit amount you have chosen will be paid** for one of the covered specified disease critical illnesses (see chart, page 6) if you or a covered family member is diagnosed with the critical illness If you or a covered family member were diagnosed with a specified disease prior to the effective date of coverage, or had a pre-existing condition, it will be excluded and never covered under the policy.

*Subject to the pre-existing condition limitation.

[1] Heart Disease and Stroke Statistics — 2009 Update, American Heart Association

additional benefit coverage

In addition to the Initial Critical Illness benefits included in the policy, additional benefits have been added to provide you and your covered family members enhanced coverage. **These benefits do not contribute to the 200% maximum total of benefits, except where noted under the Recurrence Benefit.**

Recurrence Benefit (50%) - **A benefit will be paid at 50% of the Initial Critical Illness Benefit** for you or each covered family member, if diagnosed with another occurrence of a covered critical illness paid under the Initial Critical Illness Benefit. The benefits covered include: Heart Attack, Stroke, Coronary Artery By-Pass Surgery, Invasive Cancer, Carcinoma in situ and Rabies. Payment is subject to the following conditions: 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 for you or each covered family member.**

Waiver of Premium - **Premiums will be waived while coverage is in force** if you become disabled, and remain disabled for 90 days, due to a critical illness for which an Initial Critical Illness Benefit has been paid. After 90 days, we pay the premium for as long as the disability lasts. If you are employed at the time of disability, we pay the premiums for the first 365 days if 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, and not be working at any job for pay or benefits while premiums are waived.

National Cancer Institute (NCI) Evaluation - **A $500 benefit will be paid** for you or each covered family member who receives an evaluation or consultation at an NCI-sponsored cancer center, as a result of a previous diagnosis of a covered internal cancer. **A $250 benefit will be paid** for transportation and lodging if the NCI-sponsored cancer center is more than 100 miles from 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.***

Transportation Benefit - **This benefit will pay the actual cost, up to $1,500** for round trip transportation to a treatment center. Coach fare transportation on a common carrier or a personal vehicle allowance of $0.50 per mile, up to $1,500 will be covered. Transportation must be 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 a covered person's home to the treatment facility as described above. 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.*

Lodging Benefit - **A $60 benefit will be paid daily** for you or each covered family member receiving 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; 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 your or your covered family member's home.

Wellness Benefit - **A $75 benefit will be paid per certificate year,** for you and each covered family member, 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
2. Blood tests for triglycerides
3. Bone Marrow Testing; CA15-3 (cancer antigen 15-3 – blood test for breast cancer)
4. CA125 (cancer antigen 125 – blood test for ovarian cancer)
5. CEA (carcinoembryonic antigen – blood test for colon cancer)
6. Chest X-ray; Colonoscopy
7. Doppler screening for cancer
8. Echocardiogram
9. Electrocardiogram
10. Endoscopy
11. Flexible sigmoidoscopy
12. Hemocult stool analysis
13. Human Papillomavirus (HPV) vaccination
14. Lipid Panel
15. Mammography
16. Pap Smear, including Thin Prep Pap Test
17. Serum Protein Electrophoresis
18. Stress Tests
19. Thermography
20. Ultrasounds for cancer detection.

*Some restrictions apply. See limitations and exclusions on page 7.

[2] Heart Disease and Stroke Statistics — 2009 Update, American Heart Association

enhancing your coverage

The Major Organ Transplant Rider is added to your coverage if you are not participating in the policyholder's Freedom Medical Plan. The rider provides a wider scope of coverage and can help you to further secure your family's financial future and well being.

Major Organ Transplant Rider (100%)* - **The benefit amount you have chosen will be paid** if you or each covered family member receives a major organ transplant, as defined below, subject to all of the following: the date of diagnosis is after the rider effective date; and the date of diagnosis is while this rider is in force; and a recommendation for major organ transplant has not been made by a physician prior to the covered person's effective date of coverage under the rider; and the transplant is not excluded by name or specific description; and we have not paid a benefit for the covered person for this organ transplant before.

A major organ transplant means the surgical transplant of a heart, lung, liver, or pancreas. Major organ transplant also includes kidney transplant due to end stage renal failure, bone marrow transplant and stem cell transplant. The transplanted organ must come from a human donor.

This benefit is not payable for organ transplants using mechanical or non-human organs and is limited to 1 transplant per covered person.

Limitations and Exclusions - The Limitations and Exclusions provision of the policy applies to the rider.

If a covered person has been recommended by a physician to have a major organ transplant prior to the effective date of the person's coverage under the rider, coverage for that transplant is excluded and no benefit will be paid for the transplant of that organ.

Pre-Existing Condition Definition and Limitation - A pre-existing condition means a disease or physical condition for which the covered person has sought medical advice or treatment in the 12 months immediately before the effective date of their coverage but a recommendation by a physician for a transplant has not yet been made.

If you or a covered family member has an illness that meets the definition of pre-existing condition as defined in the rider, benefits under the rider will be payable for that illness only if the date of diagnosis, as defined in the rider, occurs more than 12 months after your effective date or the effective date of a covered family member.

Termination - The rider terminates at the earliest of: the end of the grace period for the payment of the premium for the policy and the rider; or the date the policy terminates.

Coverage under the rider terminates for you or each covered family member at the earliest of: the date you or each covered family member is no longer eligible as defined in the policy; or the date you are no longer eligible based upon the policyholder's Health and Welfare Plan; or the date that each covered family member has received the basic benefit amount for the rider.

*Not available to Associates covered under the Freedom Plan.
If not covered under the plan your premium will reflect no rider chosen.

specified disease percentage chart

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.

Specified Disease	Percentage of Basic Benefit Amount
Addison's Disease	25%
Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	25%
Cerebrospinal Meningitis (bacterial)	25%
Cerebral Palsy	25%
Cystic Fibrosis	25%
Diphtheria	25%
Encephalitis	25%
Huntington's Chorea	25%
Legionnaire's Disease (confirmation by culture or sputum)	25%
Malaria	25%
Multiple Sclerosis	25%

Specified Disease	Percentage of Basic Benefit Amount
Muscular Dystrophy	25%
Myasthenia Gravis	25%
Necrotizing fasciitis	25%
Osteomyelitis	25%
Poliomyelitis	25%
Rabies (Covered under the Recurrence Benefit)	25%
Sickle Cell Anemia	25%
Systemic Lupus	25%
Systemic Sclerosis (Scleroderma)	25%
Tetanus	25%
Tuberculosis	25%

policy specifications

PLEASE READ YOUR CERTIFICATE CAREFULLY. This section details the specifics of the policy and includes: Eligibility, Dependent Coverage, Termination of Coverage, and Limitations and Exclusions.

The policy provides coverage only for the critical illnesses indicated. It does not cover any other disease, sickness or incapacity, unless specifically stated.

Eligibility - Your employer determines the criteria for eligibility (such as length of service and hours worked each week).

Dependent Coverage - 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.

Coverage Subject to the Policy - The coverage described in the certificate of insurance is subject in every way to the terms of the policy that is issued to the policyholder (your employer). It alone makes up the agreement by which the insurance is provided. The policy may be amended or discontinued by agreement between Allstate Benefits and the policyholder in accordance with the terms of the policy. Your consent is not required for this. Allstate Benefits is not required to give you prior notice.

Termination of Coverage - Your coverage under the policy ends on the earliest of: the date the policy is canceled by the policyholder; or the last day of the period for which you made any required premium payments; or the last day you are in active employment, except as provided under the "Leave of Absence" provision; or the date you are no longer in an eligible class; or the date your class is no longer eligible. • If your spouse is a covered person, the 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 your dependent child ends on the certificate anniversary next following the date your child is no longer eligible for coverage under the terms of the policyholder's Health and Welfare Plan. Coverage may be eligible for continuation as described in the Portability Provision.

Pre-existing Condition Definition and Limitation - A pre-existing condition means any critical illness for which you or each covered family member has sought medical advice or treatment in the 12 months immediately before the effective date of 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 you or each covered family member being diagnosed previously with the critical illness. • Some critical illness benefits 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 you or each covered family member 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 you or each covered family member 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 in this brochure 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 on this page. For those benefits, unless the benefit for the particular critical illness states otherwise, if you or a covered family member has a critical illness that has been diagnosed prior to the 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 you or each covered family member.

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

Transportation Benefit - We do not pay for: transportation for someone to accompany or visit you or a covered family member receiving treatment; visits to a physician's office or clinic; or for other services. The benefit will not be paid if you or your covered family members live within 100 miles one-way of the treatment facility.

This material is valid as long as information remains current, but in no event later than March 1, 2013. Group Voluntary Critical Illness benefits provided by policy form GCIPWM. Major Organ Transplant Rider provided by rider R1CIPWM. The policy does not provide benefits for any other sickness or condition. The policy is not a Medicare Supplement Policy.

The policy and rider provide supplemental, limited benefit insurance. This is a brief overview of the coverage underwritten by American Heritage Life Insurance Company. For costs and complete details, exclusions, and limitations, contact the Allstate Benefits Walmart call center at 1-800-514-9525. Or, go to www.allstateatwork.com/walmart.