Critical Illness Insurance helps cover costs associated with diagnosis and treatment

Critical Illness Insurance

Group Voluntary Critical Illness coverage from Allstate Benefits provides a lump-sum cash benefit to help cover the out-of-pocket expenses associated with critical illnesses.

Meeting Your Needs

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

- Choose a basic-benefit option in $5,000 increments, from $5,000 - $20,000.
- Benefits payable for critical illness and specified diseases.
- Premiums are affordable.
- Benefits paid directly to you unless you choose to sign them over to someone else.
- Coverage options include: you, you and your spouse/domestic partner, you and your child(ren), or family. Coverage for spouse/domestic partner and child(ren) is only available if you enroll.
- Spouse/domestic partner and child(ren) may receive the same basic-benefit option as you.
- Section 125 qualified, so you can pay your premiums with pre-tax dollars. There could be tax consequences, so please consult with your tax advisor.

Benefit coverage for

Walmart Associates

Effective 1/1/2020

What can living with a Critical Illness mean to you and your family?

Paying for daily out-of-pocket expenses for fighting the disease while still paying your bills!

MORTGAGE

DOCTORS

MEDICINES

Meet Jasmine

Jasmine is like anyone else who has been diagnosed with heart disease. She is concerned about her family and how they will cope with her disease and its treatment. Most importantly, she worries about how she will pay for her treatment.

Here's how Jasmine's story of diagnosis and treatment turned into a happy ending, because she had supplemental Critical Illness Insurance to help with expenses.

CHOOSE

Jasmine chooses $20,000 in Critical Illness coverage plus the recurrence benefit to help cover the expenses associated with a critical illness diagnosis.

Jasmine thinks about the high cost of having heart disease, a stroke or coronary artery bypass surgery. She considers the gaps in her medical coverage and how the costs could have a significant impact on her hard-earned savings, lost income, child care, travel expenses, prescription drugs and mortgage payments. Our Critical Illness coverage helps offer peace of mind when a critical illness diagnosis occurs.

USE

1st Event

Jasmine is at home and suffers a heart attack.

2nd Event

18 mos. later - Jasmine is at work, suffers a second heart attack and is rushed to the hospital. Upon arrival at the hospital, Jasmine undergoes coronary artery bypass surgery. Jasmine is expected to fully recover, and her condition continues to improve daily.

CLAIM

Our Critical Illness insurance policy provided Jasmine the following:

Heart Attack	$ 20,000
Recurrence (Second Heart Attack)	$ 20,000
Coronary Artery Bypass	$ 20,000
Total Cash Benefits	$ 60,000

Your Benefit Coverage

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

How to Get Started

Choose your benefit amount in $5,000 increments, from $5,000 to $20,000. No proof of good health is required. Make sure to select coverage for you, you and your spouse/domestic partner, you and your child(ren), or your entire family.

DID YOU KNOW ?

Stroke —

Stroke is a leading cause of serious, long-term disability in the United States.[1]

[1] Centers for Disease Control and Prevention, 2017, https://www.cdc.gov/stroke/facts.htm

Initial Critical Illness Benefit - A benefit will be paid for heart attack, stroke, transient ischemic attack, coronary artery bypass surgery, invasive cancer or carcinoma in situ, end stage renal failure, ruptured or dissecting aneurysm, advanced Parkinson's, Alzheimer's disease, or a specified disease (see benefit descriptions below and on the next page).

The amount payable for each critical illness is the percentage next to that critical illness multiplied by the basic-benefit amount applicable to each covered person. Benefits are payable only once for each initial occurrence of a critical illness per covered person, provided the date of diagnosis occurs after the effective date of coverage, occurs while you are insured, meets the definition in the policy, and is not excluded by name or specific description; and we have not paid an initial critical illness benefit for it before.

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

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

Coronary Artery Bypass Surgery (100%) - The benefit amount you have chosen will be paid for coronary artery bypass surgery if you or a covered family member are diagnosed with the critical illness.

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

Skin Cancer - $500 will be paid if you are diagnosed with skin cancer. The date of diagnosis must occur after your effective date while the policy is in force and must not be excluded by name or specific description in the policy. We pay this benefit once per year for each covered person. A 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. Skin Cancer means basal cell carcinoma and squamous cell carcinoma. For the purposes of the 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. See previous "Cancer" benefit for melanoma that is covered.

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

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

Complete Loss of Hearing (100%) - The benefit amount you have chosen will be paid if you suffer a total and irreversible loss of hearing in both ears for 6 consecutive months after the sickness 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. The date of diagnosis for Complete Loss of Hearing is the date the audiologist makes an accurate certification of total and permanent hearing loss.

Benign Brain Tumor (100%) - The benefit amount you have chosen will be paid for a non-cancerous brain tumor that is confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination and resulting in persistent neurological deficits including but not limited to loss of vision, loss of hearing, or balance disruption. Benign brain tumor does not include tumors of the skull, pituitary adenomas, or germinomas. The date of diagnosis for Benign Brain Tumor is the date a physician determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Coma (100%) - The benefit amount you have chosen will be paid for continuous profound state of unconsciousness lasting 7 or more consecutive days due to an underlying sickness. It is associated with severe neurologic dysfunction and unresponsiveness of a prolonged nature requiring significant medical intervention and life support measures. Coma does not include a medically induced coma. The date of diagnosis for Coma is the first day of the period for which a physician confirms a coma has lasted for 7 consecutive days.

Paralysis (100% Quadriplegia and 100% Paraplegia) - The benefit amount you have chosen will be paid for the total and permanent loss of voluntary movement or motor function of 2 or more limbs as the result of sickness. The date of diagnosis for Paralysis is the date a physician establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.

Parkinson's Disease (100% loss of 2 ADLs) - The benefit amount you have chosen will be paid for Parkinson's disease that causes the covered person to be incapacitated. Parkinson's disease is a brain disorder that is diagnosed by a psychiatrist or neurologist resulting in the insured requiring substantial physical assistance from another adult to perform at least 2 of the activities of daily living (ADLs).*

Benefit Limitation - We will not pay benefits for Parkinson's Disease if the covered person was diagnosed with Parkinson's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage. Date of diagnosis for Advanced Parkinson's Disease is the date a physician diagnoses the covered person as incapacitated due to Parkinson's disease.

Complete Loss of Sight (100% both eyes and 100% one eye) - The permanent and uncorrectable loss of sight in both eyes certified by an ophthalmologist with sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-chart Acuity), or visual field restriction to 20 degrees or less in both eyes. The date of diagnosis for Complete Loss of Sight is the date an ophthalmologist makes an accurate certification of complete loss of sight.

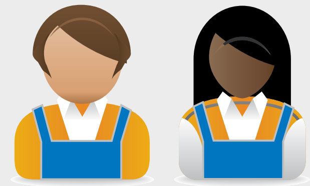
Dismemberment - The benefit amount you have chosen will be paid for the following critical illness if a covered person is diagnosed with the critical illness, provided that: the date of diagnosis is after the effective date of coverage; and the date of diagnosis is while insured; and the critical illness is not excluded by name or specific description; and we have not paid an initial critical illness benefit for this critical illness before. Dismemberment that is diagnosed prior to the effective date of coverage is excluded and is never covered under this policy.

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

Specified Disease (50%) - The benefit amount you have chosen will be paid** for one of the covered specified disease critical illnesses (see chart on page 6). If you or a covered family member are diagnosed with the critical illness or a specified disease prior to the effective date of coverage, it will be excluded and never covered under the policy.

* Activities of daily living include: bathing, dressing, toileting, eating, or taking medication.

** Some restrictions apply. See limitations and exclusions on page 8.



Don't Wait for a Sign

There are different signs that doctors look for when diagnosing critical illnesses. Being diagnosed with a critical illness can be one of the most frightening experiences anyone has to face, especially if you are unprepared. Don't wait before you start thinking about the future of your finances. You can rely on our Critical Illness Insurance to help give you peace of mind so you can cope with the challenges of treatment.

Budget Friendly

Sometimes, undergoing expensive treatments for a critical illness is difficult if your money is tight. That's where we can help. Our supplemental benefit coverage pays in addition to your major medical insurance to help provide additional dollars that may be used to cover your out-of-pocket expenses.

Let our supplemental insurance help you and your family cover expenses for a critical illness, if and when one occurs. It's the financially smart thing to do.

It's never too early to prepare for the future.

Additional Benefit Coverage

In addition to the Initial Critical Illness benefits included in the policy, additional benefits have been added to provide you and your covered family members enhanced coverage.

Recurrence Benefit (100%) - **A benefit will be paid at 100% of the Initial Critical Illness Benefit** for you or each covered family member if diagnosed with another occurrence of a covered critical illness paid under the Initial Critical Illness Benefit. The benefits covered include: Heart Attack, Stroke, Coronary Artery Bypass Surgery, Ruptured or Dissecting Aneurysm, Invasive Cancer, Carcinoma in situ, Rabies, Benign Brain Tumor, and Coma. Payment is subject to the following conditions: the same condition is excluded for 180 days after the prior occurrence; and for the cancer-related benefits, the covered person must be symptom- and treatment-free during the 180 days after the prior occurrence.

Ruptured or Dissecting Aneurysm (25%) - **A benefit will be paid** for a ruptured or dissecting aneurysm if a covered person is diagnosed with the critical illness and undergoes surgery, provided that the date of diagnosis is after the effective date of coverage; and the date of diagnosis is while insured; and the critical illness is not excluded by name or specific description; and we have not paid an initial critical illness benefit for the critical illness before. The date of diagnosis is the date of the rupture or dissection as determined by ultrasound, CT Scan, Angiogram or MRI. A ruptured or dissecting aneurysm that is diagnosed prior to the effective date of coverage is excluded and is never covered under this policy.

National Cancer Institute (NCI) Evaluation - **A $500 benefit will be paid** for you or each covered family member who receives an evaluation or consultation at an NCI-sponsored cancer center as a result of a previous diagnosis of a covered internal cancer. **A $250 benefit will be paid** for transportation and lodging if the NCI-sponsored cancer center is more than 100 miles from the covered person's home. The reason for such evaluation or consultation at an NCI-sponsored cancer center must be to determine the appropriate treatment for a covered cancer. ***This benefit is paid once per initial and recurrence diagnosis of invasive cancer or carcinoma in situ.***

Transportation Benefit - **This benefit will pay the actual cost, up to $1,500** for round-trip transportation to a treatment center. Coach fare transportation on a common carrier or a personal vehicle allowance of $0.50 per mile, up to $1,500 will be covered. Transportation must be required for treatment of a covered critical illness at a hospital (inpatient or outpatient); or radiation therapy center; or chemotherapy or oncology clinic; or any other specialized free-standing treatment center. Mileage is measured from a covered person's home to the treatment facility as described above. If the treatment is for a covered child and common carrier travel is necessary, we will pay this benefit for up to two adults to accompany the child.

Lodging Benefit - **A $60 benefit will be paid daily** for you or each covered family member receiving treatment for a critical illness on an outpatient basis. The benefit is for lodging at a motel, hotel, or other accommodations acceptable to us. This benefit is limited to 60 days per calendar year and is not payable for lodging occurring more than 24 hours prior to treatment, or for lodging occurring more than 24 hours following treatment. Outpatient treatment must be received at a treatment facility more than 100 miles from your or your covered family member's home.

Ambulance - **A $250 ground ambulance or $2,000 air ambulance benefit will be paid** for you or each covered family member who requires ambulance transportation to a hospital or emergency center as a result of a covered critical illness. Service must be provided by a licensed professional ambulance company.

Post-Traumatic Stress Disorder† - **A $100 benefit will be paid** each day a covered person receives counseling for post-traumatic stress disorder (PTSD). This benefit is payable only once per day per covered person, and is limited to 6 days per coverage year. PTSD is a mental health condition that is triggered by a terrifying event. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event. Post-traumatic stress disorder is diagnosed based on signs and symptoms and a thorough psychological evaluation. The PTSD diagnosis is made using the following criteria: the covered person experienced or witnessed an event that involved death or serious injury, or the threat of death or serious injury; their response to the event involved intense fear, horror or a sense of helplessness; they relive experiences of the event; they try to avoid situations or things that remind them of the traumatic event; their symptoms last longer than one month; their symptoms cause significant distress in their life or interfere with their ability to perform normal daily tasks.

†The PTSD Critical Illness Benefit is payable when a covered person has received this diagnosis by a licensed mental health professional and is receiving group or individual therapy, or both.

Enhancing Your Coverage

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

Major Organ Transplant Rider (100%)* -

Candidate Benefit - The benefit amount you have chosen will be paid when you or any covered family member are added to the National Transplant List as a candidate for a major organ transplant. The Candidate Benefit is not payable if we previously paid the Candidate Benefit on the covered person for any reason; or the Surgery Benefit on the covered person for the same major organ.

Surgery Benefit - We pay the basic benefit amount for this rider if a covered person undergoes a major organ transplant performed by a physician. Emergency situations that occur while the covered person is outside the United States may be reviewed and considered for approval by a United States physician on foreign soil or when the covered person returns to the United States. The Surgery Benefit is not payable if we previously paid the Candidate Benefit on the covered person for the same major organ. If we paid the Candidate Benefit for a covered person listed as a candidate for multiple major organ transplants, only the first major organ transplanted will be considered the same major organ.

NOTE: If you are enrolled in the HSA plan, you are not eligible for the Major Organ Transplant Rider.

Termination -

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

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

Specified Disease Percentage Chart

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

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

Policy Specifications

PLEASE READ YOUR POLICY CAREFULLY.

This section details the specifics of the policy and includes Eligibility, Dependent Coverage, Coverage Subject to the Policy, Termination of Coverage, and Limitations and Exclusions.

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

Eligibility

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

Dependent Coverage

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

Coverage Subject to the Policy

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

Termination of Coverage

Your coverage under the policy ends on the earliest of: the date the policy is canceled by the policyholder; or the last day of the period for which you made any required premium payments; or the last day you are in active employment, except as provided under the "Leave of Absence" provision; or the date you are no longer in an eligible class; or the date your class is no longer eligible. If your spouse/domestic partner is a covered person, the spouse's/domestic partner's coverage ends upon valid decree of divorce, end of partnership or your death, or when you move to an eligible class that does not provide spouse/domestic partner coverage. Coverage for your dependent child(ren) ends on the next certificate anniversary following the date your child is no longer eligible for coverage under the terms of the policyholder's Health and Welfare Plan. Coverage may be eligible for continuation as described in the Portability Provision.

Limitations and Exclusions

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

Transportation Benefit

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

Register your account and get started today at www.AllstateBenefits.com/MyBenefits
For more information about your Critical Illness plan, visit www.AllstateAtWork.com/Walmart

This brochure is for use in enrollments sitused in AR.

Rev. 1/20. This material is valid as long as information remains current, but in no event later than January 15, 2023. Group Voluntary Critical Illness benefits provided by policy form GCIPWM. Major Organ Transplant Rider provided by rider R1CIPWM1. The policy does not provide benefits for any other sickness or condition. The policy is not a Medicare Supplement Policy.

The coverage provided is limited benefit supplemental critical illness insurance. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from Allstate Benefits.

This is a brief overview of the benefits available under the group policy underwritten by American Heritage Life Insurance Company (Home Office, Jacksonville, FL). Details of the coverage, including exclusions and other limitations are included in the certificates issued. For additional information, contact the Allstate Benefits Walmart call center at 1-800-514-9525 or go to www.allstateatwork.com/walmart.

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

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