AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

A Stock Company

(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.

Secretary

President

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

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GENERAL PROVISIONS

COVERAGE SUBJECT TO POLICY

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

ELIGIBILITY OF DEPENDENTS

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

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

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

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

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.

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.
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

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.

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.

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.

PREMIUMS

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

WAIVER OF PRE-EXISTING CONDITION DEFINITION AND LIMITATION

If you were insured by the policy prior to January 1, 2012, we will waive the Pre-existing Condition Definition and Limitation provision for those covered benefits that:

1. were available prior to January 1, 2012; and
2. satisfied the Pre-existing Condition Limitation provision under the prior coverage.

This waiver of the Pre-existing Condition Definition and Limitation provision does not apply to Benign Brain Tumor; Coma; Complete Loss of Hearing; Complete Loss of Sight; Dismemberment; Paralysis; and Parkinson's Disease.

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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.

Portability coverage will also be available for a covered person with a Basic Benefit Amount in excess of $20,000 on the effective date of this amendment. The excess amount over $20,000 will be provided as portability coverage. Claims already paid toward the maximum total percentage of 200% of the basic benefit amount will still apply to the excess amount provided as portability coverage. We must receive a request for portability of the excess amount and payment of the first premium for the portability coverage not later than 30 days after the effective date of this amendment.

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 according to the terms of the policyholder’s Health and Welfare Plan; 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.

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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 this 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. The 200% includes any basic benefit amounts previously paid to for each covered person under any other American Heritage Life Insurance Company Group Critical Illness certificate sponsored by the policyholder's Health and Welfare Plan.

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 and Transient Ischemic Attacks (TIA's):** The date a stroke or transient ischemic attack 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.
- **For Benign Brain Tumor:** The date neurological symptoms and deficiencies were documented by a physician to have first occurred after the covered person's effective date of coverage.
- **For Coma:** The first day of the period for which a physician confirms a coma has lasted for 7 consecutive days.
- **For Complete Loss of Hearing:** The date the audiologist makes an accurate certification of total and permanent hearing loss in both ears.
- **For Complete Loss of Sight:** The date the opthamologist makes an accurate certification of total and permanent loss of sight in both eyes.
- **For Dismemberment:** The date the actual dismemberment for the covered person occurs.
- **For Paralysis:** The date a physician establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.
- **For Parkinson's Disease:** The date diagnosis is established by a physiatrist or neurologist based on clinical and/or diagnostic findings as supported by the covered person's medical records.

A. INITIAL CRITICAL ILLNESS BENEFIT (Continued)

Pre-existing Condition Definition and Limitation

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.

1. **Heart Attack, Stroke and Transient Ischemic Attack (TIA's).** We will pay a benefit for the following heart attack, stroke and transient ischemic attack 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.

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

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.

Critical Illness	Percentage of Basic Benefit Amount
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.

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

A. INITIAL CRITICAL ILLNESS BENEFIT (Continued)

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.

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

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 the policy.

Critical Illness	Percentage of Basic Benefit Amount
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 the policy.

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%

A. INITIAL CRITICAL ILLNESS BENEFIT (Continued)

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

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.

Critical Illness	Percentage of Basic Benefit Amount
Benign Brain Tumor	50%

8. Coma. We will pay a benefit for the following 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.

Critical Illness	Percentage of Basic Benefit Amount
Coma	100%

9. Complete Loss of Hearing. We will pay a benefit for the following critical illness if a covered person is diagnosed with the critical illness, provided that:

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.

Complete loss of hearing 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.

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

10. Complete Loss of Sight. We will pay a benefit for the following critical illness if a covered person is diagnosed with the critical illness, provided that:

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.

Complete loss of sight 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.

Critical Illness	Percentage of Basic Benefit Amount
Loss of sight in both eyes	100%
Loss of sight in one eye	50%

A. INITIAL CRITICAL ILLNESS BENEFIT (Continued)

11. Dismemberment. We will pay a benefit for the following 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.

Dismemberment 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.

Critical Illness	**Percentage of Basic Benefit Amount**
Both arms or both legs	100%
Both feet, hands, arms or legs	100%
One foot, hand, arm or leg	50%
One or more fingers and/or one or more toes	25%

12. Paralysis. We will pay a benefit for the following 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.

Paralysis 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.

Critical Illness	**Percentage of Basic Benefit Amount**
Quadriplegia (Paralysis of 4 limbs)	100%
Paraplegia (Paralysis of 2 limbs)	50%

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

Parkinson'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.

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

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.

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 or any Walmart Center of Excellence as defined in the policyholder's Health and Welfare Plan as a result of a previous diagnosis of a covered 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 or Walmart Center of Excellence is more than 100 miles from the covered person's home.

The reason for such evaluation or consultation at an NCI-sponsored cancer center or Walmart Center of Excellence 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.

G. SKIN CANCER BENEFIT. We pay $250 if a covered person is diagnosed with skin cancer if:

1. The date of diagnosis is after the effective date of coverage; and
2. The date of diagnosis is while the policy is in force; and
3. It is not excluded by name or specific description in the policy.

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

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CLAIM INFORMATION

NOTICE OF CLAIM

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

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

FILING A CLAIM

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

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

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.

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

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

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

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

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

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

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

Benign brain tumor does not include: tumors of the skull; or pituitary adenomas; or germanomas.

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 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.

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

Coma does not include a medically induced coma.

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.

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

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

Complete Loss of Sight. Means the permanent and uncorrectable loss of sight in both eyes due to sickness and certified by an ophthalmologist with:
1. sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (snellen or E-chart Acuity); or
2. visual field restriction to 20 degrees or less in both eyes.

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.

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

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

Guaranteed Issue Limit. Means the maximum basic benefit amount of $20,000 for which you and your eligible dependents may enroll without requiring evidence of insurability.

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.

Non-Tobacco. Means no use of tobacco for 30 or more consecutive days.

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.

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

Parkinson's Disease. Means a brain disorder that is diagnosed by a physiatrist or neurologist, resulting in the inability to perform, independently, 3 or more of the activities of daily living.

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.

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

GLOSSARY (Continued)

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.

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

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.

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

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.

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STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as division offices, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people who operate your Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including the Employer or any other person, may fire or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request materials for the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. Generally, you must complete the appeals process before filing a law suit against the Plan. However, you should consult with your own legal counsel in determining when it is proper to file a law suit against the Plan.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest regional office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration publications hotline at (866) 444-3272 or by logging on to the Internet at www.dol.gov/ebsa.

ADMINISTRATIVE INFORMATION

Plan Year: January 1 through December 31

Plan Number: 501

Type of Plan: Welfare benefit plan

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

Plan Sponsor:
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.

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.

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A Stock Company

MAJOR ORGAN TRANSPLANT RIDER

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

DEFINITIONS

Certificate. The certificate to which this rider is attached.

Date of Diagnosis. Means the date the actual surgery occurs for covered transplants.

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.

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.

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

MAJOR ORGAN TRANSPLANT BENEFIT

Subject to the pre-existing condition limitation, we pay the basic benefit amount for this rider if a covered person receives a major organ transplant, as defined, subject to all of the following:

1. the date of diagnosis is after the rider effective date; and
2. the date of diagnosis is while this optional rider is in force; and
3. a recommendation for major organ transplant has not been made by a physician prior to the covered person’s effective date of coverage under this rider; and
4. the transplant is not excluded by name or specific description; and
5. we have not paid a benefit for the covered person for this organ transplant before.

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

Claims for organ transplant benefits under this rider not satisfying all the criteria for diagnosis may be subject to review by an independent physician consultant.

The organ transplant must be performed by a physician. Emergency situations that occur while the covered person is outside the United States may be reviewed and considered for approval by a United States physician on foreign soil or when the covered person returns to the United States.

LIMITATIONS AND EXCLUSIONS

The Limitations and Exclusions provision of the policy and certificate applies to this 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 this rider, coverage for that transplant is excluded and no benefit will be paid for the transplant of that organ.

PRE-EXISTING CONDITION LIMITATION

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

TERMINATION

This rider terminates at the earliest of:

1. the end of the grace period for the payment of the premium for the policy and this rider; or
2. the date the policy terminates.

A covered person's coverage under this rider terminates at the earliest of:

1. the date the covered person is no longer eligible as defined in the policy; or
2. the date the insured employee is no longer eligible based upon the policyholder's Health and Welfare Plan; or
3. the date that each covered person has received the basic benefit amount for this rider.

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

Secretary

President

Important Privacy Policy Notice

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

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

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

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

What do we do with your information?

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

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

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

These persons or organizations may include:

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

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

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

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

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

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

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

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

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

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

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

American Heritage Life Insurance Company
First Colonial Insurance Company
Bluegrass Life Insurance Company
Acme United Insurance Company
SMA Life Assurance Company
Northbrook Indemnity Company
Holiday Life Insurance Company
Concord Heritage Life Insurance Company
Kentucky Home Mutual
Keystone State Life
National Guardian Life

NOTICE OF PRIVACY PRACTICES

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

EFFECTIVE APRIL 14, 2003

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

This Notice applies to "Medical Information" associated with "Health Plans" issued by:

- American Heritage Life Insurance Company

This Notice describes how we may use and disclose Medical Information to perform claims handling, payment, general insurance operations, and for other purposes that are permitted or required by law.

We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all of your Medical Information that we maintain, including any information we created or received prior to issuing the new notice. If we do revise our Privacy Notice, copies will be sent to you if you are then currently insured under our Plan.

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

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

Uses and Disclosures of Medical Information With Your Written Authorization

Except as described in the next section of this Notice, we will not use or disclose your Medical Information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing at any time. However, any action already taken by the Plan or others in reliance on the authorization cannot be changed.

Uses and Disclosures of Medical Information Without Your Written Authorization

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

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

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

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

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

To Our Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these may include, but are not limited to our duly appointed insurance agents, financial auditors, reinsurers, legal services, enrollment and billing services, claim payment and

medical management services. We may provide access to your Medical Information without your written authorization to one or more of these outside persons or organizations who assist us with payment or Plan administrative operations. We require these business associates to appropriately safeguard the privacy of your information.

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

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

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

- We may release your Medical Information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.

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

- We may release your Medical Information for public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.

- We may release your Medical Information as required by law if we suspect child abuse or neglect or if we believe you to be a victim of abuse, neglect or domestic violence.

- We may disclose your Medical Information to the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls.

- We may release your Medical Information to law enforcement officials as required by law to report wounds, injuries or crimes.

- We may release your Medical Information to coroners and/or funeral directors consistent with law.

- We may release your Medical Information for a national security or intelligence activity or, if you are a member of the military, as required by the armed forces.

- We may release your Medical Information to workers' compensation agencies if necessary for your workers' compensation benefit determination.

Your Rights

Right to Inspect and Copy Your Medical Information. You may have access to our records that contain your Medical Information in order to inspect and obtain copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from our Privacy Officer and submit the completed form to our Privacy Office. If you request copies, we may charge you copying and mailing costs.

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

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

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

Right to Request Restrictions on Use and Disclosure of Your Medical Information. You have the right to request restrictions on some of our uses and disclosures of your Medical Information for medical treatment, payment, or Plan administrative operations by notifying us of your request for a restriction in writing mailed to the contact identified at the end of this Notice. Your request must describe in detail the restriction you are

requesting. We are not required to agree to your restriction request but will attempt to accommodate your requests. We retain the right to terminate an agreed-to restriction. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination, but the termination will only be effective for Medical Information we receive after we have notified you of the termination. You also have the right to terminate any agreed-to restriction by contacting us using the "Contact Information" provided at the end of this Notice.

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

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

Complaints

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

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

Contact Information

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

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

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

IMPORTANT NOTICE

To obtain information or to make a complaint:

You may call or write us at:

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

1-800-521-3535

You may also contact your agent by calling or writing:

AGENT NAME : John Doe
AGENT NUMBER : 33333
TELEPHONE NO : (999) 999-9999
ADDRESS : 1234 Anyplace Drive
Anytown, Anywhere 88888

You may contact the Arkansas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-852-5494

You may write the Arkansas Department of Insurance at:

1200 W. Third Street
Little Rock, Arkansas 72201

ATTACH THIS NOTICE TO YOUR POLICY:

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

ARCN

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

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

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

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

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net coverage is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

The Guaranty Association also does NOT provide coverage for:

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

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.