2020 Associate Benefits Book

Summary Plan Descriptions with 2021 Summaries of Material Modifications

What's inside

- Medical plan
- Pharmacy benefit
- Dental plan
- Vision plan
- Life insurance and disability plans
- Associate Stock Purchase Plan
- Walmart 401(k) Plan
- 2021 Summaries of Material Modifications

Effective **January 1, 2020**

Walmart 401(k) Plan effective **February 1, 2020**

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Information obtained during communications with Walmart Inc. or any Plan service provider does not waive any provision or limitation of the Plan. Information given or statements made through any form of communication do not guarantee payment of benefits. In addition, benefits quotes that are given by phone are based wholly on the information supplied at the time. If additional relevant information is discovered, it may affect payment of your claim. All benefits are subject to eligibility, payment of premiums, limitations, and all exclusions outlined in the applicable Plan documents, including any insurance policies. You can request a copy of the documents governing these plans by writing to: Custodian of Records, People Services, 508 SW 8th Street, Bentonville, Arkansas 72716-3500.

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O puede llamar para cualquier pregunta al 800-421-1362. Tenemos asociados quienes hablan Español y pueden ayudarles a Ud comprender sus beneficios de Walmart. El Libro de beneficios para asociados esta disponible en Español. Si usted desea una copia en Español, favor de ver su Representante de Personal.

Welcome to your 2020 Associate Benefits Book

This is where you'll find the Summary Plan Descriptions (SPDs) for the Associates' Health and Welfare Plan (the Plan), and the Walmart 401(k) Plan.

The prospectus for the Associate Stock Purchase Plan is here, too.

Check out the table of contents for a complete list of what you'll find in this book. It's a great resource to help you understand your benefits.

This is also where you'll find the **2021 Summary of Material Modifications to the Associates' Health and Welfare Plan** and the **2021 Summary of Material Modifications to the Walmart 401(k) Plan**. The addition of these "SMMs" brings the 2020 *Associate Benefits Book* up to date for another year. You'll find the SMMs on page 296, along with several important legal notices.

Throughout this book you'll also see many spots where we have alerted you to details that have been updated in one of the SMMs—look for the page icon like the one to the left. When you see that, you'll know where to turn to find the most current information.

Lots of information. So easy to find.

When you download the 2020 *Associate Benefits Book* from **One.Walmart.com**, you'll have answers to your benefit questions at your fingertips.

Just launch the PDF with Adobe Reader and click "Edit" on the toolbar. Then click "Find," and enter a word or phrase that describes what you're looking for, like "preventive" or "copay." Easy!

Key words

Many of the terms used throughout the 2020 *Associate Benefits Book* may be unfamiliar to you, or have specific meanings within the context of the Plans. You'll find many of them defined in the **Glossary** on page 294, and we have also included important definitions at critical points throughout the text.

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If you have Medicare or will become eligible for Medicare in the next 12 months, you have more choices for your prescription drug coverage. See page 287 in the **Legal information** chapter for more details. **See page 332**

Eligibility and enrollment

RESOURCES		
Find What You Need	**Online**	**Other Resources**
• Enroll in Walmart benefits • Notify People Services within 60 days of a status change event	Go to **One.Walmart.com** or **Workday** for Jet associates	Call People Services at **800-421-1362**
Notify People Services if you have questions about the payroll deductions for your benefits		Call People Services at **800-421-1362**
Pay premiums for benefits while on a leave of absence		See **Continuing benefit coverage if you go on a leave of absence** in this chapter for detailed information. If you are required to pay your premiums to keep coverage current, you must pay the premiums to keep coverage current. You may pay by credit or debit card with a Visa, MasterCard, American Express, or Discover card by calling **800-421-1362** and saying "make a payment." You may also send a check or money order payable to the Associates' Health and Welfare Trust to: **Walmart People Services** **P.O. Box 1039** **Department 3001** **Lowell, Arkansas 72745** To ensure timely posting of your payment, be sure to include your WIN (Walmart ID) number on the check.

What you need to know about eligibility and enrollment

- You can enroll for benefits during your initial enrollment period as a newly eligible associate, during Annual Enrollment, or when you have a status change event.
- Your job classification (or changes to your job classification) determines when your initial enrollment period begins. If you are a Hawaii associate, see the **Eligibility and benefits for associates in Hawaii** chapter.
- Medical, dental, vision, critical illness, accident, and accidental death and dismemberment (AD&D) insurance benefits cannot be changed except during Annual Enrollment or after you have a status change event.
- If you choose to enroll in the short-term disability enhanced, long-term disability, or truck driver long-term disability benefits options, you may drop your coverage at any time, but you will only be able to add this coverage again during an initial enrollment period, Annual Enrollment, or when you have a status change event.
- You may enroll in, drop, or change optional life insurance benefits at any time but if you enroll after your initial enrollment period, you will have to provide Proof of Good Health.

See page 298

The Associates' Health and Welfare Plan

The Associates' Health and Welfare Plan (the Plan) is a comprehensive employee benefit plan that offers medical, dental, vision, critical illness insurance, accident insurance, AD&D, business travel accident insurance, life insurance, disability, and Resources for Living (employee assistance and wellness) benefits to eligible associates and their eligible dependents. Eligibility for these benefits is described in this chapter, and the terms and conditions for these benefits are described in the applicable chapters of this 2020 *Associate Benefits Book*. The Plan is sponsored by Walmart Inc. (the company).

You are automatically enrolled for certain benefits under the Plan on your date of hire or a later date. For other benefits, however, you must enroll to have coverage. Refer to the **Enrollment and effective dates by job classification** section in this chapter for details about initial enrollment periods and when coverage is effective, for all benefits available under the Plan.

Associate eligibility

The benefits you are eligible for depend on a number of factors, which may include your date of hire, average weekly hours, and your job classification in the Walmart Inc. payroll system. In addition, for most benefits, you may be required to meet an eligibility waiting period. See the **Enrollment and effective dates by job classification** section in this chapter for a list of the benefits you are eligible for and for your eligibility waiting period based on your job classification.

Our expectation is that you will use correct and accurate information when applying for or enrolling in benefits. If you do not, you may be subject to the loss of benefits and/or loss of employment. To review Walmart's policy about intentional dishonesty, refer to the Statement of Ethics, which can be found on **One.Walmart.com**. See **Legal documentation for dependent coverage** later in this chapter for information about documents that may be requested of you to verify dependent eligibility.

NOTE: Your eligibility for benefits is determined by the eligibility rules detailed in this *Associate Benefits Book*. To the extent that any information provided to you through other sources conflicts with the *Associate Benefits Book*, the eligibility rules in the *Associate Benefits Book* will control.

MANAGEMENT ASSOCIATE ELIGIBILITY

To be eligible for benefits as a management associate, you must be classified in the company's payroll system as a management associate, management trainee, California pharmacist, or full-time truck driver.

FULL-TIME HOURLY ASSOCIATE ELIGIBILITY

To be eligible for benefits as a full-time hourly associate, you must be classified in the company's payroll system as a full-time hourly associate.

PART-TIME HOURLY ASSOCIATE ELIGIBILITY

To be eligible for benefits as a part-time hourly associate, you must be classified in the company's payroll system as a part-time hourly associate.

To be eligible to enroll in medical benefits, you must work an average of at least 30 hours per week, with the following exceptions:

- Part-time hourly pharmacists hired prior to February 1, 2012, do not need to work a minimum number of hours per week.
- Part-time hourly pharmacists hired on or after February 1, 2012, must work an average of at least 24 hours per week.
- Part-time hourly associates in the field supply chain must work an average of at least 24 hours per week.
- Part-time hourly nurse practitioners must work an average of at least 24 hours per week.

Part-time hourly associates are subject to the annual eligibility check process described later in this chapter, with the exception of part-time hourly pharmacists hired prior to February 1, 2012. The annual eligibility check determines your eligibility for medical benefits based on the number of hours you work on average in the 52-week period preceding the date of the annual eligibility check. For more information, see the section titled **Part-time hourly and temporary associates: eligibility checks for medical benefits**.

PART-TIME TRUCK DRIVER ELIGIBILITY

To be eligible for benefits as a part-time truck driver, you must be classified in the company's payroll system as a part-time truck driver. You do not need to work a minimum numbers of hours per week to be eligible to enroll in medical benefits as a part-time truck driver.

TEMPORARY ASSOCIATE ELIGIBILITY

To be eligible for benefits as a temporary associate, you must be classified in the company's payroll system as a temporary associate.

To be eligible to enroll in medical benefits, you must work an average of at least 30 hours per week, with the exception of temporary associates in the field supply chain, who must work an average of at least 24 hours per week.

Temporary associates are subject to the annual eligibility check process described later in this chapter. The annual eligibility check determines your eligibility for medical benefits based on the number of hours you work on average in the 52-week period preceding the date of the annual benefits eligibility check. For more information, see the section titled **Part-time hourly and temporary associates: eligibility checks for medical benefits**.

ASSOCIATES WHO ARE NOT ELIGIBLE

You are not eligible for the Plan if you fall in any of the following categories, even if you are reclassified by a court, the IRS, or the Department of Labor as a common-law employee of the company or any participating affiliate:

- A leased employee
- A nonresident alien (except for optional associate life insurance, optional dependent life insurance, accidental death and disability insurance, and business travel accident insurance, and unless covered under a specific insurance policy for expatriates or third-country nationals who are employed by the company)
- An independent contractor
- A consultant
- An associate residing outside the United States
- Not classified as an associate of the company or its participating affiliates
- An associate who is enrolled in Medicare Part D (applicable only to eligibility for medical plan options, including HMOs and the eComm PPO Plan), or
- An associate covered by a collective bargaining agreement, to the extent that the agreement does not provide for participation in the Plan.

ELIGIBILITY INFORMATION FOR ADDITIONAL ASSOCIATE CATEGORIES

Associates in HMOs and eComm PPO Plans: HMO and eComm PPO Plans are available for some work locations. The policies and enrollment materials for the HMO and eComm PPO Plans may describe different eligibility requirements and waiting periods than those described in this chapter. If there is any difference between the HMO's or eComm PPO Plan's eligibility terms and the eligibility terms of the Associates' Medical Plan (AMP) as described in this chapter, eligibility terms in this chapter will control.

In addition, some HMOs require participants to accept an arbitration agreement, where permitted by law, before coverage under the HMO will become effective. Your agreement must be received by the HMO within 60 days of your initial enrollment or your HMO coverage will not take effect. If the HMO does not receive your agreement, you will not have medical coverage under the Plan unless you have a valid status change event, as described later in this chapter.

Hawaii associates: Special rules govern benefits eligibility and enrollment in the state of Hawaii. If you are a full-time hourly, part-time hourly, or temporary associate in Hawaii, please refer to the chapter titled **Eligibility and benefits for associates in Hawaii**. For management associates in Hawaii, the eligibility and enrollment terms described in this **Eligibility and enrollment** chapter apply.

Localized associates: If you have been approved by the company as having localized status, you and your dependents residing in the United States are eligible for the same benefits under the Plan as associates who are United States citizens residing and working in the United States. Any applicable waiting period is waived. You are not eligible for expatriate coverage under the Plan. If you are a localized associate and an eligible dependent resides outside the United States, medical claims will be processed as network benefits regardless of the provider's network status and paid at the applicable copay or coinsurance rate for network charges, subject to applicable limitations and exclusions under the Plan. You or your enrolled dependents must file a claim for reimbursement under the Plan's claims procedures.

See page 298 *for important information for part-time hourly and temporary associates about eligibility checks.*

Part-time hourly and temporary associates: eligibility checks for medical benefits

INITIAL ELIGIBILITY CHECK FOR MEDICAL BENEFITS

If you are a part-time hourly or temporary associate (other than a part-time truck driver), your initial eligibility for medical benefits is determined during your initial measurement period. Your initial measurement period is the 52 consecutive weeks beginning on your date of hire, during which your average hours worked per week are reviewed.

If you work an average of at least 30 hours a week (24 hours a week for part-time nurse practitioners, part-time hourly pharmacists, part-time hourly and temporary associates in the field supply chain) over the 52-week review period without a break in employment greater than 13 weeks, you will become eligible for medical benefits at the close of your initial measurement period. Specifically, your eligibility for medical benefits will begin on the first day of the second calendar month following your one-year anniversary date. For example, if your date of hire is April 16, 2019, your average hours worked from that day through April 15, 2020 will be calculated. If you meet the average-hours-worked requirement over this initial measurement period, your coverage would begin June 1, 2020 (assuming you enroll in a timely manner).

Initial medical coverage for associates who meet the average-hours-worked requirement continues through the end of the second calendar year following date of hire. In the example above, your coverage (if you enroll in a timely manner) would continue through the end of 2021. You would then be subject to annual eligibility checks, as described below.

ANNUAL ELIGIBILITY CHECK FOR MEDICAL BENEFITS

If you are classified as a part-time hourly or temporary associate (other than a part-time truck driver or a part-time hourly pharmacist hired before Feb. 1, 2012), you will be subject to an annual eligibility check to establish your eligibility for medical benefits for the next calendar year. You will also be subject to the annual eligibility check if you were originally hired as a management or full-time hourly associate and were employed one year or more before changing to part-time hourly or temporary status.

The measurement period for the annual eligibility check will be the 52 weeks preceding an annually designated date in early October prior to each calendar year's Annual Enrollment. For example, the annual eligibility check occurring in fall 2020 (for the 2021 calendar year) will review your hours worked from October 5, 2019, through October 4, 2020. If you meet the average hours requirement (24 or 30 hours per week, depending on job classification) over the 52-week period, you will be eligible to enroll in medical benefits during Annual Enrollment for coverage during 2021.

If you do not meet the average weekly hours requirement in the annual eligibility check, your medical coverage may continue for a period of time, as described below under **If you do not meet the annual eligibility check for medical benefits**.

If you have questions about the annual eligibility check, call People Services at **800-421-1362**.

IF YOU MEET THE ANNUAL ELIGIBILITY CHECK FOR MEDICAL BENEFITS

If you are currently a part-time hourly or temporary associate who is enrolled for medical coverage and you meet the annual eligibility check in October, you will remain enrolled for medical coverage for the remainder of the current year. You will receive Annual Enrollment materials and be eligible to enroll for medical benefits for the following year.

You will be subject to the annual eligibility check each year to determine your eligibility for medical benefits for the following year.

IF YOU DO NOT MEET THE ANNUAL ELIGIBILITY CHECK FOR MEDICAL BENEFITS

If you are currently a part-time hourly or temporary associate who is enrolled for medical coverage, but you do not meet the annual eligibility check in October, you will remain enrolled for medical coverage for the remainder of the current calendar year. You will not be eligible for medical benefits for the following year unless your job classification changes and you meet the eligibility requirements based on your new classification. You will receive a letter describing your options under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue your medical coverage when the current calendar year ends. (See the **COBRA** chapter for more information.)

You will be subject to the annual eligibility check each year to determine your eligibility for medical benefits for the following year.

IF YOU TAKE TIME OFF DURING THE ANNUAL MEASUREMENT PERIOD FOR THE ELIGIBILITY CHECK

If you take any type of unpaid time off that is not an approved leave of absence, as described below, your number of actual service hours will still be used in the calculation of your average hours for the annual eligibility check (even if it is zero).

If your absence is an approved leave (including for jury duty, Family and Medical Leave Act of 1993 [FMLA] leave, or military leave), your average-hours-worked calculation will be based on the number of weeks during the 52-week measurement period that you worked. For example, if you take an approved leave during two weeks of the 52-week measurement period, your average hours worked will be calculated over 50 weeks rather than 52.

Dependent eligibility

If you are a management or full-time hourly associate and are eligible for benefits under the Plan, you may also enroll all eligible dependents as described below. If you are a part-time hourly or temporary associate or a part-time truck driver, and you are eligible for benefits under the Plan, you may also enroll only your dependent child; you may not enroll any other dependent.

EMPLOYMENT CLASSIFICATION	ELIGIBLE DEPENDENTS (AS DEFINED BELOW)
• Management • Full-time hourly	**Can elect to cover:** • Spouse/partner • Dependent child(ren)
• Part-time hourly • Temporary • Part-time truck driver	**Can elect to cover:** • Dependent child(ren) But *not* spouse/partner

DEFINITIONS: ELIGIBLE DEPENDENTS	
SPOUSE/PARTNER	• Your spouse, as long as you are not legally separated • Your domestic partner (or "partner"), as long as you and your domestic partner: – Are in an exclusive and committed relationship similar to marriage and have been for at least 12 months – Are not married to each other or anyone else – Meet the age for marriage in your home state and are mentally competent to consent to contract – Are not related in a manner that would bar a legal marriage in the state in which you live, and – Are not in the relationship solely for the purpose of obtaining benefits coverage. • Any other person to whom you are joined in a legal relationship recognized as creating some or all of the rights of marriage in the state or country in which the relationship was created (also referred to as "partner")
DEPENDENT CHILD(REN)	• Your dependent children through the end of the month in which the child reaches age 26. Your dependent children are: – Your natural children – Your adopted children or children placed with you for adoption – Your stepchildren or children of your eligible partner, provided however: • Eligibility will end upon divorce or change in partner status, even if the child is under age 26 • Eligibility will end upon death of your spouse or partner, if the child is under age 18, or • Eligibility will continue until age 26 in the event of the death of your spouse or partner, if at the time of death: i) the child has attained age 18, and ii) the child is enrolled in the Plan. – Your foster children – Someone for whom you have legal custody or legal guardianship, provided he or she is living as a member of your household and you provide more than half of his or her support

If an individual is your eligible dependent and subsequently no longer satisfies the definition of eligible dependent, that individual will no longer be eligible for coverage under the Plan and you are required to report the change. See **When your dependent becomes ineligible** later in this chapter for information. If you fail to report the change, you may be subject to the loss of benefits and/or loss of employment.

If a court order requires you to provide medical, dental, and/or vision coverage for your child, the child must be an eligible dependent as defined above. For more information on how the Plan handles a Qualified Medical Child Support Order (QMCSO), see the **Qualified Medical Child Support Orders (QMCSO)** section later in this chapter.

If you are enrolled in a medical plan option that does not offer out-of-network coverage and you have an eligible dependent living outside the service area of your medical plan, you may still enroll your eligible dependents, but they will not have access to network providers in the geographic area in which they live and may have access only to emergency coverage. If you are unsure if your eligible dependent lives outside your medical plan's service area, call your health care advisor at the number on your plan ID card.

IF YOUR CHILD IS INCAPABLE OF SELF-SUPPORT

If your child is enrolled for coverage under the Plan, you may continue the child's coverage beyond the end of the month in which your child reaches age 26 if:

- The child is physically or mentally incapable of self-support and primarily dependent on you for legal support, and
- The child's doctor provides written medical evidence of the child's incapacity.

Additional coverage may be added if your child experiences a valid status change event. For information regarding a status change event, refer to the **Status change events** section of this chapter.

Legal documentation for dependent coverage

The Plan reserves the right to conduct a verification audit of dependent eligibility. You may be required to provide legal documentation to prove the eligibility of your dependent. It is your responsibility to provide the written documentation if requested to do so by the Plan. If you do not provide necessary documentation in a timely manner, the Plan has the right to cancel your dependent's coverage until the requested documentation is received. It is your responsibility to notify the Plan of any changes in your dependent's eligibility.

Examples of valid documentation are as follows:

- **Spouse:** marriage certificate and jointly filed federal tax return
- **Domestic partner:** domestic partner affidavit and joint mortgage statement or rental agreement
- **Children:** state- or county-issued birth certificate or signed court order

Dependents who are not eligible

Your dependent is not eligible for coverage under the Plan if he or she is:

- Residing outside the U.S. (not applicable to optional dependent life insurance, AD&D, critical illness, and accident insurance, and not applicable if your dependent is attending college full-time outside the U.S.)
- Covered under an expatriate plan
- An undocumented immigrant
- Not an eligible dependent as defined under **Dependent eligibility** on the previous page
- A Walmart associate already enrolled in coverage under the Plan (not applicable to optional dependent life insurance, AD&D, critical illness, and accident insurance)
- A dependent of another Walmart associate and already enrolled in coverage under the Plan (not applicable to optional dependent life insurance, AD&D, critical illness, and accident insurance)
- Enrolled in Medicare Part D (applicable only to eligibility for medical plan options, including HMOs and the eComm PPO Plan)

When your dependent becomes ineligible

If your dependent is enrolled in coverage under the Plan and becomes ineligible for coverage, you must notify People Services at **800-421-1362** within 60 days from the date your dependent becomes ineligible. If you notify People Services within this time frame, the Plan will send an election notice, allowing you to elect Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage. Your dependent's election to enroll in COBRA coverage must be received within 60 days from the date your dependent loses coverage or the date of the election notice, if later. See the **COBRA** chapter for more information.

Failure to notify the Plan by calling People Services at **800-421-1362** when your dependent becomes ineligible for coverage may be considered an intentional misrepresentation of material facts, which may result in your coverage being canceled. If your dependent becomes ineligible for coverage and you fail to notify the Plan by calling People Services, you may be responsible for any charges mistakenly paid by the Plan after the date that your dependent became ineligible.

When you enroll for benefits

Once you have completed any applicable eligibility waiting period, you can enroll for benefits during your initial enrollment period, which is the first time you are eligible to enroll. The timing of your initial enrollment period varies by job classification and may change if your job classification changes. For more information, see **Enrollment and effective dates by job classification** later in this chapter and refer to the chart that applies to your job classification. You may also enroll for benefits at the following times:

- During Annual Enrollment, which generally occurs in the fall of each year. Benefits you enroll in during Annual Enrollment are generally effective January 1 of the following year, but there are exceptions. See the appropriate chart in the **Enrollment and effective dates by job classification** section for important details.
- If you choose to enroll in the short-term disability enhanced, long-term disability, or truck driver long-term disability benefits options, you may drop your coverage at any time, but you will only be able to add this coverage again during an initial enrollment period, Annual Enrollment, or when you have a status change event
See page 298
- At any time for optional associate life insurance and optional dependent life insurance. If you are enrolling in optional associate life insurance or optional dependent life insurance during Annual Enrollment, your coverage is effective upon the date of approval by Prudential (not January 1 of the following year).

If you do not enroll during your initial enrollment period, you will not be able to enroll for the following benefits until the next Annual Enrollment, unless you have a status change event (see the **Status change events** section of this chapter for additional details):

- Medical, including HMO plans and the eComm PPO Plan (subject to the annual eligibility check described in the **Annual eligibility check for medical benefits** section earlier in this chapter)
- Dental
- Vision
- Critical illness insurance
- Accident insurance
- Short-term disability enhanced plan (see important exception immediately below)
- Long-term disability (LTD) or truck driver LTD (see important exception immediately below)
- Accidental death and dismemberment (AD&D)

There is an important exception that can delay the effective date of the short-term disability enhanced plan or the long-term disability plan. If you do not enroll in the short-term disability enhanced plan or the long-term disability plan, and you later choose to enroll during Annual Enrollment or when you have a status change event, you will be considered a late enrollee and will be required to complete a 12-month waiting period before your coverage is effective. If your late enrollment is due to a status change event, your 12-month waiting period will begin as of the date of the event. If your late enrollment is during Annual Enrollment, your 12-month waiting period will begin as of the date you enroll.

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See the **Truck driver long-term disability** chapter for additional information about coverage effective dates for late enrollees in that benefit.

CHOOSING A COVERAGE LEVEL

Your eligible dependents enrolled in the Plan must have the same coverage you elect for yourself. You may change your coverage during Annual Enrollment or if you have a status change event. See the **Status change events** section later in this chapter.

Under the medical, dental, and vision plans, and critical illness and accident insurance, you may elect one of the following coverage levels:

- Associate only
- Associate + spouse/partner (except for part-time hourly associates, temporary associates, and part-time truck drivers)
- Associate + child(ren), or
- Associate + family (except for part-time hourly associates, temporary associates, and part-time truck drivers).

CONFIRMING YOUR ENROLLMENT

Once you enroll for coverage, you can view your confirmation statement on **One.Walmart.com** or **Workday** for Jet associates. If you see an error regarding the benefits you enrolled in, immediately contact People Services at **800-421-1362**.

YOUR PLAN ID CARD

When you enroll in any of the medical coverage options available under the Associates' Medical Plan (AMP), you receive a plan ID card at your home address. If your third-party administrator is BlueAdvantage of Arkansas, Aetna, or HealthSCOPE Benefits, plan ID cards for dependents whose address is different from yours are sent directly to the dependent's address. If your third-party administrator is UnitedHealthcare, a plan ID card for a dependent is sent to your home address even if the dependent's address is different from yours. Your plan ID card also serves as your pharmacy ID card.

If you enroll in any of the medical coverage options under the AMP or the eComm PPO Plan (if applicable) and you also enroll in the Associates' Dental Plan (the "dental plan") and/or the Associates' Vision Plan (the "vision plan"), your plan ID card will also serve as your dental ID card and/or your vision ID card.

If you enroll in an HMO and you also enroll in the dental plan and/or the vision plan, you will receive separate ID cards for the dental and/or vision plan.

If you enroll in the dental plan and/or the vision plan only, you will receive separate ID cards for those plans. ID cards will be mailed to your home address.

You can update your address or that of your dependents who are under the age of 18 when you enroll online or at any time on **One.Walmart.com** or **Workday** for Jet associates. If your dependent is age 18 or over, they need to contact People Services at **800-421-1362** to update their address.

When coverage is effective

See the **Enrollment and effective dates by job classification** section of this chapter for more details about coverage effective dates.

If you are not at work on the day your coverage becomes effective (including for a leave of absence) for medical, vision, dental, critical illness insurance, accident insurance, accidental death and dismemberment ("AD&D") insurance, Resources for Living, business travel accident insurance, or company-paid life insurance, your coverage is effective on the first day you are "actively at work," as defined on the next page, as long as you are enrolled for the benefit and have paid the applicable premiums. No enrollment is required for Resources for Living, business travel accident insurance, short-term disability basic, or company-paid life insurance.

If you are not at work for any reason (including for a leave of absence) other than scheduled paid time off (PTO) on the day your coverage becomes effective for optional associate life insurance, optional dependent life insurance, short-term disability enhanced, long-term disability (LTD), or truck driver LTD insurance, your coverage will be effective on the first day you are "actively at work," as defined below.

"ACTIVE WORK" OR "ACTIVELY AT WORK"

See page 300 *for information replacing the following two paragraphs.*

For medical, dental, vision, critical illness insurance, accident insurance, AD&D and Resources for Living coverage, "active work" (or "actively at work") means you are on active status and have reported to your first day of work at the company, even if you are not at work the day coverage begins (for example, due to illness).

For company-paid life insurance, optional associate life insurance, optional dependent life insurance, business travel accident insurance, and all types of disability coverage, being actively at work means you are at work with the company on a day that is one of your scheduled work days and performing all of the regular duties of your job on a full-time basis or part-time basis according to your employment classification. You are deemed to be actively at work on a day that is not one of your scheduled work days only if you were actively at work on the preceding scheduled work day.

AUTOMATIC REENROLLMENT

If you currently have coverage and are eligible for benefits during the following calendar year, but do not actively enroll for those benefits during Annual Enrollment, you and any dependents you cover will be automatically reenrolled. You will be reenrolled in the coverage options closest to what you have currently. For more information, refer to the Annual Enrollment materials provided to you and posted online at **One.Walmart.com** or on **Workday** for Jet associates. Call People Services at **800-421-1362** for information.

If you do not actively enroll during Annual Enrollment and are automatically enrolled in coverage as described above, you may not change this coverage except during a subsequent Annual Enrollment, unless you experience a status change event.

If you do not actively reenroll during Annual Enrollment, you will be deemed to have consented to automatic reenrollment and your payroll deductions will be adjusted accordingly.

If you leave the company and are rehired

MANAGEMENT AND FULL-TIME HOURLY ASSOCIATES

If you are enrolled for medical benefits before you terminate employment and you return to the company within 13 weeks, you will be automatically reenrolled in your previous coverage (or the most similar coverage offered under the Plan). If you return within 30 days, your annual deductible and out-of-pocket maximum under the AMP for the calendar year in which you terminate will not reset. If you return after 30 days but within 13 weeks, your annual deductible and out-of-pocket maximum will reset and you will be responsible for meeting the new deductible and out-of-pocket maximum in their entirety.

You will have 60 days after resuming employment to drop or otherwise change the coverage in which you were automatically reenrolled. If you return after 13 weeks, you will be treated as a new associate.

PART-TIME HOURLY AND TEMPORARY ASSOCIATES

If you return to employment as a part-time hourly or temporary associate within 13 weeks after leaving *during* your initial measurement period, you will be treated as if you had not left, for the remainder of the measurement period. All hours worked during the measurement period will be used in the average-hours-worked calculation. For example, if you have a four-week break in service during the 52-week measurement period, your average hours will be calculated using the 48 weeks during which you worked, rather than 52 weeks.

If you terminate employment *after* the completion of a measurement period and return to employment as a part-time hourly or temporary associate within 13 weeks, you will retain your previous status through the end of the calendar year.

If you are enrolled for medical benefits before you terminate employment and you return to the company within 13 weeks, you will be automatically reenrolled in your previous coverage (or the most similar coverage offered under the Plan). If you return within 30 days, your annual deductible and out-of-pocket maximum under the AMP for the calendar year in which you terminate will not reset. If you return after 30 days but within 13 weeks, your annual deductible and out-of-pocket maximum will reset and you will be responsible for meeting the new deductible and out-of-pocket maximum in their entirety.

You will have 60 days after resuming employment to drop or otherwise change the coverage in which you were automatically reenrolled. If you return after 13 weeks, you will be treated as a new associate and will be subject to the initial eligibility check for medical benefits before you will be eligible.

Effective dates for benefits under the Plan

The following **Enrollment and effective dates by job classification** charts provide your coverage effective dates if you enroll during your initial enrollment period. If you terminate employment before enrolling for benefits during your initial enrollment period, you will not be eligible to enroll.

If you are an associate in Hawaii, see the chapter titled **Eligibility and benefits for associates in Hawaii**.

Enrollment and effective dates by job classification

FULL-TIME HOURLY ASSOCIATES
Includes pharmacists (except California pharmacists*), field supply chain, field supervisor positions in stores and clubs; excludes Vision Center managers

Plan	Enrollment periods and coverage effective dates	
• Medical • HMO plans • Dental (enrollment is for two full calendar years) • Vision • Critical illness insurance • Accident insurance • AD&D	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and the day prior to the date your coverage is effective. **When coverage is effective:** Your coverage is effective the first day of the calendar month during which your 89th day of continuous full-time employment falls.	**NOTE:** IRS regulations require that the pretax benefit elections you make stay in effect through the full Plan year (Jan. 1 – Dec. 31) unless you have a status change event.
• Company-paid life insurance	You are automatically enrolled on the first day of the calendar month during which your 89th day of continuous full-time employment falls.	
• Resources for Living • Business travel accident insurance	You are automatically enrolled on your date of hire.	
• Short-term disability basic plan (not available to associates who work in California, Hawaii, New Jersey, and Rhode Island; different coverage is available in New York)	You are automatically enrolled on your 12-month anniversary.	
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and the day prior to the date your coverage is effective. **When coverage is effective:** • **If you enroll during your initial enrollment period:** – The guaranteed issue amount is effective on the later of your enrollment date or the first day of the calendar month during which your 89th day of continuous full-time employment falls. – When you enroll for more than the guaranteed issue amount, you must provide Proof of Good Health for yourself and/or your spouse/partner. Following Prudential's approval, your coverage is effective upon the later of the date of Prudential's approval or the first day of the calendar month during which your 89th day of continuous full-time employment falls. • **If you enroll after your initial enrollment period:** You may enroll or drop coverage at any time during the year, but Proof of Good Health is required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage is effective upon the date of approval by Prudential.	
• Short-term disability enhanced plan (not available to associates who work in California, Hawaii, New Jersey, and Rhode Island; New York short-term disability enhanced plan is available in New York) • Long-term disability (LTD) plan • LTD enhanced plan	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and the first day of the calendar month during which your 89th day of continuous full-time employment falls. **When coverage is effective:** If you enroll during your initial enrollment period, coverage is effective on your 12-month anniversary.	If you enroll after your initial enrollment period, your coverage is effective 12 months after the date you enroll or, in the event of a status change, 12 months after the date of the event. See page 298

*If you are classified as a "California pharmacist" in payroll systems, you are eligible for the benefits listed in the chart for management associates.

NOTE: Some benefits require you to meet the definition of active work. See the **"Active work" or "actively at work"** section in this chapter for information.

FULL-TIME HOURLY VISION CENTER MANAGERS

Plan	Enrollment periods and coverage effective dates	
• Medical • HMO plans • Dental (enrollment is for two full calendar years) • Vision • Critical illness insurance • Accident insurance • AD&D	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and prior to the 60th day after your date of hire. **When coverage is effective:** Your coverage is effective on your date of hire.	**NOTE:** IRS regulations require that the pretax benefit elections you make stay in effect through the full Plan year (Jan. 1 – Dec. 31) unless you have a status change event.
• Resources for Living • Company-paid life insurance • Business travel accident insurance • Short-term disability basic plan (not available to associates in California, Hawaii, New Jersey, and Rhode Island; different coverage is available in New York)	You are automatically enrolled on your date of hire.	
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and prior to the 60th day after your date of hire. **When coverage is effective:** • **If you enroll during your initial enrollment period:** – The guaranteed issue amount is effective on your enrollment date. – When you enroll for more than the guaranteed issue amount, you must provide Proof of Good Health for yourself and/or your spouse/partner. Your coverage is effective upon the date of Prudential's approval. • **If you enroll after your initial enrollment period:** You may enroll or drop coverage at any time during the year, but Proof of Good Health is required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage is effective upon the date of approval by Prudential.	
• Short-term disability enhanced plan (not available to associates who work in California, Hawaii, New Jersey, and Rhode Island; New York short-term disability enhanced plan is available in New York) • Long-term disability (LTD) plan • LTD enhanced plan	**Initial enrollment period:** You must enroll between the date of your first paycheck and prior to the 60th day after your date of hire. **When coverage is effective:** If you enroll during your initial enrollment period, coverage is effective as of your date of hire.	If you enroll after your initial enrollment period, your coverage is effective 12 months after the date you enroll or, in the event of a status change, 12 months after the date of the event. **See page 298**
NOTE: Some benefits require you to meet the definition of active work. See the **"Active work" or "actively at work"** section in this chapter for information.		

<table>
<tr><th colspan="3">PART-TIME HOURLY AND TEMPORARY ASSOCIATES</th></tr>
<tr><th>Plan</th><th colspan="2">Enrollment periods and coverage effective dates</th></tr>
<tr><td rowspan="2">• Medical*
• HMO plans
• Dental (enrollment is for two full calendar years)
• Vision
• Critical illness insurance
• Accident insurance
• AD&D</td><td>Initial enrollment period: See page 300
You must enroll in coverage during the 60-day period beginning with your 52-week anniversary date.
When coverage is effective:
Your coverage is effective the first day of the second calendar month following your 52-week anniversary date.*</td><td>NOTE: IRS regulations require that the pretax benefit elections you make stay in effect through the full Plan year (Jan. 1 – Dec. 31) unless you have a status change event.</td></tr>
<tr><td colspan="2">*To be eligible for medical coverage, part-time hourly and temporary associates must work the required number of hours and pass the initial or annual benefits eligibility check (as applicable) described under Associate eligibility earlier in this section. Part-time hourly pharmacists hired before February 1, 2012, are exempt from this requirement.</td></tr>
<tr><td>• Resources for Living
• Business travel accident insurance</td><td colspan="2">You are automatically enrolled on your date of hire.</td></tr>
<tr><td>• Optional associate life insurance
• Optional dependent life insurance</td><td colspan="2">Initial enrollment period: See page 300
You must enroll in coverage during the 60-day period beginning with your 52-week anniversary date.
When coverage is effective:
• If you enroll during your initial enrollment period:
– Your guaranteed issue amount becomes effective on the later of your enrollment date or the first day of the second calendar month following your 52-week anniversary date.
– When you enroll for more than the guaranteed issue amount, you must complete Proof of Good Health. Your coverage is effective upon the later of the date of Prudential's approval or your benefits eligibility date.
• If you enroll after your initial enrollment period: You may enroll or drop coverage at any time during the year, but Proof of Good Health is required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage is effective upon the date of approval by Prudential.</td></tr>
<tr><td colspan="3">NOTE: Part-time hourly and temporary associates may only cover their eligible dependent children and may not cover their spouse/partners. Disability coverage and company-paid life insurance are not available to part-time hourly and temporary associates.</td></tr>
</table>

PART-TIME TRUCK DRIVERS		
Plan	**Enrollment periods and coverage effective dates**	
• Medical • HMO plans • Dental (enrollment is for two full calendar years) • Vision • Critical illness insurance • Accident insurance • AD&D	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and the day prior to your effective date. **When coverage is effective:** Your coverage is effective the first day of the calendar month during which your 89th day of continuous employment falls.	**NOTE:** IRS regulations require that the pretax benefit elections you make stay in effect through the full Plan year (Jan. 1 – Dec. 31) unless you have a status change event.
• Resources for Living • Business travel accident insurance	You are automatically enrolled on your date of hire.	
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and the day prior to your effective date. **When coverage is effective:** • If you enroll during your initial enrollment period: – The guaranteed issue amount is effective on your enrollment date or the first day of the calendar month during which your 89th day of continuous employment falls. – When you enroll for more than the guaranteed issue amount, you must provide Proof of Good Health. Your coverage will be effective upon the later of the date of Prudential's approval or your benefits eligibility date. • If you enroll after your initial enrollment period: You may enroll or drop coverage at any time during the year, but Proof of Good Health is required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage is effective upon the date of approval by Prudential.	
Part-time truck drivers are not subject to the benefits eligibility checks described earlier in this chapter. **NOTE:** Part-time hourly and temporary associates may only cover their eligible dependent children and may not cover their spouse/partners. Disability coverage and company-paid life insurance are not available to part-time hourly and temporary associates.		

MANAGEMENT ASSOCIATES
Includes management trainees, California pharmacists,* and full-time truck drivers

Plan	Enrollment periods and coverage effective dates	
• Medical • HMO plans • Dental (enrollment is for two full calendar years) • Vision • Critical illness insurance • Accident insurance • AD&D	**Initial enrollment period:** You must enroll between the date of your first paycheck and prior to your 60th day after your date of hire. **When coverage is effective:** Your coverage is effective on your date of hire.	**NOTE:** IRS regulations require that the pretax benefit elections you make stay in effect through the full Plan year (Jan. 1 – Dec. 31) unless you have a status change event.
• Resources for Living • Company-paid life insurance • Business travel accident insurance • Short-term disability plan**	You are automatically enrolled on your date of hire.	
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and prior to the 60th day after your date of hire. **When coverage is effective:** • **If you enroll during your initial enrollment period:** – Your guaranteed issue amount is effective on your enrollment date – When you enroll for more than the guaranteed issue amount, you must provide Proof of Good Health for yourself and/or your spouse/partner. Your coverage is effective upon the date of approval by Prudential. • **If you enroll after your initial enrollment period:** You may enroll or drop coverage at any time during the year, but Proof of Good Health is required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage is effective upon the date of approval by Prudential.	
• Long-term disability (LTD) plan • LTD enhanced plan • Truck driver LTD plan • Truck driver LTD enhanced plan	**Initial enrollment period:** You must enroll between the date of your first paycheck and prior to the 60th day after your date of hire. **When coverage is effective:** If you enroll during your initial enrollment period, coverage is effective as of your date of hire. If you enroll after your initial enrollment period, coverage under the LTD plan is effective after a 12-month wait from the date you enroll or, in the event of a status change, 12 months after the date of the event. Under the truck driver LTD plan, you must provide Evidence of Insurability and coverage is effective the first day of the pay period after People Services receives approval from Lincoln. **See page 298**	

* Pharmacists who work in California and have the designation of "California pharmacist" in payroll systems are eligible for the benefits listed here for management associates.

**The salaried and truck driver short-term disability plans are not covered by ERISA and are not part of the Associates' Health and Welfare Plan.

NOTE: Some benefits require you to meet the definition of active work. See the **"Active work" or "actively at work"** in this chapter for information.

Paying for your benefits

When you have enrolled for coverage, payroll deductions for the premium amounts are withheld from your paycheck to pay for your benefits coverage. The first paycheck after your effective date generally reflects deductions for each day you had coverage during that pay period. If a pay period spans two calendar years, your deductions will reflect the amount for the prior year through December 31 and the new amount for the new year, prorated for the number of days covered from January 1 until the end of the pay period.

Your payroll deductions reflect your cost for benefits for the payroll period stated on your paycheck. So, if you are paid biweekly (every other week), your deductions pay for coverage for the previous two weeks. Deductions are based on biweekly pay periods (except in Rhode Island, which has weekly pay periods).

If your payroll deductions are not sufficient to pay any portion of a premium due, you are responsible for paying any unpaid premiums to the extent the premiums would have been paid if withheld as a payroll deduction. If you owe premiums for benefits coverage, any check issued by the company (e.g., paid time off, incentive, etc.), including during or after a leave of absence, will have premiums deducted on an after-tax basis, as permitted by law.

Be sure to check your statement of earnings and deductions on your pay stub to verify that the proper deductions are being taken. You can view your paycheck stub the Monday before payday by going to Online Paystub on **One.Walmart.com** or **Workday** for Jet associates. If you believe the coverage or deductions are not correct on your pay stub, call People Services immediately at **800-421-1362**. Requests for a review of premiums paid are considered if submitted within one year from the date of a possible overpayment. A premium reconciliation up to a maximum of one year will be completed.

Many of your Plan benefits are paid for with pretax dollars, which means your payroll deductions for coverage are deducted from your paycheck before federal and, in most cases, state taxes are withheld. Because Social Security taxes are not withheld on any pretax dollars you spend for benefits, amounts you pay for benefits with pretax dollars are not counted as wages for Social Security purposes. As a result, your future Social Security benefits may be reduced somewhat.

If you are enrolled in the Saver Plan, you may also be eligible to contribute to a health savings account on a pretax basis. See the **Health savings account** chapter for information.

Deductions for premiums or contributions that are past due or for retroactive elections generally must be made on an after-tax basis.

WHEN SPECIAL ARRANGEMENTS ARE NECESSARY TO MAINTAIN COVERAGE

If your payroll deductions are not sufficient to pay any portion of a premium due, you are responsible, regardless of your job status, for making arrangements to pay any unpaid premiums to the extent the premiums would have been paid if withheld as payroll deductions. These terms apply to the following benefits:

- Medical
- Dental
- Vision
- Critical illness insurance
- Accident insurance
- Optional associate life insurance
- Optional dependent life insurance
- Accidental death and dismemberment (AD&D)

Your premium payments for coverage during a pay period are due by the close of that pay period and will be made on an after-tax basis. Your failure to make your premium payments by the due date may result in your coverage being canceled due to nonpayment of premiums.

To avoid interruption or cancellation of coverage, premium payments can be made in advance through the automated system with a VISA, MasterCard, American Express, or Discover credit or debit card by logging into the payment portal on **One.Walmart.com**. You can also call People Services at **800-421-1362** and say "make a payment." To confirm the premium amount owed, call People Services.

Payments of premiums may also be made by check or money order and should be made payable to Associates' Health and Welfare Trust and mailed to:

Walmart People Services
P.O. Box 1039
Department 3001
Lowell, Arkansas 72745

To ensure proper credit when you send payment, include your name and WIN number on your payment. Please allow 10–14 days for processing.

If you have a break in coverage as the result of a coverage cancellation:

- If you are an active associate, you will not be able to enroll again until the next Annual Enrollment or until you have a valid status change event.
- If you are on a leave of absence and return to active work within one year of the leave, you will be enrolled for the same coverage (or the most similar coverage offered under the Plan). Your coverage will be effective the first day of the pay period that you return to active work.

- If you are on a leave of absence and return to active work after one year of the leave, you will be considered a newly eligible associate and will be required to meet any applicable eligibility requirements before you may enroll for coverage.

TAX CONSEQUENCES OF PARTNER BENEFITS

Partners generally do not qualify as spouses or dependents for federal income tax purposes. Therefore, the value of company-provided medical (including the HRA) coverage that relates to your partner, or your partner's children, is generally considered imputed income and taxable to you. This value is subject to change from year to year as the underlying benefit values change. Tax and other withholdings are made from your paycheck and the value of those benefits is included in your Form W-2. During any period in which partner benefits that have an imputed income are maintained by you but you are not receiving a paycheck from the company, the company reserves the right to collect your portion of FICA tax liability directly from you.

These rules do not apply if your partner satisfies the requirements to be considered your tax dependent under the Internal Revenue Code.

Tobacco rates

You can receive lower tobacco-free rates for medical and prescription drug coverage, optional associate life insurance, optional dependent life insurance for a spouse, and critical illness insurance if:

- You and/or a covered spouse/partner do not use tobacco and are considered to be "tobacco free," or
- You and/or a covered spouse/partner use tobacco and you complete participation in a quit-tobacco program of your choice between the time of Annual Enrollment and December 31, 2020. Alternatively, if you call Walmart's Quit Tobacco program at **866-577-7169**, the program will work with you (and, if you wish, your doctor) to find a program that is right for you.

"Tobacco free" means that you (and/or your covered spouse/partner) do not use tobacco in any form — cigarettes, cigars, pipes, snuff, or chewing tobacco. For purposes of establishing tobacco-free rates, being "tobacco free" also means that you do not use e-cigarettes or any such nicotine-delivery devices.

You will be asked to attest to your tobacco use at your initial enrollment, to determine your eligibility for tobacco-free rates for your initial eligibility period, and each year at Annual Enrollment, to determine your eligibility for tobacco-free rates for the next calendar year.

The statement below is shown on the screen when you enroll for benefits and answer the questions regarding tobacco use:

"Our expectation is that you will use correct and accurate information when applying for or enrolling in benefits. If you do not, you may be subject to the loss of benefits and/or loss of employment."

To review the company's policy about intentional dishonesty, please refer to the Statement of Ethics, which can be found on **One.Walmart.com**. If we receive a report of abuse, we will conduct an ethics investigation.

Please note that your eligibility for tobacco-free rates can be established only at your initial enrollment and at Annual Enrollment. If you become tobacco-free during the year, you will not become eligible for tobacco-free rates until the following calendar year.

The company offers the Quit Tobacco program at no cost to all associates. For information, see **Quit Tobacco program** in **The medical plan** chapter.

IMPORTANT

If you are a first-time enrollee, you must actively complete an online enrollment session at **One.Walmart.com** or on **Workday** for Jet associates to receive tobacco-free rates.

Continuing benefit coverage if you go on a leave of absence

While you are on a Family Medical Leave Act (FMLA) leave, personal leave, or military leave, you retain any medical, dental, vision, critical illness insurance, accident insurance, optional associate life, optional dependent life, AD&D, and Resources for Living coverage that you had on the day immediately preceding the first day of the leave. Coverage generally is maintained on the same terms and conditions as if you had continued to work during the leave.

During your leave, you are responsible for paying any unpaid premiums to the extent the premiums would have been paid if withheld as a payroll deduction. See **When special arrangements are necessary to maintain coverage** earlier in this chapter for details.

If you cancel your coverage during your FMLA, personal or military leave and return to work, you may contact People Services at **800-421-1362** within 60 days of returning to work to reinstate your coverage. See the **If you go on a leave of absence** section in the respective chapters for each of the above-named benefits to learn more.

Decisions about leaves of absence are made by the company, not the Plan.

Contact a member of your management team or Sedgwick for additional information about FMLA, personal or military leave, or refer to the company's Leave of Absence Policy on **One.Walmart.com** for specific information. You may also contact your personnel representative if you have questions about the FMLA, personal or military leave policy.

PAYING FOR BENEFITS WHILE ON A LEAVE OF ABSENCE

To continue benefit coverage while on a leave of absence, you must pay your premiums on an after-tax basis. For details on making payments while on a leave of absence, refer to **When special arrangements are necessary to maintain coverage** earlier in this chapter.

If you are on a leave of absence and you owe premiums for benefits coverage, any check issued by the company (e.g., paid time off, incentive, etc.) will have premiums deducted on an after-tax basis, as permitted by law.

Continuing benefit coverage while disabled

If you are a salaried associate or truck driver receiving short-term disability benefits, please see the **Salaried short-term disability plan** or the **Truck driver short-term disability plan** chapter for information about continuing benefit coverage while disabled.

If you are receiving disability benefits and wish to continue your coverage under other benefits offered under the Plan, this chart describes how your coverage costs are handled:

TO MAINTAIN COVERAGE UNDER THESE BENEFITS	
• Medical • Dental • Vision • Critical illness insurance	• Accident insurance • Optional associate life • Optional dependent life • AD&D
WHILE YOU ARE RECEIVING…	
Short-term disability benefits for full-time hourly associates (except for those who work in CA, HI, NJ, NY, and RI)	Your premiums for the coverage listed above ***will*** be deducted from your short-term disability benefit checks (issued through the company payroll system). **NOTE:** You are not required to pay short-term disability enhanced plan or long-term disability plan premiums from any short-term disability benefit payments you receive.*
Short-term disability benefits for full-time hourly associates who work in CA, HI, NJ, NY, or RI	Your premiums for the coverage listed above ***will not*** be deducted from your short-term disability benefit checks because they are not issued through the company payroll system. You must make premium payments each pay period or risk cancellation of your benefits. **NOTE:** You are not required to pay short-term disability enhanced plan or long-term disability plan premiums from any short-term disability benefit payments you receive.*
• **Long-term disability benefits** • **Truck driver long-term disability benefits**	Your premiums for the coverage listed above ***will not*** be deducted from your long-term disability benefit checks because they are not issued through the company payroll system. You must make premium payments each pay period or risk cancellation of your benefits. **NOTE:** You are not required to pay short-term disability enhanced plan or long-term disability plan premiums from any long-term disability benefit payments you receive.*
*If you receive any other earnings, including bonuses, through the company payroll systems while you are receiving disability benefits, your applicable disability premiums will be withheld from those payments.	

Status change events

Certain benefits can be changed at any time during the year, but others can be changed only during Annual Enrollment or if you have a status change event, as follows:

- Optional associate life insurance and optional dependent life insurance can be added or dropped at any time.
- The AMP, HMO plans, the eComm PPO Plan, dental, vision, AD&D, critical illness insurance, and accident insurance can be changed only during Annual Enrollment unless you have a status change event.
- Short-term disability enhanced, long-term disability, and truck driver long-term disability can be dropped at any time. (The change becomes effective the day after you drop coverage.) They can be added only at Annual Enrollment unless you have a status change event.
  See page 298

Federal tax law generally requires that your pretax benefit choices remain in effect for the entire calendar year for which the choice was made. This does not apply to pretax contributions to a health savings account, which can be changed at any time.

You may make certain coverage changes if you experience a status change event. A status change event is an event that allows you to make changes to your coverage outside of annual or initial enrollment. Any change you make must be directly related to the impact of the event on your benefits or eligibility. In other words, there must be a logical relationship between the event and the change you request. For example, if you (the associate) and your spouse divorce, you can only drop coverage for your spouse. Changing another dependent's coverage due to this event would not be permitted.

When you have a status change event (including the loss or gain of other coverage as described below), any changes to your coverage must be made within 60 days from the date of the event.

Status change events include:

- Events that change your marital status:
  - Marriage
  - Death of your spouse
  - Divorce (including the end of a common-law marriage in states where a divorce decree is required to end a recognized common-law marriage)
  - Annulment, or
  - Legal separation.
- Events that change your domestic partnership status:
  - Commencement of domestic partnership
  - Termination of domestic partnership, or
  - Death of your domestic partner.
- Events that change the status of a legal relationship with a person other than a spouse or domestic partner, as specified in the definition of partner:
  - Commencement of legal relationship
  - Termination of legal relationship, or
  - Death of the other person to whom you are joined in legal relationship.
- Events that change the number of your dependents:
  - Birth
  - Adoption
  - Placement for adoption
  - Death of a dependent
  - Gain of legal custody of a dependent
  - Loss of legal custody of a dependent for whom you have previously been awarded legal custody or guardianship by a judge
  - Your paternity test result
  - A dependent loses eligibility, such as at the end of the month in which the dependent reaches age 26, or
  - You receive valid documentation establishing the eligibility of a dependent previously deemed ineligible.
- Employment changes experienced by you, your spouse/partner or your dependent:
  - Going on or returning from an approved leave of absence
  - Gain or loss of coverage due to starting or ending employment
  - A change in work location that affects your medical coverage. If the change affects your medical coverage options (such as if a new HMO, local plan, or the eComm PPO Plan is offered), you will have 60 calendar days from your transfer to submit a request to change your coverage. If you transfer work locations where your medical benefits are affected and do not submit a request, you will automatically be enrolled in a predetermined plan
  - Gain or loss of coverage under any other employer plan, or
  - If you are a part-time hourly or temporary associate and your hours are reduced such that you work an average of less than 30 hours per week (regardless of whether the reduction in hours affects your eligibility for medical benefits) and you intend to enroll in another plan that provides minimum essential coverage that is effective no later than the first day of the second month following the month that your medical coverage under the Plan would end, you may drop coverage in the AMP or an HMO plan or the eComm PPO Plan.

LOSS OF COVERAGE

- You may add medical, dental, or vision coverage for you and/or your eligible dependents if:
  - You originally declined coverage because you and/or your dependents had COBRA coverage and that COBRA coverage has ended (nonpayment of premiums is not sufficient for this purpose)
  - You and/or your dependents had non-COBRA medical coverage and the other coverage has terminated due to your loss of eligibility, or
  - Employer contributions toward other coverage have terminated.
- A change may also be allowed if there is a significant loss of coverage under the benefits available at the company, such as if an HMO plan in your area discontinues service. The Plan determines when a significant loss of coverage has occurred.
- If you or your eligible dependents lose coverage under a governmental plan including Medicaid or a state children's health insurance plan, an educational institution's plan, or a tribal government plan, you can add coverage under the AMP, an HMO plan, the eComm PPO Plan, accident insurance, or critical illness insurance within 60 days of the loss of coverage. (This does not apply to loss of coverage under a Health Insurance Marketplace plan.)
- A change may also be allowed pursuant to a court order.

GAIN OF OTHER COVERAGE

- If an order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order — See **Qualified Medical Child Support Orders (QMCSO)** later in this chapter) requires you to provide medical, dental, and/or vision coverage for your eligible dependent child, you may add coverage for your eligible dependent child (and yourself, if you are not already covered). If the order requires your spouse, former spouse, or other person to provide medical, dental, and/or vision coverage for your dependent child, and that other coverage is in fact provided, you may drop coverage for the dependent child.
- If you are eligible for a Special Enrollment Period to enroll in a qualified health plan through a Marketplace, or you seek to enroll in a qualified health plan through a Marketplace during the Marketplace's annual enrollment, as described on the next page in **Changes in your coverage following a status change event**, you can drop coverage in the AMP, an HMO plan, or the eComm PPO Plan in accordance with rules set forth by the Department of Health and Human Services. You and any dependent who cease coverage under the Plan must provide evidence of your enrollment rights and state that you intend to enroll in a qualified health plan through a Marketplace effective no later than the day immediately following the last day of your coverage under the AMP, HMO plan, or eComm PPO Plan.
- If you or your eligible dependents are enrolled in the AMP, an HMO plan, the eComm PPO Plan, accident insurance, or critical illness insurance, you can drop that coverage if you or your dependents become entitled to Medicare or Medicaid benefits or coverage under a state children's health insurance plan.

NOTE: If you or your eligible dependents gain eligibility under a governmental plan (other than Medicare, Medicaid, TRICARE, or a state children's health insurance plan), you cannot drop the AMP, an HMO plan, the eComm PPO Plan, accident insurance, or critical illness insurance coverage except during Annual Enrollment.

ADDITIONAL CIRCUMSTANCES IN WHICH YOU MAY CHANGE YOUR BENEFITS

In addition to the circumstances under which you may change your benefits, as listed on the previous page, there are additional circumstances, including cost changes, reduction of coverage, and/or additions/improvements of a benefit option, in which the Plan may allow you to make mid-year changes to your elections.

If you or your eligible dependents become eligible for assistance under Medicaid or a state children's health insurance plan to help you pay for Plan coverage, you must request coverage under the Plan within 60 days of becoming eligible for assistance.

For information about circumstances in which you may change your benefits, contact People Services at **800-421-1362**.

CHANGES IN YOUR COVERAGE FOLLOWING A STATUS CHANGE EVENT

When you have a status change event, you must request your change within 60 days from the date of the event.

Unless otherwise provided in the Plan, if you add a spouse or partner or other eligible dependent due to a status change event, each person must individually meet any applicable benefit waiting period (for example, for transplant coverage or weight loss surgery) and will be subject to applicable Plan limitations. If you change medical plans due to a status change event, your annual deductible and out-of-pocket maximum will reset, and you will be responsible for meeting the new deductible and out-of-pocket maximum in their entirety. If you change from the Contribution Plan to another plan, your HRA balance under the Contribution Plan will be forfeited. See **The medical plan** chapter for information.

If you are covered as a dependent and move to coverage as an associate during the Plan year, you will generally not receive credit under the AMP for expenses incurred prior to the date of the change. However, if you are covered as a dependent and you experience a qualifying event that affects your status as a dependent and makes you eligible for your own continuation coverage under COBRA, you will receive credit

toward your deductibles and out-of-pocket maximum under the AMP for expenses incurred as a covered dependent. You will also receive credit toward any waiting periods.

The Plan reserves the right to request additional necessary documentation to show proof of a status change event.

HIPAA SPECIAL ENROLLMENT FOR MEDICAL COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you also may have a right to a special enrollment in medical coverage under the Plan if you lose other coverage or acquire a dependent. These events are described in the list of status change events and include:

- If you decline enrollment for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself, and if you choose, your dependents in this Plan if you or your dependents lose eligibility for that coverage (or if the employer stops contributing toward your or your dependents' other coverage). You must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your eligible dependents. You must request enrollment within 60 days.
- If you or a dependent is no longer eligible for coverage under Medicaid or a state children's health plan, or you or a dependent becomes eligible for assistance for Plan coverage under Medicaid or a state children's health plan, you must request enrollment within 60 days of the prior coverage terminating or your becoming eligible for assistance. Such coverage will be effective upon the date you enroll in the Plan.
- To request special enrollment or obtain more information, refer to the information earlier in this chapter regarding status change events or contact People Services at **800-421-1362**.

HOW TO CHANGE YOUR ELECTIONS DUE TO A STATUS CHANGE EVENT

You can make changes online within 60 days of the event on **One.Walmart.com** or **Workday** for Jet associates for status changes due to:

- Adoption
- Birth
- Commencement of domestic partnership
- Commencement of legal relationship with a person other than your spouse or domestic partner
- Death of spouse/partner
- Divorce or legal separation
- Gain or loss of legal custody
- Gain or loss of coverage by you, your dependent(s), or your eligible spouse/partner
- Going on leave of absence
- Marriage
- Returning from leave of absence
- Special enrollment period
- Termination of domestic partnership, or
- Termination of legal relationship with a person other than a spouse or domestic partner.

For all other types of status changes, call People Services at **800-421-1362**.

If your status change event is the birth of a dependent, the Plan will accept provider billing charges related to the birth as notice that the newborn is to be added as a dependent under your coverage, so long as the charges are submitted within 60 days of the birth.

If you are seeking to add a dependent as a result of marriage, commencement of a domestic partnership, or commencement of a legal relationship with a person other than a spouse or domestic partner, but the individual to be added as a dependent dies before you have provided notice of the status change event, the individual will not be added to your coverage as a dependent.

Changes to your coverage are effective on the event date or on the day after the status change event date. If a change is made due to your unpaid leave of absence, the change is effective as of the effective date of your leave of absence.

This does not apply to optional associate life insurance, optional dependent life insurance, short-term disability enhanced plan coverage, long-term disability, or truck driver long-term disability; see the respective chapters for information about effective dates.

If your status change results in an increase in your coverage costs, such as if you change from associate-only coverage to associate + dependent coverage, the increased charge will be deducted from your pay after you notify People Services of your status change event and will be retroactive to the effective date of your new coverage. These retroactive deductions are made on an after-tax basis.

If you do not notify People Services or go online and make a change within 60 days of the status change event, you cannot add or drop coverage until the next Annual Enrollment or until you have a different status change event.

Also, if the status change event is due to your dependent losing eligibility, your dependent will lose the right to elect COBRA coverage for medical, dental, and/or vision benefits if you do not notify People Services of the event within 60 days. Similarly, if the status change event is due to your divorce, the

termination of a domestic partnership, or the termination of a legal relationship with a person other than your spouse or domestic partner, your former spouse/partner will lose the right to elect COBRA coverage for medical, dental, and/or vision benefits if People Services is not notified of the event within 60 days. See the **COBRA** chapter for more information.

If your job classification changes

Transitioning from one job classification to another may affect your eligibility for certain benefits.

If you are classified as a part-time hourly or temporary associate and your classification is changed to full-time, you will be eligible for full-time benefits, as described in the chart below.

If your job classification changes from full-time associate to part-time or temporary associate or part-time truck driver, your spouse/partner will no longer be eligible for medical, dental, vision, dependent life insurance, AD&D, critical illness, or accident coverage. You will no longer be eligible for company-paid life or disability coverage. If this change results in your spouse/partner or other dependent losing coverage, see the **COBRA** chapter to learn how you and/or your eligible dependents may be able to continue medical, dental, and vision coverage.

NOTE: If your job classification changes to part-time hourly or temporary associate, see the earlier section of this chapter titled **Part-time hourly and temporary associates: eligibility checks for medical benefits**.

Transferring from one job classification to another

PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO A FULL-TIME HOURLY POSITION

Your status at transition	Coverage effective dates and details
You have been continuously employed for more than 52 weeks and were eligible for medical coverage under the Plan as a part-time hourly or temporary associate immediately prior to your transition	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: – If you enroll online, coverage is effective the date you enroll. – If you enroll by phone call to People Services, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date. • You are enrolled automatically in the short-term disability basic plan effective the first day of the pay period in which your transition occurs, and are eligible to enroll in the short-term disability enhanced plan at the same time, unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans. (Associates in New York can enroll in the NY short-term disability enhanced plan.) • You are enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs. • You are eligible to enroll in optional dependent life insurance for your spouse/partner: – If you enroll during the enrollment period following your transition in status, your guaranteed issue amount becomes effective on your enrollment date. – If you enroll for more than the guaranteed issue amount, you must complete Proof of Good Health for your spouse/partner. Your coverage becomes effective upon the date of approval by Prudential. • You are eligible to enroll in long-term disability (LTD) plan coverage. • If you are currently enrolled in medical, dental, vision, AD&D, critical illness, and/or accident insurance, you can increase your coverage type to associate + spouse/partner or associate + family as a result of your change in job classification. If you are not currently enrolled in medical, dental, vision, AD&D, critical illness, and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next Annual Enrollment or until you have a valid status change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types as a part-time hourly or temporary associate.

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO A FULL-TIME HOURLY POSITION (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
You have been continuously employed for more than 52 weeks and were not eligible for medical coverage under the Plan as a part-time hourly associate immediately prior to your transition	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: – If you enroll online, coverage is effective the date you enroll. – If you enroll by phone call to People Services, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date. • You become eligible to enroll in medical coverage. See **The medical plan** chapter for information. • You are enrolled automatically in the short-term disability basic plan effective the first day of the pay period in which your transition occurs, and are eligible to enroll in the short-term disability enhanced plan at the same time, unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans. (Associates in New York can enroll in the NY short-term disability enhanced plan.) • You are enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs. • You are eligible to enroll in optional dependent life insurance for your spouse/partner: – If you enroll during the enrollment period following your transition in status, your guaranteed issue amount becomes effective on your enrollment date. – If you enroll for more than the guaranteed issue amount, you must complete Proof of Good Health for your spouse/partner. Your coverage becomes effective upon the date of approval by Prudential. • You are eligible to enroll in long-term disability (LTD) plan coverage. • If you are currently enrolled in dental, vision, AD&D, critical illness, and/or accident insurance, you can increase your coverage type to associate + spouse/partner or associate + family as a result of your change in job classification. If you are not currently enrolled in dental, vision, AD&D, critical illness, and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next Annual Enrollment or until you have a valid status change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types as a part-time hourly or temporary associate.

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO A FULL-TIME HOURLY POSITION (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
You have been continuously employed for more than 90 days but less than 52 weeks	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • Your coverage is effective (with the exception of short-term and long-term disability) either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: – If you enroll online, coverage is effective the date you enroll. – If you enroll by phone call to People Services, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date. • You are eligible to enroll in medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness, and accident insurance. See the respective chapters in this Summary Plan Description for more information. • You are enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs. • If you enroll for optional associate life insurance or optional dependent life insurance for your spouse/partner during the enrollment period following your transition in status: – Your guaranteed issue amount becomes effective on your enrollment date. – If you enroll for more than the guaranteed issue amount, you must provide Proof of Good Health for you and/or your spouse/partner. Your coverage is effective upon the date of approval by Prudential. • You are automatically enrolled in company-provided short-term disability basic coverage effective on the 12-month anniversary of your date of hire, and are eligible to enroll in the short-term disability enhanced plan during the 60-day period beginning on the first day of the pay period in which your transition occurs, unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans. (Associates in New York can enroll in the NY short-term disability enhanced plan.) You are also eligible to enroll in the long-term disability (LTD) plan during the 60-day period beginning on the first day of the pay period in which your transition occurs. Your coverage under the short-term disability enhanced plan (if applicable) and LTD plan is effective on the 12-month anniversary of your date of hire. If you enroll in the short-term disability enhanced plan or LTD plan at any time after this enrollment period following your transition in status, your coverage is not effective until after an additional 12-month waiting period from the date you enroll. (If you enroll due to a status change event, the waiting period begins as of the date of the event.) **See page 298**

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO A FULL-TIME HOURLY POSITION (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
You have been continuously employed for less than 90 days	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • Your coverage is effective (with the exception of short-term and long-term disability) as follows: – If you enroll online or by calling People Services during the 60-day period but before the first day of the month during which your 89th day of continuous employment falls, your effective date is the first day of the calendar month during which your 89th day of continuous employment falls. – If you enroll online during the 60-day period but after the first day of the month during which your 89th day of continuous employment falls, your effective date is the date you enroll. However, if you enroll by calling People Services you may choose to have your benefits effective the first day of the month during which your 89th day of continuous employment falls. • Premiums may be deducted from your paycheck on an after-tax basis retroactively to your effective date of coverage if you enroll after your 90th day of continuous employment. • You are eligible to enroll in medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness, and accident insurance. See the respective chapters in this Summary Plan Description for more information. • You are enrolled automatically in company-paid life insurance on the first day of the calendar month during which your 89th day of continuous employment falls. • If you enroll for optional associate life insurance or optional dependent life insurance for your spouse/partner during your initial enrollment period: – Your guaranteed issue amount becomes effective on your enrollment date or your eligibility date, whichever is later. – If you enroll for more than the guaranteed issue amount, you must provide Proof of Good Health for you and/or your spouse/partner. Your coverage is effective upon the date of approval by Prudential. • You are automatically enrolled in company-provided short-term disability basic coverage effective on the 12-month anniversary of your date of hire, and are eligible to enroll in the short-term disability enhanced plan during the 60-day period beginning on the first day of the pay period in which your transition occurs, unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans. (Associates in New York can enroll in the NY short-term disability enhanced plan.) You are also eligible to enroll in the long-term disability (LTD) plan during the 60-day period beginning on the first day of the pay period in which your transition occurs. Your coverage under the short-term disability enhanced plan (if applicable) and LTD plan is effective on the 12-month anniversary of your date of hire. If you enroll in the short-term disability enhanced plan or LTD plan at any time after this enrollment period following your transition in status, your coverage is not effective until after an additional 12-month waiting period from the date you enroll. (If you enroll due to a status change event, the waiting period begins as of the date of the event.) **See page 298**

PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO MANAGEMENT	
Your status at transition	**Coverage effective dates and details**
You have been continuously employed for more than 52 weeks and were eligible for medical coverage under the Plan as a part-time hourly associate immediately prior to your transition	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: – If you enroll online, coverage is effective the date you enroll. – If you enroll by phone call to People Services, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date. • You are enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs. • The maximum amount of optional associate life insurance coverage you can select increases from $200,000 to $1,000,000. (If you increase your coverage, Proof of Good Health is required; coverage is effective upon the date of approval by Prudential.) • You are eligible to enroll in optional dependent life insurance for your spouse/partner. • If you enroll for optional dependent life insurance for your spouse/partner during the enrollment period following your transition in status: – Your guaranteed issue amount becomes effective on your enrollment date. – If you enroll for more than the guaranteed issue amount, you must provide Proof of Good Health for your spouse/partner. Your coverage is effective upon the date of approval by Prudential. • If you are currently enrolled in medical, dental, vision, AD&D, critical illness, and/or accident insurance, you can increase your coverage type to associate + spouse/partner or associate + family as a result of your change in job classification. If you are not currently enrolled in medical, dental, vision, AD&D, critical illness, and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next Annual Enrollment or until you have a valid status change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types as a part-time hourly or temporary associate. • You are enrolled automatically in the salaried short-term disability plan or truck driver short-term disability plan, as appropriate, effective the first day of the pay period in which your transition occurs. • You are eligible to enroll in the long-term disability (LTD) plan or truck driver LTD plan, as appropriate. See the respective chapters in this Summary Plan Description for information.

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO MANAGEMENT (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
You have been continuously employed for more than 52 weeks and were not eligible for medical coverage under the Plan as a part-time hourly associate immediately prior to your transition	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: – If you enroll online, coverage is effective the date you enroll. – If you enroll by phone call to the People Services Center, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date. • You are eligible to enroll in medical coverage and long-term disability (LTD) or truck driver LTD, as appropriate. See the respective chapters in this Summary Plan Description for information. • You are enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs. • The maximum amount of optional associate life insurance coverage you can select will increase from $200,000 to $1,000,000. (If you increase your coverage, Proof of Good Health is required; coverage is effective upon the date of approval by Prudential.) • You are eligible to enroll in optional dependent life insurance for your spouse/partner: – If you enroll during the enrollment period following your transition in status, your guaranteed issue amount will become effective on your enrollment date. – If you enroll for more than the guaranteed issue amount, you must complete Proof of Good Health for your spouse/partner. Your coverage is effective upon the date of approval by Prudential. • If you are currently enrolled in dental, vision, AD&D, critical illness, and/or accident insurance, you can increase your coverage type to associate + spouse/partner or associate + family as a result of your change in job classification. If you are not currently enrolled in dental, vision, AD&D, critical illness, and/or accident insurance, you may enroll only in associate + spouse/partner or associate + family coverage as a result of your change in job classification, until the next Annual Enrollment or until you have a valid status change event. You may not select associate-only or associate + child(ren) coverage as a result of your change in job classification, as you were already eligible for those coverage types as a part-time hourly or temporary associate. • You are enrolled automatically in the salaried short-term disability plan or truck driver short-term disability plan, as appropriate, effective the first day of the pay period in which your transition occurs. • You are eligible to enroll in the long-term disability (LTD) plan or truck driver LTD plan, as appropriate. See the respective chapters in this Summary Plan Description for information.

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO MANAGEMENT (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
You have been continuously employed for less than 52 weeks	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: – If you enroll online, coverage is effective the date you enroll. – If you enroll by phone call to the People Services Center, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date. • You are eligible to enroll in medical, dental, vision, AD&D, optional associate and dependent life insurance, critical illness insurance, accident insurance, and long-term disability (LTD) or truck driver LTD, as appropriate. See the respective chapters in this Summary Plan Description for information. • You are enrolled automatically in company-paid life insurance on the first day of the pay period in which your transition occurs. • If you enroll for optional associate life insurance or optional dependent life insurance during the enrollment period following your transition in status: – Your guaranteed issue amount becomes effective on your enrollment date. – If you enroll for more than the guaranteed issue amount, you must complete Proof of Good Health for you and/or your spouse/partner. Your coverage becomes effective upon the date of approval by Prudential. • You are enrolled automatically in the salaried short-term disability plan or truck driver short-term disability plan, as appropriate, effective the first day of the pay period in which your transition occurs. • You are eligible to enroll in the long-term disability (LTD) plan or truck driver LTD plan, as appropriate. See the respective chapters in this Summary Plan Description for information.

FULL-TIME HOURLY ASSOCIATES TRANSFERRING TO MANAGEMENT	
Your status at transition	**Coverage effective dates and details**
You have been continuously employed for 90 days or more	• The maximum amount of optional associate life insurance coverage you can select increases from $200,000 to $1,000,000. (If you increase your coverage, Proof of Good Health is required; coverage is effective upon the date of approval by Prudential.) • The terms of your short-term disability coverage change as follows: – You are enrolled automatically in the salaried short-term disability plan or truck driver short-term disability plan, as appropriate, effective the first day of the pay period in which your transition occurs. – Your eligibility for coverage under the short-term disability plan for hourly associates terminates, effective the first day of the pay period in which your transition occurs. (This includes both short-term disability basic and enhanced coverage, and applies whether you were already covered under the plan or were awaiting the start of coverage.) • If you elected long-term disability (LTD) or truck driver LTD during your initial enrollment period, coverage is effective as of the first day of the pay period in which your transition occurs.
You have been continuously employed for less than 90 days	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: – If you enroll online, coverage is effective the date you enroll. – If you enroll by phone call to the People Services Center, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you enroll. Once you enroll, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date. • You are eligible to enroll in medical, dental, vision, AD&D, optional associate and dependent life insurance, long-term disability (LTD) or truck driver LTD insurance, critical illness insurance, and accident insurance. See the respective chapters in this Summary Plan Description for more information. • If you enroll for optional associate life insurance or optional dependent life insurance during your initial enrollment period: – Your guaranteed issue amount becomes effective on your enrollment date. – If you enroll for more than the guaranteed issue amount, you must complete Proof of Good Health for you and/or your spouse/partner. Your coverage becomes effective upon the date of approval by Prudential. • The terms of your short-term disability coverage change as follows: – You are enrolled automatically in the salaried short-term disability plan or truck driver short-term disability plan, as appropriate, effective the first day of the pay period in which your transition occurs. – Your eligibility for coverage under the short-term disability plan for hourly associates or truck driver short-term disability terminates, effective the first day of the pay period in which your transition occurs. (This includes both short-term disability basic and enhanced coverage, and applies whether you were already covered under the plan or were awaiting the start of coverage.)

FULL-TIME HOURLY VISION CENTER MANAGERS TRANSFERRING TO MANAGEMENT	
	Coverage effective dates and details
	• The terms of your short-term disability coverage change as follows: – You are enrolled automatically in the salaried short-term disability plan effective the first day of the pay period in which your transition occurs. – Your eligibility for coverage under the short-term disability plan for hourly associates terminates, effective the first day of the pay period in which your transition occurs. (This includes both short-term disability basic and enhanced coverage, and applies whether you were already covered under the plan or were awaiting the start of coverage.)

MANAGEMENT ASSOCIATES TRANSFERRING TO FULL-TIME HOURLY	
Your status at transition	**Coverage effective dates and details**
Within 60 days of your date of hire and before you have enrolled for benefits	**You have 60 days to enroll from the date your transition in status occurs.** • The terms of your benefit plans as a full-time hourly associate are effective as of the date of your transition in status. You can find details about benefits available to full-time hourly associates in the **Enrollment and effective dates by job classification** charts earlier in this chapter. • Premiums are deducted from your paycheck on an after-tax basis retroactively to your coverage effective date. • Salaried short-term disability or truck driver short-term disability coverage is canceled effective the first day of the pay period in which your transition occurs. • You are automatically enrolled in short-term disability enhanced coverage for hourly associates as of the first day of the pay period in which your transition occurs, unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans. (Associates in New York are automatically enrolled in the NY short-term disability enhanced plan.) See the **Short-term disability for full-time hourly associates** chapter for more information. • You are eligible to enroll in the long-term disability plan. **See page 300** • If you enroll for optional associate life insurance or optional dependent life insurance: – Your guaranteed issue amount becomes effective on your enrollment date. – If you enroll for more than the guaranteed issue amount, you must provide Proof of Good Health for you and/or your spouse/partner, as applicable. Your coverage is effective upon the date of approval by Prudential.
Within 60 days of your date of hire and after you have enrolled for benefits	**You have 60 days to enroll from the date your transition in status occurs.** • The terms of your benefit plans as a full-time hourly associate are generally effective as of the date of your transition in status. You can find details about benefits available to full-time hourly associates in the **Enrollment and effective dates by job classification** charts earlier in this chapter. • Premiums are deducted from your paycheck as of your coverage effective date for any new benefit election you make. For benefit plans in which you were already enrolled, premiums are adjusted to your full-time hourly status on an after-tax basis retroactively to the date of your transition in status. • Optional associate life insurance amounts selected over $200,000 are reduced to $200,000. • If you were not previously enrolled in optional associate life insurance or optional dependent life insurance and choose to enroll in either plan after your transition in status: – Your guaranteed issue amount becomes effective as of your enrollment date. – If you enroll for more than the guaranteed issue amount, you must provide Proof of Good Health for you and/or your spouse/partner, as applicable. Your coverage is effective upon the date of approval by Prudential. • Salaried short-term disability coverage or truck driver short-term disability is canceled effective the first day of the pay period in which your transition occurs. • You are automatically enrolled in short-term disability enhanced coverage for hourly associates as of the first day of the pay period in which your transition occurs, unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans. (Associates in New York are automatically enrolled in the NY short-term disability enhanced plan.) See the **Short-term disability for full-time hourly associates** chapter for more information. • You are eligible to enroll in the long-term disability plan. **See page 300**

(Continued on the next page)

MANAGEMENT ASSOCIATES TRANSFERRING TO FULL-TIME HOURLY (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
More than 60 days after your date of hire	**If you are currently enrolled for benefits, you have 60 days to make a new enrollment from the date your transition occurs.** • The terms of your benefit plans as a full-time hourly associate are effective as of the date of your transition in status. You can find details about benefits available to full-time hourly associates in the **Enrollment and effective dates by job classification** charts earlier in this chapter. You can make limited changes only in plans you're already enrolled in. You cannot add or drop benefits until the next Annual Enrollment or until you have a valid status change event. If you are not currently enrolled for benefits, you cannot enroll until the next Annual Enrollment or until you have a valid status change event. • Optional associate life insurance amounts selected over $200,000 are reduced to $200,000. • You may enroll in optional associate life insurance or optional dependent life insurance at any time during the year, but Proof of Good Health will be required if you enroll or increase coverage after your initial enrollment period has ended. • Salaried short-term disability coverage or truck driver short-term disability is canceled effective the first day of the pay period in which your transition occurs. • You are automatically enrolled in short-term disability enhanced coverage for hourly associates as of the first day of the pay period in which your transition occurs, unless you work in the states of California, Hawaii, New Jersey, or Rhode Island, which have legally mandated disability plans. (Associates in New York are automatically enrolled in the NY short-term disability enhanced plan.) If you had not enrolled for benefits before your transition in status, your coverage under the LTD plan will not be effective until the 12-month anniversary of your date of hire. See the **Short-term disability for full-time hourly associates** and **Long-term disability** chapters for more information. **See page 300**

FULL-TIME HOURLY ASSOCIATES TRANSFERRING TO PART-TIME HOURLY OR TEMPORARY	
Your status at transition	**Coverage effective dates and details**
You have met your eligibility waiting period and were eligible for coverage under the Plan immediately prior to your transition	• If you are enrolled in medical, dental, vision, AD&D, critical illness, and/or accident insurance coverage, your coverage type is automatically adjusted to associate-only or associate + child(ren) (depending on whether you have covered dependents) effective the first day of the pay period after your transition occurs. Associate + spouse/partner and associate + family coverage are not available to part-time associates. • Company-paid life, dependent life for your spouse/partner and disability coverage are canceled effective the first day of the pay period after your transition occurs. You may be able to convert your company-paid life insurance and your dependent's life insurance to individual policies.

FULL-TIME HOURLY ASSOCIATES TRANSFERRING TO PART-TIME HOURLY OR TEMPORARY	
Your status at transition	**Coverage effective dates and details**
You have NOT met your eligibility waiting period	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • Your coverage is effective as follows: – If you enroll online or by calling People Services during the 60-day period but before the first day of the month during which your 89th day of continuous employment falls, your effective date is the first day of the calendar month during which your 89th day of continuous employment falls. – If you enroll online during the 60-day period but after the first day of the month during which your 89th day of continuous employment falls, your effective date is the date you enroll. However, if you enroll by calling People Services, you may choose to have your benefits effective the first day of the month during which your 89th day of continuous employment falls. • Premiums may be deducted from your paycheck on an after-tax basis retroactively to your effective date of coverage if you enroll after your 90th day of continuous employment. • You are eligible to enroll in medical, dental, vision, AD&D, optional associate life insurance and dependent life insurance for your children, critical illness, and accident insurance. See the respective chapters in this Summary Plan Description for more information. • If you enroll for optional associate life insurance during your initial enrollment period: – Your guaranteed issue amount becomes effective on your enrollment date or your eligibility date, whichever is later. – If you enroll for more than the guaranteed issue amount, you must complete Proof of Good Health. Your coverage becomes effective upon the date of approval by Prudential. • If you enrolled in the short-term disability enhanced plan for full-time hourly associates during your initial enrollment period but you have not reached the 12-month anniversary of your date of hire, coverage under the plan will not take effect as of that date. • If you enrolled in the LTD or LTD enhanced plan during your initial enrollment period, coverage will not take effect. • You are eligible to enroll in associate-only or associate + child(ren) coverage types.

MANAGEMENT ASSOCIATES TRANSFERRING TO PART-TIME HOURLY OR TEMPORARY	
Your status at transition	**Coverage effective dates and details**
You are within 60 days of your date of hire but have not enrolled for benefits	**You have 60 days to enroll from the date your transition in status occurs.** • You can find details about benefits for part-time hourly and temporary associates in the **Enrollment and effective dates by job classification** charts earlier in this chapter. • Premiums are deducted from your paycheck on an after-tax basis retroactively to your coverage effective date. • Company-paid life coverage and disability coverage are canceled effective the first day of the pay period after your transition occurs. You may be able to convert your company-paid life insurance to an individual policy.
You are within 60 days of your date of hire and you have enrolled for benefits	**You have 60 days to make a new enrollment from the date your transition in status occurs.** • You can find details about benefits for part-time hourly and temporary associates in the **Enrollment and effective dates by job classification** charts earlier in this chapter. • Premiums will be adjusted to your new benefit elections on an after-tax basis retroactively to your coverage effective date. • Optional associate life insurance amounts selected over $200,000 will be reduced to $200,000. • Company-paid life, optional dependent life for your spouse/partner, and disability coverage will be canceled effective the first day of the pay period after your transition occurs. You may be able to convert your company-paid life insurance and your dependent's life insurance to individual policies.
More than 60 days have passed since your date of hire	**If you are currently enrolled for benefits, you have 60 days to make a new enrollment from the date your transition occurs.** • The terms of your benefit plans as a part-time hourly or temporary associate are effective as of the date of your transition. You can find details about benefits for part-time hourly and temporary associates in the **Enrollment and effective dates by job classification** charts earlier in this chapter. You can make limited changes only in plans you're already enrolled in. You cannot add or drop benefits until the next Annual Enrollment or until you have a valid status change event. • Optional associate life insurance amounts selected over $200,000 are reduced to $200,000. • Company-paid life, optional dependent life for your spouse/partner, and disability coverage are canceled effective the first day of the pay period after your transition occurs. You may be able to convert your company-paid life insurance and your dependent's life insurance to individual policies. **If you are not currently enrolled for benefits, you cannot enroll until the next Annual Enrollment or until you have a valid status change event.**

You have 60 days from the date of your transition to a part-time hourly, temporary, or part-time truck driver position to elect any other medical coverage option available to you and/or your dependents under the Plan. You may not drop medical, dental, AD&D, critical illness, accident, or vision coverage for yourself and/or your dependent children during the Plan year. If you do not elect to change your coverage option within the 60-day enrollment period, you will continue to be covered by the same full-time medical option, but excluding spouse/partner coverage. You may change elections during any future Annual Enrollment or as the result of a status change event.

Qualified Medical Child Support Orders (QMCSO)

A QMCSO is a court or administrative agency order requiring an associate or other parent or guardian to provide health care coverage for eligible dependents after a divorce or child custody proceeding. Federal law requires the Plan to provide medical, dental, and/or vision benefits to any eligible dependent of a Plan participant required by a court order meeting the qualifications of a QMCSO.

You can obtain the written procedures for determining whether an order meets the federal requirements, free of charge, by contacting Medical Support Services at **877-930-5607**.

Once the Plan determines an order to be a QMCSO, coverage begins the first day of the pay period in which the Plan receives the order, unless another date is specified in the order. If you are eligible for the medical, dental, and/or vision plan and did not elect coverage before the order was received, you will be enrolled in the 2020 default Premier Plan with associate + child(ren) coverage at the tobacco rate, unless the QMCSO specifies otherwise. If you are in the state of Hawaii, the default plan is Health Plan Hawaii (HMSA). If you are in a location where the eComm PPO Plan is offered, the default plan is the Saver Plan.

If you were enrolled for coverage before the order was received, your child will be added under your existing coverage, with the following exceptions:

- If you are enrolled in an HMO plan or one of the local plans, your coverage will change to the Premier Plan, under which the child would have coverage regardless of where he or she lives.
- If you are enrolled in the eComm PPO Plan, your coverage will change to the Saver Plan, under which the child would have coverage regardless of where he or she lives.
- If you are in the state of Hawaii, your coverage will change to HMSA.

You have 60 days to call Medical Support Services at **877-930-5607** to select an alternative medical plan.

If the Plan receives a QMCSO 61–90 days prior to you satisfying your initial waiting period, the order will be put into effect when your initial waiting period is satisfied. If the Plan receives a QMCSO more than 90 days prior to you satisfying your initial waiting period, the order will be held until coverage takes effect. When the third-party administrator enforces coverage for a court-ordered dependent, information regarding the dependent is shared only with the legal custodian. If you have questions, contact Medical Support Services at **877-930-5607**.

See page 301

DROPPING OR CHANGING QMCSO COVERAGE

You may drop the court-ordered QMCSO coverage if the following applies:

- The QMCSO is terminated by a court or administrative agency order — you must request your change within 60 days.
- The QMCSO is rescinded by a court or administrative agency order.
- A child who is the subject of the court order reaches the age identified in the state issuing the court order for termination of coverage. Contact your state child support enforcement agency for details.

If the QMCSO is terminated or rescinded by court or administrative agency order, the court-ordered coverage will end on the date specified in the order or the first day of the pay period in which the Plan receives the order. If the order to rescind coverage is received, coverage will be retroactively withdrawn and you will be returned to the coverage status you had before the QMCSO was enforced, to the extent permitted by law.

When a QMCSO terminates, you may drop medical, dental, and/or vision coverage for the children named in the QMCSO. However, you may not drop your own coverage or coverage for any dependent voluntarily added after the QMCSO became effective unless there is a change in status for you or your child, or during Annual Enrollment. For dental coverage, you may not drop associate-level coverage at Annual Enrollment or due to a status change event unless you have been covered for two full calendar years.

When your Plan coverage ends

Coverage under the Associates' Health and Welfare Plan for you and your dependents ends on the earliest of the following:

- At termination of your employment
- The last day of coverage for which premiums were paid, if you fail to pay your premiums within 30 days of the date your premium is due
- On the date of your (the associate's) death, for you and your dependents
- On the date of death for a deceased dependent
- On the date you, a dependent spouse/partner, or child loses eligibility
- When the benefit is no longer offered by Walmart
- Upon misrepresentation or the fraudulent submission of a claim for benefits or eligibility
- Upon an act of fraud or a misstatement of a material fact, or
- The day after you drop coverage.

Premium deductions are withheld from your final paycheck since your deductions pay for coverage for the previous two weeks.

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Eligibility and benefits for associates in Hawaii

Because you work in Hawaii, there are some special rules about medical and short-term disability benefits. Those differences are described in this chapter. The rest of the information in this 2020 *Associate Benefits Book* applies to you.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Health Plan Hawaii (HMSA)	Go to **hmsa.com**	**808-948-6372**
Kaiser Foundation Health Plan	Go to **kaiserpermanente.org**	**800-966-5955**
Enroll in Walmart benefits	Go to **One.Walmart.com**	Call People Services at **800-421-1362**
Report a claim under the legally mandated state disability insurance program	Go to **One.Walmart.com** or directly to **MyLincolnPortal.com**	Call Lincoln at **800-492-5678**
Notify People Services within 60 days of a status change event	Go to **One.Walmart.com**	Call People Services at **800-421-1362**

What you need to know as a Hawaii associate

- Associates in Hawaii have two medical coverage options: Health Plan Hawaii (HMSA) and the Kaiser Foundation Health Plan. For information about these medical options, go to **One.Walmart.com**.
- Because Hawaii has a legally mandated disability plan, the company short-term disability plan for hourly associates is not an option for associates in Hawaii.
- Initial eligibility periods for coverage vary for Hawaii associates based on their employment status, as described in this chapter.

Eligibility waiting periods for medical coverage

MANAGEMENT ASSOCIATES

If you are a management associate in Hawaii, the eligibility terms described in the **Eligibility and enrollment** chapter apply to you; management associates and management trainees in Hawaii are eligible for medical coverage on their date of hire. For details on eligibility and enrollment in all of the benefits available under the Associates' Health and Welfare Plan, refer to the chart for management associates in the **Enrollment and effective dates by job classification** section of the **Eligibility and enrollment** chapter.

FULL-TIME HOURLY, PART-TIME HOURLY AND TEMPORARY ASSOCIATES

If you are a full-time hourly associate (including full-time hourly pharmacists and field supervisor positions in stores and clubs) or a part-time hourly and temporary associate in Hawaii, you are subject to legally mandated rules governing eligibility for medical coverage. For benefits other than medical, you follow the eligibility terms described in the **Eligibility and enrollment** chapter. For details, refer to the appropriate chart under **Enrollment and effective dates for Hawaii associates** later in this chapter.

Medical coverage options for Hawaii associates

Associates in Hawaii have two coverage options:

- Health Plan Hawaii (HMSA), and
- Kaiser Foundation Health Plan.

For details about these medical options, go to **One.Walmart.com**.

Paying premiums during a leave of absence for Hawaii associates

Because the associate portion of your medical premium is wage-based, no premium is due from you if you are not receiving wages during an approved leave of absence. The only premium due for medical coverage while you are on an approved leave of absence with no wages is the dependent portion of your premium. All other coverage options require payment as described in the **Eligibility and enrollment** chapter.

Under Hawaii law, Walmart must contribute at least 50% of the premium for your (associate only) medical coverage, but not for dependent coverage. Associates are required to pay the rest of the biweekly cost of the premium, but only up to 1.5% of their wages or 50% of the biweekly cost of the premium, whichever is less. For example: if your biweekly wages are $1,000 and you qualify for tobacco-free rates, you are not required to pay more than $15 biweekly for coverage (assuming that the entire premium is at least $30 biweekly).

Enrollment and effective dates for Hawaii associates

FULL-TIME HOURLY ASSOCIATES
Includes full-time hourly pharmacists and field supervisor positions in stores and clubs

Plan	Enrollment Periods and Effective Dates	
Medical	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and the day prior to your effective date. **When coverage is effective:** Your coverage is effective the earlier of: • The first day of the pay period following a period of working at least 20 hours per week for four consecutive weeks, or • The first day of the calendar month during which your 89th day of continuous full-time employment falls.	**NOTE:** The pretax benefit elections you make stay in effect through the full Plan year (Jan. 1 – Dec. 31) unless you have a status change event recognized by IRS regulations.
Dental (enrollment is for two full calendar years) Vision Critical illness insurance Accident insurance AD&D	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and the day prior to your effective date. **When coverage is effective:** Your coverage is effective the first day of the calendar month during which your 89th day of continuous full-time employment falls.	
Company-paid life insurance	You are automatically enrolled on the first day of the calendar month during which your 89th day of continuous full-time employment falls.	
Resources for Living Business travel accident insurance	You are automatically enrolled on your date of hire.	
Optional associate life insurance Optional dependent life insurance	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and the day prior to your effective date. **When coverage is effective:** **If you enroll during your initial enrollment period:** • The guaranteed issue amount is effective on the later of your enrollment date or the first day of the calendar month during which your 89th day of continuous full-time employment falls. • When you enroll for more than the guaranteed issue amount, you must provide Proof of Good Health for yourself and/or your spouse/partner. Following Prudential's approval, your coverage is effective upon the later of the date of Prudential's approval or the first day of the calendar month during which your 89th day of continuous full-time employment falls. **If you enroll after your initial enrollment period:** You may enroll or drop coverage at any time during the year, but Proof of Good Health is required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage is effective upon the date of approval by Prudential.	
Long-term disability (LTD) plan LTD enhanced plan	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and the first day of the calendar month during which your 89th day of continuous full-time employment falls. **When coverage is effective:** If you enroll during your initial enrollment period, coverage is effective on your 12-month anniversary. *If you enroll after your initial enrollment period, your coverage is effective 12 months after the date you enroll or, in the event of a status change, 12 months after the date of the event.* **See page 298**	

PART-TIME HOURLY AND TEMPORARY ASSOCIATES		
Plan	**Enrollment Periods and Effective Dates**	
Medical* * Part-time hourly and temporary associates in Hawaii are not subject to the requirements described under **Part-time hourly and temporary associates: eligibility checks for medical benefits** in the **Eligibility and enrollment** chapter.	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and the day prior to your effective date. **When coverage is effective:** Your coverage is effective the earlier of: • The first day of the pay period following a period of working at least 20 hours per week for four consecutive weeks, or • The first day of the calendar month during which your 89th day of continuous employment falls.	**NOTE:** The pretax benefit elections you make stay in effect through the full Plan year (Jan. 1 – Dec. 31) unless you have a status change event recognized by IRS regulations.
Dental (enrollment is for two full calendar years) Vision Critical illness insurance Accident insurance AD&D	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and the day prior to your effective date. **When coverage is effective:** Your coverage is effective the first day of the calendar month during which your 89th day of continuous employment falls.	
Resources for Living Business travel accident insurance	You are automatically enrolled on your date of hire.	
Optional associate life insurance Optional dependent life insurance	**Initial enrollment period:** You must enroll between the date of your first paycheck and the day prior to your effective date. **When coverage is effective:** • **If you enroll during your initial enrollment period:** – The guaranteed issue amount is effective on the later of your enrollment date or the first day of the calendar month during which your 89th day of continuous full-time employment falls. – When you enroll for more than the guaranteed issue amount, you must provide Proof of Good Health for yourself and/or your spouse/partner. Following Prudential's approval, your coverage is effective upon the later of the date of Prudential's approval or the first day of the calendar month during which your 89th day of continuous full-time employment falls. • **If you enroll after your initial enrollment period:** You may enroll or drop coverage at any time during the year, but Proof of Good Health is required if you enroll (or increase your coverage) at any time after your initial enrollment period. Your coverage is effective upon the date of approval by Prudential.	

NOTE: Part-time hourly and temporary associates may only cover their eligible dependent children and may not cover their spouses/partners. Disability coverage and company-paid life insurance are not available to part-time hourly and temporary associates.

Management associates: Refer to the chart for management associates in the **Enrollment and effective dates by job classification** section of the **Eligibility and enrollment** chapter.

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The medical plan

RESOURCES			
Find What You Need	**Online**	**By Phone: Health Care Advisor**	**Other Resources**
Aetna	Go to **One.Walmart.com** or **aetna.com**	**855-548-2387**	**Aetna** **151 Farmington Avenue** **Hartford, Connecticut 06156**
BlueAdvantage Administrators of Arkansas	Go to **One.Walmart.com** or **blueadvantagearkansas.com**	**866-823-3790**	**BlueAdvantage Administrators of Arkansas** **P.O. Box 1460** **Little Rock, Arkansas 72203-1460**
Grand Rounds (Administration in North Carolina and South Carolina for BlueAdvantage Administrators of Arkansas)		**855-377-2200** Personal Healthcare Assistant	
HealthSCOPE Benefits	Go to **One.Walmart.com** or **healthscopebenefits.com**	**800-804-1272** **877-385-8786** Expanded telehealth in MN, CO, and WI	**HealthSCOPE Benefits** **P.O. Box 16367** **Lubbock, Texas 79490-6367**
UnitedHealthcare	Go to **One.Walmart.com** or **myuhc.com**	**888-285-9255**	**UnitedHealthcare** **P.O. Box 30555** **Salt Lake City, Utah 84130-0555**
Request a paper copy of this 2020 *Associate Benefits Book*		Call People Services at **800-421-1362**	

What you need to know about medical benefits

- If you are eligible for coverage under the Associates' Medical Plan (AMP), you can choose one of various national plans or locally available plans. This chapter describes these plan options and where they are available.
- Eligible preventive care services are paid at 100% with no deductible, when received from any network provider.
- Plan options have no annual or lifetime maximum dollar limits and have no limitations on pre-existing conditions.
- All plan options provide access to a network of providers. Depending on your plan and work location, some options offer out-of-network coverage.
- Depending on the medical option you choose, you may be eligible for funds in the form of a Health Reimbursement Account (HRA), which you can use for eligible medical expenses, or a company match to your own tax-free contributions to a health savings account (HSA), which you can save or use for eligible medical expenses.
- HMO plans are offered in select areas. Refer to your personnel representative to find out if an HMO is available in your area and to request HMO plan information.
- The eComm PPO Plan is offered in some locations. If the eComm PPO Plan is available at your work location, the plan benefits are described in materials provided separately by Aetna, the Plan's third-party administrator.
- The AMP provides prescription drug coverage through the pharmacy benefit. For information, see **The pharmacy benefit** chapter.
- If you enroll in the Premier Plan and you have a balance in the Health Reimbursement Account (HRA) associated with the former HRA Plan option, you can use the remaining funds for limited purposes through the end of 2021, provided you remain enrolled in the Premier Plan option.

The Associates' Medical Plan (AMP)

If you are eligible to enroll in the AMP, you may choose from among several options available under the AMP. The specific options available to you depend on your work location. Generally, there are three options available nationwide: the Walmart Premier Plan, the Walmart Contribution Plan, and the Walmart Saver Plan. Terms for these national options vary in specified geographic areas, as described below. Local plan options are also available in certain regions. All options available to you are described in this chapter.

If you work in Hawaii, see the chapter titled **Eligibility and benefits for associates in Hawaii**.

CHOOSING A COVERAGE LEVEL

When you enroll in the AMP, you also select your coverage level depending on which, if any, of the eligible dependents you wish to cover:

- Associate only
- Associate + spouse/partner (except for part-time hourly associates, temporary associates, or part-time truck drivers)
- Associate + child(ren), or
- Associate + family (except for part-time hourly associates, temporary associates, or part-time truck drivers).

For information on dependent eligibility and when dependents can be enrolled, see the **Eligibility and enrollment** chapter.

National plan options

The charts on the following pages summarize the coverage offered under the AMP coverage options.

The national plan options under the AMP are the Premier Plan, the Contribution Plan, and the Saver Plan. Under each of these options, plan terms in most areas nationwide are summarized in the left-hand charts on the following pages.

If you participate in the Premier Plan, Contribution Plan, or Saver Plan and your work location is within certain geographic areas, as listed below, these national plans have slightly different terms from the terms of the national plan options available in most areas nationwide. These different terms apply if you work in one of the following areas:

- **Central Florida (including Orlando and Tampa)**
  - Counties within this area are Brevard, Citrus, Hernando, Hillsborough, Lake, Manatee, Marion, Orange, Osceola, Pasco, Pinellas, Polk, northern Sarasota (Sarasota area only), Seminole, Sumter, and Volusia
- **Dallas/Fort Worth**
  - Counties within this area are Collin, Dallas, Denton, Ellis, Hunt, Johnson, Kaufman, Parker, Rockwall, Tarrant, and Wise
- **Northwest Arkansas**
  - Counties within this area are Benton, Madison, and Washington

References throughout this chapter to "central Florida, Dallas/Fort Worth, and northwest Arkansas" are references to these listed counties, respectively.

Terms of the national plan options available in central Florida, Dallas/Fort Worth, and northwest Arkansas are summarized in the right-hand charts on the following pages.

See page 301 *for information replacing the text above headed* ***National plan options****, and the charts on pages 47, 48, and 49.*

See pages 302-305

THE WALMART PREMIER PLAN

PREMIER PLAN BENEFITS		PREMIER PLAN BENEFITS (Associates with work locations in central FL, Dallas/Fort Worth, northwest AR)	
Annual deductible (Individual/Family) • Network • Out-of-network	 $2,750/$5,500 $5,500/$11,000	**Annual deductible** (Individual/Family) • Network (Network benefits only)	 $2,750/$5,500
Annual out-of-pocket maximum (Individual/Family) • Network • Out-of-network	 $6,850/$13,700 None	**Annual out-of-pocket maximum** (Individual/Family) • Network (Network benefits only)	 $6,850/$13,700
Eligible preventive care • Network provider • Non-network provider	 100% (no deductible) 50% (no deductible)	**Eligible preventive care** • Network provider • Non-network provider	 100% (no deductible) No coverage
Doctor visits *Including routine same-day diagnostic tests performed in doctor's office* **Primary care** • Network provider • Non-network provider **Specialist** • Network provider • Non-network provider	 100% after $35 copay 50% after deductible 100% after $75 copay 50% after deductible	**Doctor visits** *Including routine same-day diagnostic tests performed in doctor's office* **Primary care** • Network provider • Non-network provider **Specialist** • Network provider • Non-network provider	 100% after $35 copay No coverage 100% after $75 copay No coverage
Telehealth video visits Doctor On Demand • Network provider • Non-network provider	 100% after $4 copay N/A	**Telehealth video visits** Doctor On Demand • Network provider • Non-network provider	 100% after $4 copay N/A
Urgent care • Network provider • Non-network provider	 100% after $75 copay 50% after deductible	**Urgent care** • Network provider • Non-network provider	 100% after $75 copay No coverage
Diagnostic tests *All nonpreventive tests ordered or performed outside a doctor's office* • Network provider • Non-network provider	 75% after deductible 50% after deductible	**Diagnostic tests** *All nonpreventive tests ordered or performed outside a doctor's office* • Network provider • Non-network provider	 75% after deductible No coverage
Advanced imaging MRI, CT scans • Alternate network provider • Network provider • Non-network provider	 75% after deductible 50% after deductible 50% after deductible	**Advanced imaging** MRI, CT scans • Alternate network provider • Network provider • Non-network provider	 75% after deductible 50% after deductible No coverage
Hospitalization Inpatient & outpatient care • Network provider • Non-network provider	 75% after deductible 50% after deductible	**Hospitalization** Inpatient & outpatient care • Network provider • Non-network provider	 75% after deductible No coverage
Behavioral health **Inpatient & outpatient (facility)** • Network provider • Non-network provider **Outpatient (provider's office)** • Network provider • Non-network provider	 75% after deductible 50% after deductible 100% after $35/visit copay 50% after deductible	**Behavioral health** **Inpatient & outpatient (facility)** • Network provider • Non-network provider **Outpatient (provider's office)** • Network provider • Non-network provider	 75% after deductible No coverage 100% after $35/visit copay No coverage
Emergency room visit • Network provider For non-network coverage, see **The Premier Plan** later in chapter.	 100% after deductible and $300 copay	**Emergency room visit** • Network provider For non-network coverage, see **The Premier Plan** later in chapter.	 100% after deductible and $300 copay
Pharmacy	See **The pharmacy benefit** chapter.	**Pharmacy**	See **The pharmacy benefit** chapter.
Centers of Excellence	See the **Centers of Excellence** section of this chapter.	**Centers of Excellence**	See the **Centers of Excellence** section of this chapter.
Walmart Care Clinic and Walmart Health	See the **Walmart Care Clinic and Walmart Health** section of this chapter.	**Walmart Care Clinic and Walmart Health**	See the **Walmart Care Clinic and Walmart Health** section of this chapter.
		No benefits are payable for services provided outside the network except for emergency services.	

See pages 302-305

THE WALMART CONTRIBUTION PLAN

CONTRIBUTION PLAN BENEFITS		CONTRIBUTION PLAN BENEFITS (Associates with work locations in central FL, Dallas/Fort Worth, northwest AR)	
Annual deductible (Individual/Family) • Network • Out-of-network	 $1,750/$3,500 $3,500/$7,000	**Annual deductible** (Individual/Family) • Network (Network benefits only)	 $1,750/$3,500
Walmart-provided funds (Individual/Family)	$250/$500 *Maximum company contribution to HRA*	**Walmart-provided funds** (Individual/Family)	$250/$500 *Maximum company contribution to HRA*
Annual out-of-pocket maximum (Individual/Family) • Network • Out-of-network	 $6,850/$13,700 None	**Annual out-of-pocket maximum** (Individual/Family) • Network (Network benefits only)	 $6,850/$13,700
Eligible preventive care • Network provider • Non-network provider	 100% (no deductible) 50% (no deductible)	**Eligible preventive care** • Network provider • Non-network provider	 100% (no deductible) No coverage
Doctor visits *Including routine same-day diagnostic tests performed in doctor's office* **Primary care** • Network provider • Non-network provider **Specialist** • Network provider • Non-network provider	 75% after deductible 50% after deductible 75% after deductible 50% after deductible	**Doctor visits** *Including routine same-day diagnostic tests performed in doctor's office* **Primary care** • Network provider • Non-network provider **Specialist** • Network provider • Non-network provider	 75% after deductible No coverage 75% after deductible No coverage
Telehealth video visits Doctor On Demand • Network provider • Non-network provider	 100% after $4 copay N/A	**Telehealth video visits** Doctor On Demand • Network provider • Non-network provider	 100% after $4 copay N/A
Urgent care • Network provider • Non-network provider	 75% after deductible 50% after deductible	**Urgent care** • Network provider • Non-network provider	 75% after deductible No coverage
Diagnostic tests *All nonpreventive tests ordered or performed outside a doctor's office* • Network provider • Non-network provider	 75% after deductible 50% after deductible	**Diagnostic tests** *All nonpreventive tests ordered or performed outside a doctor's office* • Network provider • Non-network provider	 75% after deductible No coverage
Advanced imaging MRI, CT scans • Alternate network provider • Network provider • Non-network provider	 75% after deductible 50% after deductible 50% after deductible	**Advanced imaging** MRI, CT scans • Alternate network provider • Network provider • Non-network provider	 75% after deductible 50% after deductible No coverage
Hospitalization Inpatient & outpatient care • Network provider • Non-network provider	 75% after deductible 50% after deductible	**Hospitalization** Inpatient & outpatient care • Network provider • Non-network provider	 75% after deductible No coverage
Behavioral health **Inpatient & outpatient (facility)** • Network provider • Non-network provider **Outpatient (provider's office)** • Network provider • Non-network provider	 75% after deductible 50% after deductible 75% after deductible 50% after deductible	**Behavioral health** **Inpatient & outpatient (facility)** • Network provider • Non-network provider **Outpatient (provider's office)** • Network provider • Non-network provider	 75% after deductible No coverage 75% after deductible No coverage
Emergency room visit • Network provider For non-network coverage, see **The Contribution Plan** later in chapter.	100% after deductible and $300 copay	**Emergency room visit** • Network provider For non-network coverage, see **The Contribution Plan** later in chapter.	100% after deductible and $300 copay
Pharmacy	See **The pharmacy benefit** chapter.	**Pharmacy**	See **The pharmacy benefit** chapter.
Centers of Excellence	See the **Centers of Excellence** section of this chapter.	**Centers of Excellence**	See the **Centers of Excellence** section of this chapter.
Walmart Care Clinic and Walmart Health	See the **Walmart Care Clinic and Walmart Health** section of this chapter.	**Walmart Care Clinic and Walmart Health**	See the **Walmart Care Clinic and Walmart Health** section of this chapter.
		No benefits are payable for services provided outside the network except for emergency services.	

THE WALMART SAVER PLAN

SAVER PLAN BENEFITS	
Annual deductible (Individual/Family) • Network • Out-of-network	 $3,000/$6,000 $6,000/$12,000
Walmart-provided funds (Individual/Family)	$350/$700 *Maximum company matching contribution to HSA*
Annual out-of-pocket maximum (Individual/Family) • Network • Out-of-network	 $6,650/$13,300 None
Eligible preventive care • Network provider • Non-network provider	 100% (no deductible) 50% (no deductible)
Doctor visits *Including routine same-day diagnostic tests performed in doctor's office* **Primary care** • Network provider • Non-network provider **Specialist** • Network provider • Non-network provider	 75% after deductible 50% after deductible 75% after deductible 50% after deductible
Telehealth video visits Doctor On Demand • Network provider • Non-network provider	 100% after deductible and $4 copay N/A
Urgent care • Network provider • Non-network provider	 75% after deductible 50% after deductible
Diagnostic tests *All nonpreventive tests ordered or performed outside a doctor's office* • Network provider • Non-network provider	 75% after deductible 50% after deductible
Advanced imaging MRI, CT scans • Alternate network provider • Network provider • Non-network provider	 75% after deductible 50% after deductible 50% after deductible
Hospitalization Inpatient & outpatient care • Network provider • Non-network provider	 75% after deductible 50% after deductible
Behavioral health **Inpatient & outpatient (facility)** • Network provider • Non-network provider **Outpatient (provider's office)** • Network provider • Non-network provider	 75% after deductible 50% after deductible 75% after deductible 50% after deductible
Emergency room visit • Network provider For non-network coverage, see **The Saver Plan** later in chapter.	 100% after deductible and $300 copay
Pharmacy	See **The pharmacy benefit** chapter.
Centers of Excellence	See the **Centers of Excellence** section of this chapter.
Walmart Care Clinic and Walmart Health	See the **Walmart Care Clinic and Walmart Health** section of this chapter.

SAVER PLAN BENEFITS (Associates with work locations in central FL, Dallas/Fort Worth, northwest AR)	
Annual deductible (Individual/Family) • Network (Network benefits only)	 $3,000/$6,000
Walmart-provided funds (Individual/Family)	$350/$700 *Maximum company matching contribution to HSA*
Annual out-of-pocket maximum (Individual/Family) • Network (Network benefits only)	 $6,650/$13,300
Eligible preventive care • Network provider • Non-network provider	 100% (no deductible) No coverage
Doctor visits *Including routine same-day diagnostic tests performed in doctor's office* **Primary care** • Network provider • Non-network provider **Specialist** • Network provider • Non-network provider	 75% after deductible No coverage 75% after deductible No coverage
Telehealth video visits Doctor On Demand • Network provider • Non-network provider	 100% after deductible and $4 copay N/A
Urgent care • Network provider • Non-network provider	 75% after deductible No coverage
Diagnostic tests *All nonpreventive tests ordered or performed outside a doctor's office* • Network provider • Non-network provider	 75% after deductible No coverage
Advanced imaging MRI, CT scans • Alternate network provider • Network provider • Non-network provider	 75% after deductible 50% after deductible No coverage
Hospitalization Inpatient & outpatient care • Network provider • Non-network provider	 75% after deductible No coverage
Behavioral health **Inpatient & outpatient (facility)** • Network provider • Non-network provider **Outpatient (provider's office)** • Network provider • Non-network provider	 75% after deductible No coverage 75% after deductible No coverage
Emergency room visit • Network provider For non-network coverage, see **The Saver Plan** later in chapter.	 100% after deductible and $300 copay
Pharmacy	See **The pharmacy benefit** chapter.
Centers of Excellence	See the **Centers of Excellence** section of this chapter.
Walmart Care Clinic and Walmart Health	See the **Walmart Care Clinic and Walmart Health** section of this chapter.
No benefits are payable for services provided outside the network except for emergency services.	

Local plan options

Local plan options are available in designated regions, as listed here:

LOCAL PLAN	AVAILABLE FOR ASSOCIATES WITH WORK LOCATIONS IN DESIGNATED AREAS	THIRD-PARTY ADMINISTRATOR
Banner Local Plan	Phoenix, Arizona metropolitan area	Aetna
Emory Local Plan	Atlanta, Georgia metropolitan area	HealthSCOPE Benefits
Memorial Hermann Local Plan	Houston, Texas metropolitan area	HealthSCOPE Benefits
Mercy Arkansas Local Plan	Portions of northwest Arkansas and McDonald County, Missouri	HealthSCOPE Benefits
Mercy Oklahoma Local Plan	Oklahoma City metropolitan area, Ada, and Ardmore areas	HealthSCOPE Benefits
Mercy Southwest Missouri (SW MO) Local Plan	Springfield, southwest and east-central Missouri	HealthSCOPE Benefits
Mercy St. Louis Local Plan	St. Louis metropolitan area and portions of eastern Missouri	HealthSCOPE Benefits
Ochsner Local Plan	New Orleans and Baton Rouge, Louisiana metropolitan areas	HealthSCOPE Benefits
St. Luke's Local Plan	Boise, Idaho metropolitan area	Aetna
UnityPoint Local Plan	Portions of Iowa, western Illinois and Peoria, Illinois area	HealthSCOPE Benefits
Select Local Plan	Designated regions nationwide	Aetna

See page 306 *for information on discontinued local plans.*

The local plan options give you access to groups of providers that offer care specifically coordinated to your needs to ensure that you receive the right high quality care at the right time. Agreements between the Plan and these providers may include financial incentives to manage care. Additional information about the local plan options can be found under the **The local plans** later in this chapter.

The following charts summarize the coverage available under the local plan options. With very limited exceptions, in the designated areas where a local plan option is available, it will generally replace the Walmart Contribution Plan as a coverage option for associates if your work location is in those areas. In other words, if a local plan is available in an area that includes your work location, you will be able to choose coverage under the Walmart Premier Plan, the Walmart Saver Plan, or the available local plan option, but in most areas you will not be able to choose the Walmart Contribution Plan.

The local plan options do not cover the services of doctors, hospitals, or other providers who are not in the local plan option's network, except in cases of emergency services.

For details about coverage under the local plan options, see the summary charts that follow and **The local plans** later in this chapter.

BANNER LOCAL PLAN AND MERCY SOUTHWEST MISSOURI (SW MO) LOCAL PLAN	
	Network Benefits Only *No benefits for services provided outside the network except for emergency services*
Annual deductible Associate only Associate + dependent(s) *Does not apply to eligible preventive care*	 $3,000 $6,000
Annual out-of-pocket maximum	$6,850 Per person $13,700 Per family
Eligible preventive care	100% No deductible
Doctor visits* *Including routine same-day diagnostic x-rays and tests performed in the doctor's office*	
Primary care physician (PCP) office visit Specialist office visit* Behavioral health office visit Urgent care visit	$35 copay $75 copay $35 copay $75 copay
Diagnostic tests *All nonpreventive tests ordered or performed outside a doctor's office*	75% after deductible
Hospitalization Inpatient, outpatient	75% after deductible
Emergency room visit	100% after deductible and $300 copay
Behavioral health Inpatient and outpatient *See above for doctor visits*	75% after deductible
Telehealth video visits Doctor On Demand	$4 copay
Pharmacy	See **The pharmacy benefit** chapter for details.
Centers of Excellence	See the **Centers of Excellence** section of this chapter for details.
Walmart Care Clinic and Walmart Health	See the **Walmart Care Clinic and Walmart Health** section of this chapter for details.

* The Mercy Southwest Missouri (SW MO) Local Plan offers limited coverage for chiropractic care office visits. There is a maximum of 10 visits per calendar year.

EMORY, MERCY ARKANSAS, MERCY OKLAHOMA, MERCY ST. LOUIS, ST. LUKE'S, UNITYPOINT, MEMORIAL HERMANN, AND OCHSNER LOCAL PLANS

	Network Benefits Only *No benefits for services provided outside the network except for emergency services*
Annual deductible Associate only Associate + dependent(s) *Does not apply to eligible preventive care*	 $1,750 $3,500
Annual out-of-pocket maximum	$6,850 Per person $13,700 Per family
Eligible preventive care	100% No deductible
Doctor visits* *Including routine same-day diagnostic x-rays and tests performed in the doctor's office*	
Primary care physician (PCP) office visit Specialist office visit* Behavioral health office visit Urgent care visit	$35 copay $75 copay $35 copay $75 copay
Diagnostic tests *All nonpreventive tests ordered or performed outside a doctor's office*	75% after deductible
Hospitalization Inpatient, outpatient	75% after deductible
Emergency room visit	100% after deductible and $300 copay
Behavioral health Inpatient and outpatient *See above for doctor visits*	75% after deductible
Telehealth video visits Doctor On Demand	$4 copay
Pharmacy	See **The pharmacy benefit** chapter for details.
Centers of Excellence	See the **Centers of Excellence** section of this chapter for details.
Walmart Care Clinic and Walmart Health	See the **Walmart Care Clinic and Walmart Health** section of this chapter for details.

* The Mercy Local Plans for Arkansas, Oklahoma, and St. Louis offer limited coverage for chiropractic care office visits. There is a maximum of 10 visits per calendar year.

See page 306 *for information on discontinued local plans.*

THE SELECT LOCAL PLAN	
	Network Benefits Only *No benefits for services provided outside the network except for emergency services*
Annual deductible Associate only Associate + dependent(s) *Does not apply to eligible preventive care*	 $2,750 $5,500
Annual out-of-pocket maximum	$6,850 Per person $13,700 Per family
Eligible preventive care	100% No deductible
Doctor visits *Including routine same-day diagnostic x-rays and tests performed in the doctor's office*	
Primary care physician (PCP) office visit Specialist office visit Behavioral health office visit Urgent care visit	$35 copay $75 copay $35 copay $75 copay
Diagnostic tests *All nonpreventive tests ordered or performed outside a doctor's office*	75% after deductible
Hospitalization	75% after deductible
Emergency room visit	100% after deductible and $300 copay
Behavioral health Inpatient and outpatient *See above for doctor visits*	 75% after deductible
Telehealth video visits Doctor On Demand	 $4 copay
Pharmacy	See **The pharmacy benefit** chapter for details.
Centers of Excellence	See the **Centers of Excellence** section of this chapter for details.
Walmart Care Clinic and Walmart Health	See the **Walmart Care Clinic and Walmart Health** section of this chapter for details.

See page 306

HMO plan options

Health maintenance organization (HMO) plan options, which are available in some locations, are offered under the Associates' Health and Welfare Plan, but are independent of the AMP, including the national plans and local plans offered under the AMP. To find out if an HMO is available at your work location, contact your personnel representative. If one is available, coverage details are described in materials provided separately by the HMO. The HMO may have different eligibility terms and waiting periods than those described in the **Eligibility and enrollment** chapter of this *Associate Benefits Book*, but if there is any difference between the HMO's eligibility terms and the eligibility terms described in the **Eligibility and enrollment** chapter, the eligibility terms described in the **Eligibility and enrollment** chapter will control.

Some HMOs require participants to accept an arbitration agreement, where permitted by law, before coverage under the HMO can become effective. Your acceptance of this agreement must be received by the HMO within 60 days of your initial enrollment or your HMO coverage will not take effect. If the HMO does not receive your agreement within 60 days of your initial enrollment, you will not have medical coverage under the Plan unless you have a valid status change event as described in the **Eligibility and enrollment** chapter.

The eComm PPO Plan

The eComm PPO Plan option, which is available in some locations, is offered under the Associates' Health and Welfare Plan, but is independent of the AMP, including the national plans and local plans offered under the AMP. To find out if the eComm PPO Plan option is available at your work location, contact your personnel representative. If

it is available, coverage details are described in materials provided separately by the eComm PPO Plan's third-party administrator. The eComm PPO Plan may have different eligibility terms and waiting periods than those described in the **Eligibility and enrollment** chapter of this *Associate Benefits Book*, but if there is any difference between the eComm PPO Plan's eligibility terms and the eligibility terms described in the **Eligibility and enrollment** chapter, the eligibility terms described in the **Eligibility and enrollment** chapter will control.

Over the next several pages you'll find detailed descriptions of the AMP options, as follows:

- The national plans, distinguishing between:
  - those that apply to most associates nationwide
  - those available to associates whose work locations are in central Florida, Dallas/Fort Worth, or northwest Arkansas *(these sections are shaded)*
- The local plans

Refer also to the summary charts at the beginning of this chapter for cost-sharing details for each plan.

The Walmart Premier Plan

PREMIER PLAN COVERAGE

If your work location is *not* in central Florida, Dallas/Fort Worth, or northwest Arkansas

This section describes coverage under the Premier Plan in all areas *except* specific geographic areas of central Florida, Dallas/Fort Worth, and northwest Arkansas. See **National Plan options** earlier in this chapter for the specific counties that make up these areas. See **Premier Plan coverage for work locations in central Florida, Dallas/Fort Worth, and northwest Arkansas** later in this chapter for details about Premier Plan coverage if your work location is in those specified geographic areas.

The Premier Plan offers you the ability to pay for doctor visits with fixed amounts, called "copayments" or "copays," as explained below under **Coinsurance, copays, and the out-of-pocket maximum**. If you were enrolled in the HRA Plan in 2019 and have a balance in the Health Reimbursement Account (HRA) associated with that plan, you can use the remaining funds to pay for the copay required for doctor's office visits (primary care or specialist), Walmart Care Clinic or Walmart Health, Doctor On Demand, or urgent care through the end of 2021, provided you remain enrolled in the Premier Plan option.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Premier Plan begins paying a portion of the cost of covered services. Copays are in addition to the annual deductible and do not count toward the deductible. The Premier Plan has a separate annual deductible for services provided by network providers and services provided by non-network providers. Amounts you pay toward the network annual deductible apply toward the out-of-network annual deductible, and vice versa.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the network annual deductible and the out-of-network annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire applicable annual deductible is met. The following expenses do not count toward the network or out-of-network annual deductible:

- Copays for doctor office visits, Doctor On Demand, urgent care, Walmart Care Clinic or Walmart Health, or emergency room visits
- Pharmacy copays/coinsurance (including copay assistance from a third party)
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services that are in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP
- Charges paid 100% by the AMP, such as charges for network preventive services and certain Centers of Excellence services, and
- Charges for out-of-network preventive services.

Coinsurance, copayments, and the out-of-pocket maximum

After you meet your network annual deductible for covered services that do not require a copayment, the Premier Plan pays 75% of the cost of covered services from a network provider and your share is 25% coinsurance. However, the Plan will pay 100% of the cost of covered preventive services from a network provider before you meet your network deductible and no copayment will be required. For covered

services subject to a copayment, you must continue to pay the copayment, even after your annual deductible has been met, until you meet your annual out-of-pocket maximum. After you meet your out-of-network annual deductible for covered services that are subject to the deductible and that do not require a copayment, the Plan pays 50% of the maximum allowable charge of covered services from a non-network provider and you pay the rest — i.e., you are responsible for the other 50% coinsurance plus any amount charged above the maximum allowable charge.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your network annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your out-of-network deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

IMPORTANT TERMS

See the **Glossary** for definitions of **coinsurance** and **copayment**.

After you meet the annual out-of-pocket maximum for network services, the Plan pays 100% of the cost of covered services from a network provider for the rest of the calendar year. There is no annual out-of-pocket maximum for services from non-network providers — you are responsible for paying your share of these charges in full throughout the year. The amounts you pay that apply toward your network annual out-of-pocket maximum include:

- Network and out-of-network annual deductibles (including amounts paid with remaining HRA funds)
- Copays for doctor office visits, Doctor On Demand, urgent care, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network, and
- Pharmacy copays/coinsurance.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for network preventive services and certain Centers of Excellence services
- Charges for out-of-network preventive services
- Coinsurance when using non-network providers
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP.

If you choose associate-only coverage under the Premier Plan, you will have an individual out-of-pocket maximum for network expenses of $6,850. If you add dependents to your coverage, you will have an out-of-pocket maximum for network expenses of $13,700 per family. Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,850. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible network expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum.

PREMIER PLAN COVERAGE FOR WORK LOCATIONS IN CENTRAL FLORIDA, DALLAS/ FORT WORTH, AND NORTHWEST ARKANSAS

The Premier Plan offers you the ability to pay for doctor visits with fixed amounts, called "copayments" or "copays," as explained below under **Coinsurance, copays, and the out-of-pocket maximum**. If you were enrolled in the HRA Plan in 2019 and have a balance in the Health Reimbursement Account (HRA) associated with that plan, you can use the remaining funds to pay for the copay required for doctor's office visits (primary care or specialist), Walmart Care Clinic or Walmart Health, Doctor On Demand, or urgent care through the end of 2021, provided you remain enrolled in the Premier Plan option.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Premier Plan begins paying a portion of the cost of covered services. Copays are in addition to the annual deductible and do not count toward the deductible.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire annual deductible is met.

The following expenses do not count toward the annual deductible:

- Copays for doctor office visits, Doctor On Demand, urgent care, Walmart Care Clinic or Walmart Health, or emergency room visits
- Pharmacy copays/coinsurance (including copay assistance from a third party)
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP, and
- Charges paid 100% by the AMP, such as charges for network preventive services and certain Centers of Excellence services.

Coinsurance, copayments, and the out-of-pocket maximum

After you meet your annual deductible for covered services that do not require a copayment, the Premier Plan pays 75% of the cost of covered services and your share is 25% coinsurance. However, the Plan will pay 100% of the cost of covered preventive services from a network provider before you meet your network deductible, and no copayment will be required. For covered services subject to a copayment, you must continue to pay the copayment, even after your annual deductible has been met, until you meet your annual out-of-pocket maximum.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum, the Plan pays 100% of the cost of covered services for the rest of the calendar year.

The amounts you pay that apply toward your annual out-of-pocket maximum include:

- Annual deductible (including amounts paid with remaining HRA funds)
- Copays for doctor office visits, Doctor On Demand, urgent care, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network, and
- Pharmacy copays/coinsurance.

See pages 306-327 for information replacing the text from here until **The local plans** on page 65.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for network preventive services and certain Centers of Excellence services
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP, including charges for services from non-network providers.

If you choose associate-only coverage under the Premier Plan, you will have an individual out-of-pocket maximum of $6,850. If you add dependents to your coverage, you will have an out-of-pocket maximum of $13,700 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,850. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum.

The Walmart Contribution Plan

CONTRIBUTION PLAN COVERAGE

If your work location is *not* in central Florida, Dallas/Fort Worth, or northwest Arkansas

This section describes coverage under the Contribution Plan in all areas *except* specified geographic areas of central Florida, Dallas/Fort Worth, and northwest Arkansas. See **National plan** options earlier in this chapter for the specific counties that make up these areas. See **Contribution Plan coverage for work locations in central Florida, Dallas/Fort Worth, and northwest Arkansas** later in this chapter for details about Contribution Plan coverage if your work location is in those specified geographic areas.

The Contribution Plan includes a Health Reimbursement Account (HRA). Each year, the company allocates money to the HRA for you and any covered dependents to use toward your portion of the cost of covered services (meaning those expenses that are your responsibility), including the annual deductible. You may not contribute your own money to the HRA. The Plan automatically pays your share of eligible medical expenses (except for prescription drug expenses, which cannot be paid from the HRA) until the HRA funds are exhausted. Amounts paid by the HRA count toward your annual deductible (both network and out-of-network) as well as your out-of-pocket maximum.

Any balance remaining in your HRA at the end of a calendar year rolls over for use during the next year, provided you remain enrolled in the Contribution Plan. However, your HRA balance (including your allocated HRA funds for the current year) cannot exceed your network annual deductible under the Contribution Plan. Each new year's allocation of HRA funds may be used only for eligible medical expenses for services rendered within that calendar year. For example, if you enroll in the Contribution Plan and receive an allocation of HRA funds for 2020, you would be able to use those funds for eligible medical expenses for services rendered in 2020 but not for services rendered prior to 2020 (such as an expense incurred in 2019 but not processed until 2020). The HRA funds that roll over from a prior year can be used for any eligible medical expense for services rendered while enrolled in the Contribution Plan.

If you cancel your coverage, lose eligibility, or change from the Contribution Plan to a different coverage option, any funds remaining in your HRA are forfeited. If you continue coverage in the Contribution Plan through COBRA, your HRA balance remains available to you under the terms

described above and the company will continue to allocate money to your HRA. See the **COBRA** chapter for more information about COBRA continuation coverage.

HRA allocations: midyear enrollments or changes

If you are hired midyear and enroll in the Contribution Plan, the company prorates your initial HRA allocation on a monthly basis; your annual deductible and out-of-pocket maximums are not prorated.

If you have a qualifying event and change your coverage level midyear, such as from associate-only to associate + dependents coverage, the company adjusts your HRA allocation, annual deductible, and annual out-of-pocket maximum accordingly.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Contribution Plan begins paying a portion of the cost of covered services. Copays are in addition to the annual deductible and do not count toward the deductible. You can meet your annual deductible with your company-provided HRA funds from the current year and any rollover HRA funds you may have from a previous year. When you have used all your company-provided HRA funds, you must use your own funds to meet the remainder of your annual deductible.

The Contribution Plan has a separate annual deductible for services provided by network providers and services provided by non-network providers. Amounts you pay toward the network annual deductible apply toward the out-of-network annual deductible, and vice versa.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the network annual deductible and the out-of-network annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire applicable annual deductible is met.

The following expenses do not count toward the network or out-of-network annual deductible:

- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Pharmacy copays/coinsurance (including copay assistance from a third party)
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP
- Charges paid 100% by the AMP, such as charges for network preventive services and certain Centers of Excellence services, and
- Charges for out-of-network preventive services.

Coinsurance, copayments, and the out-of-pocket maximum

After you meet your network annual deductible for covered services that do not require a copayment, the Contribution Plan pays 75% of the cost of covered services from a network provider and your share is 25% coinsurance. However, the Plan will pay 100% of the cost of covered preventive services from a network provider before you meet your network deductible and no copayment will be required. For covered services subject to a copayment, you must continue to pay the copayment, even after your annual deductible has been met, until you meet your annual out-of-pocket maximum. After you meet your out-of-network annual deductible for covered services that are subject to the deductible and that do not require a copayment, the Plan pays 50% of the maximum allowable charge of covered services from a non-network provider and you pay the rest — i.e., you are responsible for the other 50% coinsurance plus any amount charged above the maximum allowable charge.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your network annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your out-of-network deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same

See pages 306-327 for information replacing the text from here until **The local plans** on page 65.

situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

IMPORTANT TERMS

See the **Glossary** for definitions of **coinsurance** and **copayment**.

After you meet the annual out-of-pocket maximum, the Plan pays 100% of the cost of covered services from a network provider for the rest of the calendar year. There is no annual out-of-pocket maximum for charges for services from non-network providers — you are responsible for paying your share of these charges in full throughout the year.

The amounts you pay that apply toward your network annual out-of-pocket maximum include:

- Network and out-of-network annual deductibles (including amounts paid with HRA funds)
- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network, and
- Pharmacy copays/coinsurance.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for network preventive services and certain Centers of Excellence services
- Charges for out-of-network preventive services
- Coinsurance when using non-network providers
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services that are in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP.

If you choose associate-only coverage under the Contribution Plan, you will have an individual out-of-pocket maximum for network expenses of $6,850. If you add dependents to your coverage, you will have an out-of-pocket maximum for network expenses of $13,700 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,850. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible network expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum.

CONTRIBUTION PLAN COVERAGE FOR WORK LOCATIONS IN CENTRAL FLORIDA, DALLAS/FORT WORTH, AND NORTHWEST ARKANSAS

The Contribution Plan includes a Health Reimbursement Account (HRA). Each year, the company allocates money to the HRA for you and any covered dependents to use toward your portion of the cost of covered services (meaning those expenses that are your responsibility), including the annual deductible. You may not contribute your own money to the HRA. The Plan automatically pays your share of eligible medical expenses (except for prescription drug expenses, which cannot be paid from the HRA) until the HRA funds are exhausted. Amounts paid by the HRA count toward your annual deductible as well as your out-of-pocket maximum.

Any balance remaining in your HRA at the end of a calendar year rolls over for use during the next year, provided you remain enrolled in the Contribution Plan. However, your HRA balance (including your allocated HRA funds for the current year) cannot exceed your annual deductible under the Contribution Plan. Each new year's allocation of HRA funds may be used only for eligible medical expenses for services rendered within that calendar year. For example, if you enroll in the Contribution Plan and receive an allocation of HRA funds for 2020, you would be able to use those funds for eligible medical expenses for services rendered in 2020 but not for services rendered prior to 2020 (such as an expense incurred in 2019 but not processed until 2020). The HRA funds that roll over from a prior year can be used for any eligible medical expense for services rendered while enrolled in the Contribution Plan.

If you cancel your coverage, lose eligibility, or change from the Contribution Plan to a different coverage option, any funds remaining in your HRA are forfeited. If you enroll in the Contribution Plan through COBRA coverage, your HRA balance remains available to you under the terms described above and the company will continue to allocate money to your HRA. See the **COBRA** chapter for more information about COBRA continuation coverage.

HRA allocations: midyear enrollments or changes

If you are hired midyear and enroll in the Contribution Plan, the company prorates your initial HRA allocation on a monthly basis; your annual deductible and out-of-pocket maximums are not prorated.

If you have a qualifying event and change your coverage level midyear, such as from associate-only to associate + dependents coverage, the company adjusts your HRA allocation, annual deductible, and annual out-of-pocket maximum accordingly.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Contribution Plan begins paying a portion of the cost of covered services. Copays are in addition to the annual deductible and do not count toward the deductible. You can meet your annual deductible with your company-provided HRA funds from the current year and any rollover HRA funds you may have from a previous year. When you have used all your company-provided HRA funds, you must use your own funds to meet the remainder of your annual deductible.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire annual deductible is met.

The following expenses do not count toward the annual deductible:

- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Pharmacy copays/coinsurance (including copay assistance from a third party)
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP, and
- Charges paid 100% by the AMP, such as charges for network preventive services and certain Centers of Excellence services.

Coinsurance, copayments, and the out-of-pocket maximum

After you meet your annual deductible for covered services that do not require a copayment, the Contribution Plan pays 75% of the cost of covered services and your share is 25% coinsurance. However, the Plan will pay 100% of the cost of covered preventive services from a network provider before you meet your network deductible, and no copayment will be required. For covered services subject to a copayment, you must continue to pay the copayment, even after your annual deductible has been met, until you meet your annual out-of-pocket maximum.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum, the Plan pays 100% of the cost of covered services for the rest of the calendar year.

See pages 306-327 for information replacing the text from here until **The local plans** on page 65.

The amounts you pay that apply toward your annual out-of-pocket maximum include:

- Annual deductible (including amounts paid with HRA funds)
- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network, and
- Pharmacy copays/coinsurance.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for network preventive services and certain Centers of Excellence services
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP, including charges for services from non-network providers.

If you choose associate-only coverage under the Contribution Plan, you will have an individual out-of-pocket maximum of $6,850. If you add dependents to your coverage, you will have an out-of-pocket maximum of $13,700 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,850. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum.

The Walmart Saver Plan

SAVER PLAN COVERAGE

If your work location is *not* in central Florida, Dallas/Fort Worth, or northwest Arkansas

This section describes coverage under the Saver Plan in all areas *except* specific geographic areas of central Florida, Dallas/Fort Worth, and northwest Arkansas. See **National plan options** earlier in this chapter for the specific counties that make up these areas. See **Saver Plan coverage for work locations in central Florida, Dallas/Fort Worth, and northwest Arkansas** later in this chapter for details about Saver Plan coverage if your work location is in those areas.

If you enroll in the Saver Plan and contribute to a Health Savings Account (HSA), the company matches your payroll deductions into your HSA, dollar-for-dollar up to $350 if you have individual coverage or $700 if you have family coverage. Combined contributions to your HSA (your own and the company's) cannot exceed the 2020 annual IRS limit of $3,550 for individual coverage or $7,100 for family coverage, plus a $1,000 catch-up contribution if you are age 55 or over.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Saver Plan begins paying a portion of the cost of covered services. Copays are in addition to the annual deductible and do not count toward the deductible. The Saver Plan has a separate annual deductible for services provided by network providers and services provided by non-network providers. Amounts you pay toward the network annual deductible apply toward the out-of-network annual deductible, and vice versa.

Preventive care services, as described in the **Preventive care program** section later in this chapter, are covered even if you have not met the annual deductible.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the network annual deductible and the out-of-network annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire applicable annual deductible is met.

You can choose to use money in your HSA to pay expenses that are subject to the annual deductible, or you can pay them out of your own pocket and save your HSA money for future expenses.

If you enroll in the Saver Plan, you generally must pay full cost for prescriptions until you meet your network annual deductible. The exception is medications on the OptumRx list of approved preventive medications, which are not subject to the Saver Plan's network annual deductible — you can purchase these medications at the appropriate copay or coinsurance level even if you have not met the network annual deductible. In addition, certain over-the-counter drugs are available at 100% coverage if you obtain a prescription, even if you have not satisfied your deductible. See **The pharmacy benefit** chapter for details. With the exception of these charges for approved preventive medications, pharmacy charges under the Saver Plan apply toward your network annual deductible and out-of-pocket maximum.

The following expenses do not count toward the network or out-of-network annual deductible:

- Copays for preventive medications not subject to the annual deductible
- Discounts, coupons, pharmacy discount programs or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug charges paid directly to pharmacies on your behalf through discount programs/coupons)
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP
- Charges paid 100% by the AMP, such as charges for network preventive services and certain Centers of Excellence services, and
- Charges for out-of-network preventive services.

Coinsurance, copayments, and the out-of-pocket maximum

After you meet your network annual deductible for covered services, the Saver Plan pays 75% of the cost of covered services from a network provider and your share is 25% coinsurance. However, the Plan will pay 100% of the cost of covered preventive services from a network provider before you meet your network deductible and no copayment will be required. For covered services subject to a copayment, you must continue to pay the copayment, even after your annual deductible has been met, until you meet your annual out-of-pocket maximum. After you meet your out-of-network annual deductible for covered services that are subject to the deductible and that do not require a copayment, the Plan pays 50% of the maximum allowable charge of covered services from a non-network provider and you pay the rest — i.e., you are responsible for the other 50% coinsurance plus any amount charged above the maximum allowable charge.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your network annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your out-of-network deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum for network services, the Plan pays 100% of the cost of covered services from a network provider for the rest of the calendar year. There is no annual out-of-pocket maximum for services from non-network providers — you are responsible for paying your share of these charges in full throughout the year.

The amounts you pay that apply toward your network annual out-of-pocket maximum include:

- Network and out-of-network annual deductibles (including amounts paid with HSA funds)
- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network
- Pharmacy copays/coinsurance, and
- Pharmacy charges before your annual deductible is met.

See pages 306-327 for information replacing the text from here until **The local plans** on page 65.

Your network annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for network preventive services and certain Centers of Excellence services
- Charges for out-of-network preventive services
- Coinsurance when using non-network providers
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP.

If you choose associate-only coverage under the Saver Plan, you will have an individual out-of-pocket maximum for network expenses of $6,650. If you add dependents to your coverage, you will have an out-of-pocket maximum for network expenses of $13,300 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,650. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,300, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible network expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum.

SAVER PLAN COVERAGE FOR WORK LOCATIONS IN CENTRAL FLORIDA, DALLAS/ FORT WORTH, AND NORTHWEST ARKANSAS

If you enroll in the Saver Plan and contribute to a Health Savings Account (HSA), the company matches your payroll deductions into your HSA, dollar-for-dollar up to $350 if you have individual coverage or $700 if you have family coverage. Combined contributions to your HSA (your own and the company's) cannot exceed the 2020 annual IRS limit of $3,550 for individual coverage or $7,100 for family coverage, plus a $1,000 catch-up contribution if you are age 55 or over.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Saver Plan begins paying a portion of the cost of your covered services. Copays are in addition to the annual deductible and do not count toward the deductible.

Preventive care services, as described in the **Preventive care program** section later in this chapter, are covered even if you have not met the annual deductible.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire annual deductible is met.

You can choose to use money in your HSA to pay expenses that are subject to the annual deductible, or you can pay them out of your own pocket and save your HSA money for future expenses.

If you enroll in the Saver Plan, you generally must pay full cost for prescriptions until you meet your annual deductible. The exception is medications on the OptumRx list of approved preventive medications, which are not subject to the Saver Plan's annual deductible — you can purchase these medications at the appropriate copay or coinsurance level even if you have not met the annual deductible. In addition, certain over-the-counter drugs are available at 100% coverage if you obtain a prescription, even if you have not satisfied your deductible. See **The pharmacy benefit** chapter for details. With the exception of these charges for approved preventive medications, pharmacy charges under the Saver Plan apply toward your annual deductible and out-of-pocket maximum.

The following expenses do not count toward the annual deductible:

- Copays for preventive medications not subject to the annual deductible
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug charges paid directly to pharmacies on your behalf through discount programs/coupons)
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that

the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge

- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP, and
- Charges paid 100% by the AMP, such as charges for network preventive services and certain Centers of Excellence services.

Coinsurance, copayments, and the out-of-pocket maximum

After you meet your annual deductible for covered services, the Saver Plan pays 75% of the cost of covered services and your share is 25% coinsurance. However, the Plan will pay 100% of the cost of covered preventive services from a network provider before you meet your network deductible, and no copayment will be required. For covered services subject to a copayment, you must continue to pay the copayment, even after your annual deductible has been met, until you meet your annual out-of-pocket maximum.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum, the Plan pays 100% of the cost of covered services for the rest of the calendar year.

The amounts you pay that apply toward your annual out-of-pocket maximum include:

- Annual deductible (including amounts paid with HSA funds)
- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network
- Pharmacy copays/coinsurance, and
- Pharmacy charges before your annual deductible is met.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for network preventive services and certain Centers of Excellence services
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP, including charges for services from non-network providers.

If you choose associate-only coverage under the Saver Plan, you will have an individual out-of-pocket maximum of $6,650. If you add dependents to your coverage, you will have an out-of-pocket maximum of $13,300 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,650. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,300, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the

See pages 306-327 for information replacing the text from here until **The local plans** on page 65.

family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum.

The local plans

Local plan options are available in designated regions nationwide. Your work location determines if a local plan option is available to you. See the **Local plan options** chart earlier in this chapter for a listing of the plans and the areas they serve.

Under the local plan options, you must always use the doctors, hospitals, and other providers in the plan's network. If you receive services from a provider outside the network, or if you have dependents who live and seek care outside the network coverage area, your expenses are not covered, except in cases of emergency.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Plan begins paying a portion of the cost of covered services. Copays are in addition to the deductible and do not count toward the deductible.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire applicable deductible is met.

The following expenses do not count toward the annual deductible:

- Copays for doctor office visits, Doctor On Demand, urgent care, Walmart Care Clinic or Walmart Health, or emergency room visits
- Pharmacy copays/coinsurance (including copay assistance from a third party)
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP, and
- Charges paid 100% by the AMP, such as charges for network preventive services and certain Centers of Excellence services.

Coinsurance, copayments, and the out-of-pocket maximum

After you meet your annual deductible for covered services that do not require a copayment, the Plan pays 75% of the cost of covered services and your share is 25% coinsurance. However, the Plan will pay 100% of the cost of covered preventive services from a network provider before you meet your network deductible, and no copayment will be required. For covered services subject to a copayment, you must continue to pay the copayment, even after your annual deductible has been met, until you meet your annual out-of-pocket maximum.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the services provided will not be covered by the AMP.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the out-of-pocket maximum, the Plan pays 100% of covered services for the rest of the calendar year.

The amounts you pay that apply toward your out-of-pocket maximum include:

- Annual deductible
- Copays for doctor office visits, Doctor On Demand, urgent care, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network, and
- Pharmacy copays/coinsurance.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for network preventive services and certain Centers of Excellence services
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP, including charges for services from non-network providers.

If you choose associate-only coverage under a local plan, you will have an individual out-of-pocket maximum of $6,850. If you add dependents to your coverage, you will have an out-of-pocket maximum of $13,700 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,850. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum.

Administration of the AMP

The AMP is self-insured, which means benefits are not insured by an insurance company. Instead, participating associates make contributions to cover a portion of the cost of benefits, and the rest of the cost is paid from company assets or through a Trust funded by the company.

The Plan contracts with third-party administrators (TPAs) to handle administration of the options available under the AMP: Aetna Life Insurance Company (Aetna), BlueAdvantage Administrators of Arkansas, HealthSCOPE Benefits, Inc., and UnitedHealthcare. The Plan also contracts with Contigo Health (formerly Health Design Plus) to serve as the TPA for certain procedures under the Centers of Excellence program, as described under **Centers of Excellence** later in this chapter. In some areas, Grand Rounds and Doctor On Demand may provide care management and similar services to assist the TPA. See **Helping you manage your health** later in this chapter.

Your work location and the plan option you select determine which TPA administers your AMP coverage. If you are a remote worker or are receiving continuation coverage under COBRA, you will be assigned to the nearest facility and your coverage will be administered by a TPA at that location. If you are a truck driver, your plan options and the associated TPAs may be determined by your home location rather than work location.

The TPA makes medical claim determinations and processes claims based on the Plan's terms and the TPA's policies and procedures. The TPA also provides a network of providers that accept discounted rates for services they provide to participants. See **Your provider network** later in this chapter for details.

What is covered by the AMP

The AMP pays benefits for covered expenses, which are charges for procedures, services, equipment and supplies that are defined as:

- Not in excess of the maximum allowable charge, which is determined by the third-party administrator
- Medically necessary
- Not excluded under the Plan (see **What is not covered by the AMP** later in this chapter), and
- Not in excess of AMP limits.

MAXIMUM ALLOWABLE CHARGE

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The "maximum allowable charge" (MAC) is the maximum amount the AMP covers or pays for any health care services, drugs, medical devices, equipment, supplies, or benefits covered by the Plan. The MAC applies both to network and out-of-network services.

For covered network services, the MAC is that portion of a provider's charge covered by the AMP, as determined by the provider's contract with the third-party administrator. In the case of BlueAdvantage Administrators of Arkansas, this includes contracts with an independent licensee company of the Blue Cross and Blue Shield Association; in the case of UnitedHealthcare, this includes Harvard Pilgrim Health

Care, an independent licensee of UnitedHealthcare. For information about the third-party administrator for your medical plan coverage, see **Your provider network** later in this chapter.

For covered out-of-network services, the MAC is determined by each third-party administrator, as described below. In certain circumstances, network benefits may be paid for out-of-network services, as described under **When network benefits are paid for out-of-network expenses**.

For out-of-network emergency services, the MAC will be the greatest of the following: the median in-network rate; the usual, customary, and reasonable rate; or the Medicare rate.

Aetna: The MAC is 125% of Medicare's maximum allowable charge for voluntary out-of-network services. For involuntary out-of-network service, the MAC also is 125% of Medicare's maximum allowable charge unless the provider is in Aetna's National Advantage Program (NAP). NAP provider charges are paid at a discount. If a Medicare maximum allowable charge is not published by the Center for Medicare and Medicaid Services for a specific service, Aetna uses a gap methodology to calculate the MAC that is based on the Medicare maximum allowable charge. Medicare's allowable rate is based upon the geographic area in which the service is furnished.

BlueAdvantage Administrators of Arkansas: The method for establishing the MAC for covered out-of-network services depends on whether the service is delivered by an individual health care provider (e.g., a physician), an ambulance or air ambulance service, or a hospital or facility. For services of individual providers and ambulance and air ambulance transport, the MAC is 125% of the Medicare allowed amount for such services on the date administered. For hospital and facility services or for other covered benefits (e.g., drugs, medical devices, products or implants, equipment, or supplies), the MAC for covered out-of-network services is limited to the allowance set by BlueAdvantage Administrators of Arkansas in its discretion. If BlueAdvantage Administrators of Arkansas does not have its own method or benchmark in a given case, the MAC for covered out-of-network services is limited to the pricing or allowance offered by the Blue Cross and Blue Shield Plan in the state where services are provided.

For covered out-of-network services, the Plan pays the lesser of MAC or the provider's actual billed charges. If the provider's billed charges exceed the Plan's MAC, you are responsible for paying the difference. For additional information, call your health care advisor at the number on your plan ID card.

HealthSCOPE Benefits: There is no benefit for out-of-network services sought voluntarily by participants in local plans administered by HealthSCOPE Benefits. For approved involuntary or emergency out-of-network services, HealthSCOPE Benefits will use a discount through a "wrap network," if available and consistent with the Affordable Care Act. (A wrap network is a group of non-contracted providers who have arranged to provide services to Plan participants at a discount.) If there is not a discount available through a wrap network, the MAC will be 125% of Medicare's maximum allowable charge. In cases where a Medicare maximum allowable charge is not published by the Center for Medicare and Medicaid Services for a specific service, HealthSCOPE Benefits will use a gap methodology to calculate the MAC. There may be some cases in which an individual agreement is reached with the non-network provider.

UnitedHealthcare: The MAC is 125% of Medicare's maximum allowable charge for voluntary out-of-network services. For involuntary out-of-network services, the MAC also is 125% of Medicare's maximum allowable charge unless the provider is in UnitedHealthcare's Shared Savings Program (SSP). SSP provider charges are paid at a discount. In cases where a Medicare maximum allowable charge is not published by the Center for Medicare and Medicaid Services for a specific service, UnitedHealthcare uses a gap methodology to calculate the MAC.

MEDICALLY NECESSARY

"Medically necessary" (or "medical necessity") generally means the AMP has determined the procedure, service, equipment, or supply to be:

- Appropriate for the symptoms, diagnosis, or treatment of a medical condition
- Provided for the diagnosis or direct care and treatment of the medical condition
- Within the standards of good medical practice within the organized medical community
- Not primarily for the convenience of the patient or the patient's doctor or other provider, and
- The most appropriate procedure, service, equipment, or supply that can be safely provided.

"Most appropriate" means:

- There is valid scientific evidence demonstrating that the expected health benefits from the procedure, service, equipment, or supply are clinically significant and produce a greater likelihood of benefit, without disproportionately greater risk of harm or complications, for the Plan participant with the particular medical condition being treated than other possible alternatives
- Generally accepted forms of treatment that are less invasive have been tried and found ineffective or otherwise unsuitable, and
- For hospital stays, acute inpatient care is necessary due to the kind of services the participant is receiving or the severity of the medical condition, and safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

Aetna, UnitedHealthcare, BlueAdvantage Administrators of Arkansas, HealthSCOPE Benefits, Precedence Inc. (with respect to the UnityPoint Local Plan), and Mercy Health Communities (with respect to all Mercy Local Plans) follow policies in determining whether a procedure, service, equipment, or supply is medically necessary. Your benefits are subject to the terms of these policies, which vary by third-party administrator.

You and your health care provider can access the coverage policies of Aetna, UnitedHealthcare, and BlueAdvantage Administrators of Arkansas at their respective websites, listed in the **Resources** chart at the beginning of this chapter. Access the coverage policies of HealthSCOPE Benefits by calling **800-804-1272**.

Your AMP benefits are subject to all terms, conditions, limitations, and exclusions set forth in the coverage policies administered by your third-party administrator regarding medical necessity.

Your provider network

Depending on your work location and choice of medical plan, your benefits under the AMP are administered by one of the following third-party administrators:

- Aetna
- BlueAdvantage Administrators of Arkansas
- HealthSCOPE Benefits, or
- UnitedHealthcare.

The Plan contracts with each of the above third-party administrators and also with Mercy Health Communities (for all Mercy Local Plans), Emory, UnityPoint, Memorial Hermann, and Ochsner to provide a network of health care providers from whom you can receive medical services covered under the AMP at discounted prices. Your provider may include special networks, such as Centers of Excellence and advanced imaging within its network. Network providers accept an amount negotiated by the third-party administrator for specific covered services as payment in full (the maximum allowable charge for network services), subject to the annual deductible and cost-sharing terms applicable to the coverage you chose.

For provider listings, call the number on your plan ID card or select the provider directory on **One.Walmart.com**.
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If your provider leaves the network, your benefit is adjusted accordingly, based on the terms of your medical plan. If you are covered under the Premier Plan, Contribution Plan, or Saver Plan and your work location is not in central Florida, Dallas/Fort Worth, or northwest Arkansas, services provided by a provider who has left the network are generally treated as an out-of-network benefit; you may be required to pay any amount above the maximum allowable charge, or choose another provider in the network. If you are covered under a local plan, or under the Premier Plan, Contribution Plan, or Saver Plan in central Florida, Dallas/Fort Worth, or northwest Arkansas, which provide no coverage for non-network providers except in cases of emergency, your provider's services are not covered under the Plan.

The AMP does not furnish hospital or medical services and is not liable for any act or omission of any provider or agent of such provider, including failure or refusal to render services. All medical decisions are between you and your provider. The AMP makes no representations regarding the quality of services rendered by any provider.

NOTE: The AMP, its third-party administrators, and network providers may agree to certain incentive arrangements (which may pay bonuses or withhold provider payments) designed to reward high-quality and cost-effective treatments. Some of the local plan contracts include such arrangements. Contact your third-party administrator for information regarding these arrangements.

WHEN NETWORK BENEFITS ARE PAID FOR OUT-OF-NETWORK EXPENSES

A covered expense you incur with a non-network provider may, in the following circumstances, be treated as a network expense:

- If your dependent child under age 19 requires treatment at a Children's Miracle Network hospital
- If there are no network providers with the relevant specialty within 30 miles of your home (not applicable to local plan options)
- Services from a non-network provider involving a pregnant participant are treated as network charges for up to six weeks after delivery if services began when the provider was a network provider and there is no interruption of the doctor/patient relationship
- Services from a non-network provider, until the effective date of the next Annual Enrollment, for a course of treatment that began when the provider was a network provider, where there is no interruption of the doctor/patient relationship (for example, if you change third-party administrators during the year because of a change in work location and are in the middle of a course of treatment)
- Services for laboratory, anesthesia, radiology, or pathology, if such services are received in connection with care from a network provider or from a network hospital
- Services for treatment received while on vacation or business travel in the U.S., where such treatment either could not have reasonably been foreseen prior to the travel or the course of treatment began prior to the travel and for medical reasons must be continued during such travel, or

- Until the next Annual Enrollment, when coverage under the Plan is added and utilizing a non-network provider in a course of treatment begun prior to effective date, where there is no interruption of the doctor/patient relationship.

If your third-party administrator determines that any of the above circumstances apply, services are covered at the network coinsurance rate of 75%. You may have to pay for treatment when you receive it and file a claim for reimbursement, which will be based on the maximum allowable charge. This means that the provider may bill you for the difference between the maximum allowable charge and the provider's actual charge.

In addition, with respect to transport by ambulance or air ambulance, out-of-network covered expenses may be treated as network covered expenses. The amounts paid by the AMP for ambulance or air ambulance are based on up to 200% of the maximum allowable charge if the participant is directly admitted to the hospital from an emergency room or if the participant dies prior to hospital admission.

Amounts in excess of 200% of the maximum allowable charge are your responsibility and do not count toward your annual deductible or out-of-pocket maximum. Exceptions to the maximum allowable charge are not granted in circumstances other than those described in this section. For information about air ambulance coverage, call your health care advisor at the number on your plan ID card.

Emergency room visits. The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your applicable annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If you participate in any local plan identified on page 50 of this 2020 *Associate Benefits Book*, the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the services will not be covered by the AMP. For all other participants, the AMP will pay 50% of the maximum allowable charge for covered services after you have met your deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge. The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

COVERAGE WHEN YOU TRAVEL TO A FOREIGN COUNTRY

If you travel abroad, follow these steps:

- Before you begin your travel, contact your third-party administrator (or your HMO) for details about medical coverage and emergency medical services when traveling abroad. Coverage outside the United States may vary.
- Always carry your plan ID card with you when you travel and present it when you receive medical services.

Alternate provider networks

In some locations and under certain circumstances, AMP participants have access to alternate provider networks that have coverage provisions differing in certain ways from the medical plan provisions detailed on the preceding pages. An alternate network is essentially a network within a network, a subgroup of providers within the medical plan's larger network in a particular service area. In areas where an alternate network operates, you must see the alternate network providers to receive network terms under the Plan — i.e., network annual deductibles and network-level coinsurance.

If you seek services from medical providers who are within the area served by the alternate network but have not agreed to be providers within the alternate network, those services are treated as out-of-network and covered accordingly.

General information about these special alternate networks follows.

ALTERNATE NETWORKS THROUGH BLUEADVANTAGE ADMINISTRATORS OF ARKANSAS

If you have BlueAdvantage Administrators of Arkansas as your third-party administrator, you may have access to alternate networks of providers as listed below.

- Florida: NetworkBLUE
- Georgia: Blue Open Access POS
- Kansas City, Missouri: Preferred-Care Blue
- Maryland, Northern Virginia, District of Columbia: BlueChoice Advantage Open Access
- Missouri: Blue Preferred POS
- New Hampshire: BlueChoice Open Access POS
- New Jersey: Horizon Managed Care Network
- Oklahoma: Blue Preferred

- Pennsylvania: Community Blue Network
- Tennessee: Network S
- Wisconsin: Blue Preferred POS

For information about these alternate networks, go to **One.Walmart.com** or call your health care advisor at the number on your plan ID card.

ADVANCED IMAGING NETWORK

If you participate in the Premier Plan, Contribution Plan, or Saver Plan options, at any location nationwide, an alternate network of providers for advanced imaging services (i.e., MRI and CT scans) may be available to you. For information about the alternate advanced imaging network, call your health care advisor at the number on your plan ID card.

ADDITIONAL NETWORK THROUGH UNITEDHEALTHCARE

If UnitedHealthcare is your third-party administrator and you work in the following locations, you have access to HPHC Insurance Company, an affiliate of Harvard Pilgrim Health Care:

- Massachusetts
- Maine
- New Hampshire.

Preventive care program

See page 328 *for clarifications of the preventive care program and changes to the list of preventive services effective Jan. 1, 2021.*

Eligible preventive care services from network providers are covered under the AMP at 100%.

If you are enrolled in the Premier Plan, Contribution Plan, or Saver Plan and your work location is other than central Florida, Dallas/Fort Worth or northwest Arkansas, the AMP reduces the benefit to 50% if you use a non-network provider for eligible preventive care services. Your out-of-pocket costs do not apply toward your out-of-pocket maximum.

If you are enrolled in the Premier Plan, Contribution Plan, or Saver Plan and your work location is in central Florida, Dallas/Fort Worth or northwest Arkansas, or if you are enrolled in one of the local plans, no benefits are provided if you use a non-network provider for eligible preventive care services. Your out-of-pocket costs do not count toward your out-of-pocket maximum.

For a preventive care service to be eligible for 100% coverage, it must be recommended by one of the agencies responsible for maintaining U.S. preventive care guidelines, as required under the Affordable Care Act. Many of these guidelines are specific to gender, age, or risk factors for a disease or condition. Check with your third-party administrator for details.

Covered services include those listed below. Refer to your third-party administrator for information on preventive services not listed here. For the most up-to-date list of covered preventive services, go to **One.Walmart.com** or call your third-party administrator at the number on your plan ID card.

COVERED PREVENTIVE SERVICES FOR ADULTS

- **Abdominal aortic aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol misuse** screening and counseling
- **Aspirin** use for men and women of certain ages (prescription required). See **The pharmacy benefit** for more information.
- **Blood pressure** screening for all adults
- **Colorectal cancer** screening for adults over 50
- **Depression** screening for adults
- **Diabetes (type 2)** screening for adults age 40–70 who are overweight or obese, and counseling for patients with abnormal blood glucose
- **Diet and physical activity** counseling for adults at higher risk for chronic disease
- **Exercise or physical therapy** for community-dwelling adults age 65 and older who are at increased risk for falls
- **Hepatitis B** screening for adults at high risk
- **Hepatitis C** screening for adults at high risk
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults — doses, recommended ages, and recommended populations vary:
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Herpes zoster
  - Human papillomavirus
  - Influenza (flu shot)
  - Measles, mumps, rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, diphtheria, pertussis
  - Varicella

Learn more about immunizations and see the latest vaccine schedules at: **cdc.gov/vaccines/schedules**.

- **Latent tuberculosis infection (LTBI)** screening in populations at increased risk
- **Lung cancer** screening for certain adults age 55–80 who have a smoking history
- **Obesity** screening and counseling for all adults

- **Sexually transmitted infection (STI)** prevention counseling for adults at higher risk
- **Skin cancer** counseling for young adults to age 24
- **Syphilis** screening for all adults at higher risk
- **Tobacco use** screening for all adults and cessation interventions for tobacco users

COVERED PREVENTIVE SERVICES FOR WOMEN, INCLUDING PREGNANT WOMEN

- **Aspirin (low dose)** for women 12 weeks pregnant who are at high risk for preeclampsia (prescription required). See **The pharmacy benefit** for more information.
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk; and, if indicated after counseling, BRCA testing
- **Breast cancer chemoprevention** counseling for women at higher risk
- **Breast cancer mammography** screenings every 1–2 years for women over 40
- **Breast cancer risk-reducing prescription medications** (such as Tamoxifen or Raloxifene) for certain women at increased risk for breast cancer
- **Breastfeeding** comprehensive support and three counseling visits from trained providers, as well as access to breastfeeding supplies for pregnant and nursing women. Check with your third-party administrator for details on how to obtain a breast pump.
- **Cervical cancer** screening for women age 21–65
- **Chlamydia infection** screening for younger women and other women at higher risk
- **Contraception:** Food and Drug Administration–approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs. See **The pharmacy benefit** for information about contraception.
- **Domestic and interpersonal violence** screening and counseling for all women and, when needed, initial intervention services
- **Folic acid** supplements for women who may become pregnant (prescription required). See **The pharmacy benefit** for more information.
- **Gestational diabetes** screening for women 24–28 weeks pregnant and those at high risk of developing gestational diabetes
- **Gonorrhea** screening for younger women and other women at increased risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human immunodeficiency virus (HIV)** screening and counseling
- **Osteoporosis** screening for women over age 65, and younger postmenopausal women depending on risk factors
- **Preeclampsia** screening for pregnant women, with blood pressure measurements throughout pregnancy
- **Rh incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Sexually transmitted infections (STI**) counseling for sexually active women
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Tobacco use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Well-woman** visits to obtain recommended preventive services for women

COVERED PREVENTIVE SERVICES FOR CHILDREN

- **Anemia** screening for children at 12 months
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages
- **Bilirubin** screening for newborns
- **Blood pressure** screening for children of all ages
- **Blood** screening for newborns
- **Cervical dysplasia** screening for sexually active females
- **Congenital hypothyroidism** screening for newborns
- **Critical congenital heart defect** screening for newborns
- **Depression** screening for adolescents
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride chemoprevention** supplements for children without fluoride in their water source and fluoride varnish to the primary teeth of all infants and children (prescription required)
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all children
- **Height, weight, length, head circumference, weight for length and body mass index** measurements for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **Hepatitis B** screening in adolescents at high risk
- **HIV** screening for adolescents

- **Immunization** vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:
  - Diphtheria, tetanus, pertussis (DTaP and Tdap)
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human papillomavirus
  - Inactivated poliovirus
  - Influenza (flu shot)
  - Measles, mumps, rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella

Learn more about immunizations and see the latest vaccine schedules at **cdc.gov/vaccines/schedules**.

- **Lead** screening for children at risk of exposure
- **Medical history** for all children throughout development
- **Obesity** screening and counseling
- **Oral health** risk assessment for young children, newborn to 10 years
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Physical examination** for children of all ages
- **Sexually transmitted infection (STI)** prevention counseling and screening for adolescents at higher risk
- **Skin cancer** counseling for young adults to age 24 and parents of young children
- **Tobacco, alcohol, or drug use** assessment for adolescents at higher risk
- **Tobacco use** interventions in school-aged children and adolescents
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children.

FLU VACCINE PROGRAM

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An annual flu vaccination is covered under the AMP at 100% during the September–March flu season when you receive the vaccine from a network provider.

If you are enrolled in the Premier Plan, Contribution Plan, or Saver Plan and your work location is other than central Florida, Dallas/Fort Worth, or northwest Arkansas, the AMP reduces the benefit to 50% of the maximum allowable charge if you use a non-network provider for the vaccine, and you are responsible for the other 50% plus any amount above the maximum allowable charge. Your out-of-pocket costs do not apply toward your out-of-pocket maximum.

If you are enrolled in the Premier Plan, Contribution Plan, or Saver Plan and your work location is in central Florida, Dallas/Fort Worth, or northwest Arkansas, or if you are enrolled in one of the local plans, no benefits are provided if you use a non-network provider for the vaccine. Your out-of-pocket costs do not count toward your out-of-pocket maximum.

The vaccine may also be provided in participating Walmart and Sam's Club pharmacies. If you are enrolled in the AMP, you must show your plan ID card to receive the vaccine.

BEHAVIORAL HEALTH: MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM

The AMP includes coverage for mental health and substance abuse services in the same manner as other medical and hospitalization benefits, including care at a behavioral health facility.

Coverage is provided for:

- A behavioral health facility is one that provides 24-hour inpatient care
- Residential treatment
- Partial hospitalization or outpatient care that requires six to eight hours of service per day, five to seven days per week, or
- Intensive outpatient care that requires two to four hours of service per day, three to five days per week.

Refer to the medical plan summary charts earlier in this chapter for details on how behavioral health services are covered under the available plans.

Prenotification

You or your provider may voluntarily contact your third-party administrator for information regarding coverage prior to your obtaining most medical and behavioral health services by calling the number on your plan ID card. If you choose to notify your third-party administrator of a scheduled medical or behavioral health admission, do so at least 24 hours prior to the admission. For emergency services, third-party administrators should be notified as soon as possible, but no later than 24 hours after admission. Providing notification within 24 hours after admission is not, however, required as a condition of coverage.

The third-party administrator's responses to your inquiries in a prior-notification call do not guarantee payment or ensure coverage under the AMP, nor do any statements made by the third-party administrator waive any AMP condition applicable to your claim for benefits. The third-party administrator cannot make a final claim determination on the phone or by email. This means that any responses given by phone or email are always subject to further review under the written terms, conditions, limitations, and exclusions of the AMP.

Your coverage may be limited or denied if, when claims for services are received, review shows that a benefit exclusion or limitation applies, the covered participant was not eligible for benefits on the date services were provided, coverage lapsed for nonpayment of premiums, out-of-network limitations apply, or any other basis exists for denial of the claim under AMP terms.

Preauthorization

Network providers are required to obtain prior authorization for certain services, including the following:

- Inpatient admissions (to hospital, hospice, and other facilities) for medical benefits, including residential treatment facilities
- Inpatient admissions (to behavioral health facilities) for mental health and substance abuse benefits
- Maternity inpatient stays that exceed the third-party administrator's standard length of stay
- Home health care
- Outpatient surgery
- Outpatient radiology services, including MRI and CT scans
- Outpatient dialysis
- Outpatient services for mental health and substance abuse, including:
  - Detoxification
  - Electroconvulsive therapy (ECT)
  - Applied behavior analysis (ABA)
  - Neuropsychological testing
  - Partial hospitalization day treatment
  - Intensive outpatient treatment
  - Psychiatric home care
- Non-emergency ambulance (air or ground)
- Reconstructive procedures that may be considered cosmetic
- BRCA genetic testing
- Rehabilitation services (physical therapy, occupational therapy, speech therapy)
- Certain prosthetic devices and durable medical equipment
- Clinical trials
- Specialty drugs issued by provider
- Services provided under the Centers of Excellence program, including:
  - Heart surgery
  - Spine surgery
  - Hip and knee replacement
  - Transplants (including organ, stem cell, bone marrow, and kidney)
  - CAR T-cell therapy
  - Ventricular assist devices (VADs) and total artificial hearts
  - Weight loss surgery

Prior authorization requirements vary based on third-party administrator. For a complete list of services for which preauthorization is required, call your health care advisor at the phone number on your plan ID card.

Your network provider will seek preauthorization of these services on your behalf. For non-network services, you may need to seek preauthorization yourself. If your preauthorization request is approved, the requested services will be treated as covered services under the AMP as long as you are otherwise eligible to receive benefits.

If your preauthorization request is denied, you and your provider will be notified, and either you or your provider may appeal the denial. If you proceed with a service that is not preauthorized, you may be responsible for paying all of your provider's charges. For information on how to appeal a denied request for preauthorization, see the **Claims and appeals** chapter.

Helping you manage your health

YOUR HEALTH CARE ADVISOR

When you need to communicate with your third-party administrator—to seek approval for a service, speak to a registered nurse, ask about a claim or another matter—call the number on your plan ID card. This connects you to your health care advisor, your single point of contact for all inquiries. Depending on the nature of your issue, the health care advisor will answer your question or direct you to the appropriate department. This process helps ensure that you receive consistent information and guidance for coverage-related inquiries.

CARE MANAGEMENT

If you are enrolled in a plan offered by the AMP, you have the benefit of voluntary care management services, including a personal medical team. These services are intended to bring consistency to the full range of care and services provided to AMP participants. Successful care management aims to look at the whole individual rather than just the symptoms or conditions being diagnosed; it can result in higher quality of care, improvement in your experience with your providers and third-party administrator, and potentially lower out-of-pocket medical expenses.

Circumstances in which a nurse care manager may work with you include the following:

- You are sick or injured and hospitalized
- You are scheduled for surgery
- You find out you have a chronic illness or are dealing with an ongoing chronic illness
- You have a behavioral health/substance abuse condition
- You are prescribed multiple prescription drugs with potential interactions

- You simply have a question about your health
- You are home from the hospital and need help understanding your discharge plan, or
- You are participating in the Life with Baby Maternity Program, or comparable maternity program offered by certain local plan options.

Your third-party administrator's care management program, working with your medical provider, can approve certain medically necessary services that are not otherwise covered by the AMP because they exceed a treatment limit (i.e., number of days or visits). The AMP's rules regarding annual deductibles and coinsurance continue to apply to any additional benefits authorized by the care management program. All such decisions are subject to your third-party administrator's determination of medical necessity.

Your medical team may also be able to assist you with medical costs you may incur for "involuntary" out-of-network services. These are costs you incur when you cannot control your choice of provider (such as if you have surgery in a network hospital but your anesthesia is administered by an anesthesiologist who is a non-network provider) or when you have no reasonable basis for believing your provider is a non-network provider. In some cases, out-of-network benefits may be paid as network benefits (see **When network benefits are paid for out-of-network expenses** earlier in this chapter). In other cases, your third-party administrator may negotiate with non-network providers before or after services are rendered to reduce the billed charges for which you are responsible under the Plan's out-of-network benefit. There are no guarantees that any reduction in your out-of-network costs will occur.

When you communicate with your third-party administrator, depending on the nature of your inquiry, you may be routed to your nurse care manager. On other occasions, your nurse care manager may reach out to you, for example to invite you to participate in a health management program.

To reach your medical team, call the phone number on your plan ID card. Participation in the program is voluntary and does not affect your eligibility to participate in the AMP.

QUIT TOBACCO PROGRAM

According to the National Institutes of Health, tobacco use is a leading cause of preventable disease and death in the United States. To help you kick the habit, the company offers a free Quit Tobacco program for you and your covered dependents age 18 and older who are enrolled in a company-sponsored medical plan.

When you enroll in the program, a variety of services may be available to you, including:

- **Online support** from coaches and other quitters.
- **Phone-based coaching** with a trained health coach.
- **Email support** with tips to help you quit and stay motivated.
- **Over-the-counter (OTC) medications**, including free patches, gum, or lozenges. (You may hear these medications referred to as "nicotine replacement therapy" or "NRT.")

To enroll in a Quit Tobacco program call **866-577-7169**.

If you are enrolled in an HMO, contact your provider to learn what quit-tobacco programs are offered through your plan.

Learn more about the Quit Tobacco program at the Quit Tobacco link at **One.Walmart.com**.

LIFE WITH BABY MATERNITY PROGRAM

Life with Baby is an exclusive prenatal care program offered at no cost to you, your covered spouse/partner, and other covered dependents. The program is available to you if you are enrolled in the AMP with the exception of some local plans, which provide comparable maternity programs for their participants. (Call your health care advisor for more information.)

Whether you're starting a family, adding to one, or just thinking about it, Life with Baby can help you have a safe, successful pregnancy. The program is offered at no cost, but enrollment is not automatic. The program assists with preconception, pregnancy, delivery (including three lactation visits), and child development. Enroll in Life with Baby by calling your health care advisor at the phone number on your plan ID card. Once enrolled, you'll have the opportunity to talk confidentially with a registered nurse before, during, and after your pregnancy. Participation in the program is voluntary and does not affect your eligibility to participate in the AMP.

GRAND ROUNDS: PROVIDER RESEARCH AND SECOND OPINIONS

Grand Rounds is a personalized tool that lets you search for doctors and medical services online, view quality information, obtain second opinions, and get additional details about a provider's charges. Register at **grandrounds.com/walmart** or by calling Grand Rounds at **800-941-1384**. There is no cost to you to use the Grand Rounds tool, but any medical expenses you incur as a result of your use of this tool will be subject to Plan rules.

Provider research: Participants and dependents age 18 and over who are enrolled in the Plan, with the exception of participants in central Florida, Dallas/Fort Worth, and northwest Arkansas, are eligible to use Grand Rounds' provider research functions. Register at **grandrounds.com/walmart** or by calling Grand Rounds at **800-941-1384**.

With Grand Rounds you can:

- Compare nearby doctors based on quality
- Learn about provider costs
- Review your Plan details, including your progress toward meeting your deductible and out-of-pocket maximum

If your work location is in central Florida, Dallas/Fort Worth, or northwest Arkansas, contact your health care advisor at the number on your plan ID card to obtain information on network doctors and Plan details. You can also find information on network providers on **One.Walmart.com**.

Second opinions: Participants and dependents who are enrolled in the Plan are eligible to obtain an expert second opinion with Grand Rounds (for eligible dependents under age 13, the service must be provided to a parent). Under certain circumstances, when you have received a diagnosis or been recommended for surgery or a certain treatment, the AMP will cover second opinions provided online through Grand Rounds.

Claims advocacy: Grand Rounds' care team can assist you with the financial aspects of medical claims. Specialized claims experts can answer your questions regarding medical bills or explanations of benefits, organize insurance paperwork, audit provider and hospital charges, advocate on your behalf to resolve billing inaccuracies, and negotiate with providers and insurers as needed for claim denials.

TELEHEALTH VIDEO VISITS THROUGH DOCTOR ON DEMAND

Under certain circumstances, the AMP covers doctor consultations using telecommunication technologies such as video visits. Participants enrolled in the AMP have access to Doctor On Demand, a telehealth service offering video medical and mental health visits. Doctor On Demand's contracted providers can diagnose, treat, and write prescriptions for a wide range of non-emergency medical issues. The service is available in all 50 states, 24 hours a day, seven days a week by computer, tablet, or smartphone. Doctor On Demand cannot provide treatment for medical emergencies or for chronic conditions like diabetes.

Doctor On Demand submits claims for services directly to covered participants' third-party administrators. For all eligible participants except for participants in the Saver Plan option, telehealth consultations are subject to a $4 copay. For participants in the Saver Plan option, services are subject to the same coverage terms as conventional doctor visits (deductible, coinsurance, etc.) until you meet the annual deductible, after which consultations are subject to a $4 copay. For information about services and technical requirements, visit Doctor On Demand online at **doctorondemand.com** or call **800-997-6196**.

See page 328 *for information on new programs to help you manage your health.*

Walmart clinics

Walmart Care Clinic and Walmart Health are primary care clinics found in select Walmart stores. They offer retail primary care services including office visits, lab tests, and some preventive care services, for individuals age two and older.

Office visits are offered to most covered associates at the discounted price of a $4 copay, regardless of residency or work location. Due to IRS rules governing health plans that are used with health savings accounts, if you are enrolled in the Saver Plan option you must pay the posted retail price when using the Walmart Care Clinic or Walmart Health, unless the clinic visit is limited to preventive services. HSA dollars may be used as payment for qualified medical expenses received at the clinics.

Lab tests and immunizations that are performed entirely within the clinic setting but not covered as preventive care under the AMP are available at a separate charge in addition to the visit charge. Tests ordered within the Walmart Care Clinic or Walmart Health but performed outside the clinic setting are treated as covered network charges under the AMP. These charges are subject to the AMP's maximum allowable charge and you would be responsible for any difference between the AMP's maximum allowable charge and the provider's actual charge.

Certain preventive services available at the Walmart Care Clinic or Walmart Health are covered under all AMP options. These preventive services are covered at no cost to you and your dependents. See the **Preventive care program** section earlier in this chapter for a list of services covered at 100% if you are enrolled for medical coverage under the AMP.

NETWORK COVERAGE FOR CERTAIN WALMART CLINICS

Your third-party administrator may contract with individual Walmart Care Clinics and/or Walmart Healths to be network providers, but not all Walmart clinics are network providers. The manner in which the AMP treats your out-of-pocket expenses at a Walmart clinic depends on the clinic's network status, as follows:

If the Walmart clinic is a network provider under your medical plan option: The clinic will file insurance claims with your third-party administrator. Any eligible out-of-pocket costs you incur in that clinic (after your $4 copay) will be subject to your annual deductible and out-of-pocket maximum under the same rules that apply to a network provider.

If the Walmart clinic is not a network provider under your Plan option: The clinic will not file insurance claims with your third-party administrator. Out-of-pocket costs you incur are not reimbursable under the AMP and will not be credited against your annual deductible or out-of-pocket maximum.

To find out whether a Walmart Care Clinic or Walmart Health is a network provider, view your network provider directory or contact your third-party administrator.

Centers of Excellence

The Centers of Excellence program works with specific facilities to provide medical services related to a range of treatments and procedures. Through this program, you and your covered dependents have access to specialized providers and facilities selected for their expertise in certain high-risk or high-cost procedures. The AMP offers this program so that participants facing certain serious medical conditions can receive high-quality care. The Centers of Excellence program covers:

- Surgeries for certain heart conditions (age 18 and up)
- Surgeries for certain spine conditions (age limitations apply to some spine conditions, such as scoliosis)
- Hip replacement surgery
- Knee replacement surgery
- Medical record review by a Centers of Excellence facility for certain types of cancer (all ages) to determine if an on-site evaluation is recommended
- Medical record review by a Centers of Excellence facility for outpatient kidney dialysis or end-stage renal disease (ESRD) (all ages) to determine if an on-site evaluation for kidney transplant evaluation is recommended
- Liver, kidney, heart (including durable ventricular assist devices [VADs] and total artificial hearts), lung (including lung volume reduction surgery [LVRS]), pancreas, simultaneous kidney/pancreas, multiple organ, and bone marrow/stem cell transplants (including CAR T-cell treatment), and
- Gastric bypass and gastric sleeve weight loss surgeries (age 18 and up).

This section describes the program in greater detail, including important conditions and restrictions. The **Centers of Excellence** chart below summarizes terms for the medical services covered under the program. See also the **Transplant** and **Weight loss surgery** sections later in this chapter for details about those benefits.

As shown in the **Centers of Excellence** chart below, certain eligible services performed at one of the medical centers included in the program are covered at 100% with no annual deductible (excluding weight loss surgery). However, if you are enrolled in the Saver Plan, you must meet your annual deductible before the Plan will make any payments, due to federal tax laws.

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CENTERS OF EXCELLENCE

	Centers of Excellence Program	Your Medical Plan Network
Heart surgery	100% No deductible*	75% After deductible
Cancer medical record review with on-site evaluation if recommended Eligible cancer types: breast, colorectal, lung, prostate, blood (including myeloma, lymphoma, leukemia)		
Outpatient kidney dialysis or ESRD medical record review with on-site kidney transplant evaluation if recommended		
Hip and knee replacement	100% No deductible*	**Premier, Contribution, Saver Plans in areas other than central FL, Dallas/Ft. Worth, and NW AR:** 50% after out-of-network deductible
		Premier, Contribution, Saver Plans in central FL, Dallas/Ft. Worth, or NW AR: 50% after deductible
		Local plans: No coverage**
Spine surgery	100% No deductible*	No coverage**
Transplant (Mayo Clinic only. Excludes cornea and intestinal transplant)	100% No deductible*	No coverage**
Weight loss surgery (Gastric bypass and gastric sleeve)	75% After deductible	No coverage**

* Due to federal tax law, participants in the Saver Plan must meet their annual deductible before 100% benefits can be provided.

** See the adjacent **Centers of Excellence** text for circumstances when exceptions may apply.

Additional program conditions and restrictions are described in the adjacent **Center of Excellence** text.

If you believe you may be a candidate for Centers of Excellence services, call your health care advisor at the phone number on your plan ID card. To participate in the Centers of Excellence program:

- Services must be scheduled and preauthorized by one of the administrators for the Centers of Excellence program. The particular administrators from whom preauthorization must be obtained vary, depending on the specific service to be provided and in certain cases the associate's medical coverage, as listed in the **Centers of Excellence administration** chart below.
- If your request for preauthorization of a Centers of Excellence service is denied, you have the right to appeal. See the **Claims and appeals** chapter for information. Note that services performed at a Centers of Excellence facility that are not covered services under the terms and conditions of the Centers of Excellence program are subject to regular coverage and payment terms under the AMP.
- For most eligible services, you must identify a designated caregiver who is willing and able to meet caregiver requirements.
- For most eligible services, you must be safe to travel for medical care and must not require emergency care at the time of travel.
- The medical center where you receive services is determined by where you live and the indicated service.
- You acknowledge that the medical center must receive necessary medical records prior to your acceptance into the program.
- You must supply contact information for a local physician who has agreed to manage your follow-up care after you return home from the Centers of Excellence facility.
- After consultation with you, the third-party administrator determines that your claim for benefits is not subject to subrogation under terms of the Plan (see **The Plan's subrogation and reimbursement rights** in the **Claims and appeals** chapter).

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Travel, lodging, and a daily allowance are provided for you and a caregiver for all services covered under the Centers of Excellence program except weight loss surgery. These travel services must be preauthorized and scheduled through the Centers of Excellence program. Payment is subject to applicable limits. (Travel benefits may not be available if you are enrolled in one of the local plan options.)

Specialized care benefit: In some cases, your third-party administrator may consult with Grand Rounds to determine whether services you need are available at a particular facility. If Grand Rounds recommends that you be evaluated at a specific facility based on your condition, even if the facility is not a Centers of Excellence facility, the AMP will assist with the same travel benefits as those paid for travel to a Centers of Excellence facility. These travel services must be preauthorized by Grand Rounds and scheduled by HealthSCOPE Benefits. Reimbursement for medical treatment or services at the facility are paid under otherwise applicable terms, and are not reimbursed as Centers of Excellence services at the rates listed in the chart on the previous page.

If you have a medical condition eligible for care under the Centers of Excellence program and you choose to receive treatment in a facility outside the Centers of Excellence program, your care will not be covered at the Centers of Excellence rates. Your care will instead generally be subject to regular AMP coverage terms, as summarized in the **Centers of Excellence** chart on the previous page and in greater detail earlier in this chapter. Similarly, services you receive prior to arrival or following discharge from a Centers of Excellence facility, including services approved by the Centers of Excellence program administrator, are subject to regular AMP coverage terms.

NOTE: Under limited circumstances, the AMP covers out-of-network coverage for certain Centers of Excellence procedures. These exceptions apply only to participants in the Premier Plan, Contribution Plan, or Saver Plan whose work location is other than central Florida, Dallas/Fort Worth, or northwest Arkansas. For such eligible AMP participants, if you are a candidate for heart surgery, cancer medical record review, hip or knee replacement, or outpatient kidney dialysis review, and you choose to see a non-network provider, services will be covered at a 50% coinsurance rate after you meet your out-of-network deductible.

CENTERS OF EXCELLENCE ADMINISTRATION
NOTE: If you are enrolled in a local plan, call your health care advisor to be directed to the appropriate administrator.

Heart surgery	**Contigo Health (formerly Health Design Plus)**
Cancer medical record review (On-site travel if recommended)	**HealthSCOPE Benefits**
Outpatient kidney dialysis or ESRD medical record review	**HealthSCOPE Benefits**
Spine surgery	**Contigo Health (formerly Health Design Plus)**
Hip and knee replacement	**Contigo Health (formerly Health Design Plus)**
Transplant (Mayo Clinic only. Excludes cornea and intestinal transplant)	**HealthSCOPE Benefits**
Weight loss surgery (Gastric bypass and gastric sleeve)	**Contigo Health (formerly Health Design Plus)**

SPINE SURGERY AND HIP OR KNEE REPLACEMENT

Spine surgery: If you are eligible for Centers of Excellence benefits and you choose to receive treatment in a facility outside the Centers of Excellence program, your treatment will be considered out-of-network, even if the provider is a network provider for other purposes. In such circumstances, no benefits are payable except in cases of emergency.

Hip or knee replacement: If you are eligible for Centers of Excellence benefits and you choose to receive treatment in a facility outside the Centers of Excellence program, your treatment will be considered out-of-network, even if the provider is a network provider for other purposes. In such circumstances, the AMP's coverage terms are as follows:

- If you have coverage under the Premier Plan, Contribution Plan, or Saver Plan and your work location is in central Florida, Dallas/Fort Worth, or northwest Arkansas, and you have your procedure performed by a network provider, the AMP coinsurance is 50% and you will be subject to the network deductible before benefits are payable.
- If you have coverage under the Premier Plan, Contribution Plan, or Saver Plan and your work location is in an area other than central Florida, Dallas/Fort Worth, or northwest Arkansas, and you have your procedure performed by a network provider, the AMP coinsurance is 50% and you will be subject to the out-of-network deductible before benefits are payable.
  See page 329
- If you have coverage under any of the local plan options and have your procedure performed by a provider outside the Centers of Excellence program, no benefits are payable except in cases of emergency.

Requests for exceptions to coverage terms for spine surgery and hip and knee replacement

In cases of spine surgery and hip and knee replacement, you may request an exception to the rules stated immediately above, which describe how the AMP covers these procedures when they are performed outside the Centers of Excellence program. You may request an exception so that procedures performed by a network provider that is not a Centers of Excellence provider be covered at a coinsurance rate of 75% of the network discounted rate; cost sharing will be applied to your network deductible and network out-of-pocket maximum. Depending on whether you have already received treatment when you make your request, it will be treated as a pre-service claim or post-service claim (as described below) and decided under special rules for granting exceptions to the AMP's coverage terms for spine surgery and hip and knee replacement under the Centers of Excellence program, as described in the **Claims and appeals** chapter.

Pre-service exception request: If you have not yet received treatment but are considering receiving services from a non-Centers of Excellence provider, you may file a prior authorization request (a pre-service claim). You can file a pre-service claim if travel to the Centers of Excellence provider would likely result in loss of life, paralysis, or further injury. You can also file a pre-service claim if the Centers of Excellence facility does not recommend spine surgery or hip or knee replacement because it is not deemed the appropriate medical course of treatment or you are not an appropriate candidate for surgery. Your request should be sent to Contigo Health (formerly Health Design Plus) and will be considered by an Independent Review Organization following the procedures described under **Special procedures for approval of exceptions to coverage terms for spine surgery and hip and knee replacement** in the **Claims and appeals** chapter. If your request is granted, coverage will be at the otherwise applicable network rate, including any deductibles, coinsurance, or limitations. If your request is denied because Contigo Health (formerly Health Design Plus), through an Independent Review Organization, determines that travel to a Centers of Excellence provider is safe, based on the documentation received, coverage for hip and knee joint replacement surgery at a non-Centers of Excellence facility will be paid at 50%, as outlined earlier, and no benefits will be payable in the case of spine surgery performed at a non-Centers of Excellence facility, also as outlined earlier.

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Decisions not to move forward with spine surgery or hip or knee replacement by the respective Centers of Excellence providers are not subject to review under this process if the Centers of Excellence provider's decision is based on a determination that the procedure is not appropriate because you refuse to comply with medical restrictions or requirements, including weight loss, smoking cessation, alcohol cessation, social support, or similar factors.

Post-service exception request: If you already have received services from a non-Centers of Excellence provider, you may file a post-service claim with your third-party administrator, as described in the **Claims and appeals** chapter. Your claim may be approved if:

- You experienced a traumatic injury resulting in the need for immediate surgery or were in need of immediate surgery, without which you would have likely incurred loss of life or paralysis, or
- Services were provided by a network provider that began a course of treatment prior to the effective date of this provision and there has not been an interruption of the doctor-patient relationship.

If your claim is approved, coverage will be at the otherwise applicable network or non-network rate, depending on your provider, including any deductibles, coinsurance, or limitations. If your claim is denied, you may request an appeal as described in the **Claims and appeals** chapter.

LIMITED COORDINATION OF BENEFITS

The AMP generally does not coordinate benefits with respect to claims under the Centers of Excellence program, other than coordination with Medicare in the case of certain transplant benefits or as otherwise required by law. For all other Centers of Excellence services, if any portion of a Centers of Excellence benefit could have been paid by another health plan, the AMP will not pay any amount of the claim.

TRANSPLANTS

To be eligible for transplant, lung volume reduction surgery (LVRS), or CAR T-cell treatment benefits under the Centers of Excellence program, you must be enrolled in the AMP for at least 12 months. If you are enrolled in the eComm PPO Plan or an HMO plan, you are not eligible for transplant benefits, but if you later become covered under one of the AMP options, your time enrolled in the eComm PPO Plan or an HMO will count toward the 12-month waiting period. If you are not enrolled in one of the AMP options, any time enrolled in critical illness insurance or accident insurance will not count toward the 12-month waiting period.

If you terminate coverage for any reason and reenroll, your prior time enrolled for coverage will count toward the 12-month waiting period.

The 12-month waiting period does not apply to insertion of durable ventricular assist devices (VADs) or artificial hearts, regardless of whether the VAD is related to a transplant.

The 12-month waiting period applies to the associate and, separately, to most covered dependents (except as described on the following page) — i.e., the covered associate and each covered dependent must meet his or her own 12-month waiting period. If you add AMP coverage for a new dependent through birth, or adoption of the child as of the child's date of birth, your new dependent's 12-month waiting period will be waived.

The 12-month waiting period is waived for localized associates and their covered dependents. The 12-month waiting period may also be waived when your doctor certifies that in the absence of a transplant, the covered participant's death is imminent within 48 hours. See the **Claims and appeals** chapter for information on requesting a waiver.

If your doctor recommends a transplant, call HealthSCOPE Benefits at **479-621-2830** or **800-421-1362**.

Guidelines for covered transplants

- You must undergo a pretransplant evaluation at Mayo Clinic. In performing this evaluation, Mayo Clinic is not acting as an agent of the AMP. It is the AMP's intent that this evaluation be made pursuant to the doctor/patient relationship between Mayo Clinic and the participant. Travel, lodging, and a daily allowance will be provided for you and a caregiver for required transplant evaluations at Mayo Clinic.
- Liver, kidney, heart (including durable ventricular assist devices [VADs] and total artificial hearts), lung (including lung volume reduction surgery [LVRS]), pancreas, simultaneous kidney/pancreas, multiple organ, and bone marrow/stem cell transplants (including CAR T-cell treatment) must be performed at Mayo Clinic or an approved facility, or no benefits are paid, except when a formal network exception request is reviewed and approved in instances where there is a significant risk that travel to Mayo Clinic could result in death, or the Independent Review Organization approves coverage at a different facility where Mayo Clinic determines that it will not recommend and perform a transplant because it is not the appropriate medical course of treatment, or the individual is not an appropriate candidate (see **Requests for organ transplants at facilities other than Mayo Clinic** on the next page).
- Claims for eligible transplant services performed at Mayo Clinic (including pediatric) should be filed with HealthSCOPE Benefits and are covered at 100% with no annual deductible. However, if you are enrolled in the Saver Plan, you must meet your annual deductible before the Plan will make any payments due to federal tax laws. Additionally, travel, lodging, and a daily allowance are provided for you and a caregiver, subject to applicable limits.
- The AMP does not cover transplantation of body parts (e.g., face, hands, feet, legs, arms, uterus) under any circumstances. Experimental and/or investigational transplant-related services are not covered unless those services are recommended and performed by Mayo Clinic or an approved facility.
- Benefits for a covered transplant procedure at Mayo Clinic, and related expenses, including travel, lodging, and a daily allowance, end one year post-transplant or after a one-year post-transplant evaluation is performed.
- Coverage for procedures and devices unrelated to a transplant, as determined by Mayo Clinic, are not covered at 100% and are subject to applicable AMP terms and limitations, including annual deductibles and coinsurance (network and out-of-network). This includes certain gastric-sleeve procedures performed at Mayo Clinic during a liver transplant.
- Non-transplant services performed at Mayo Clinic are not covered at 100% and are subject to applicable AMP terms and limitations, including copays, annual deductible, and coinsurance (network and out-of-network).
- Travel for transplant-related services must be arranged by a transplant coordinator. For travel arrangements, call HealthSCOPE Benefits at **479-621-2830** or **800-421-1362**.

- Claims for transplants and LVRS that are not performed in accordance with the guidelines stated in this chapter and in the **Claims and appeals** chapter will be denied.
- Coverage is limited to transplantation of human organs.

Requests for organ transplants at facilities other than Mayo Clinic

- You may file a claim with an Independent Review Organization to request an organ transplant at a facility other than Mayo Clinic if:
  - There is significant risk that travel to Mayo Clinic could result in death, or
  - Mayo Clinic determines that it will not recommend and perform a transplant because it is not the appropriate medical course of treatment or you are not an appropriate candidate for a transplant.

  Your claim must be received by the Plan within 120 calendar days of the initial denial of the transplant by Mayo Clinic. Your claim will be decided under the special rules for transplant claims at a facility other than Mayo Clinic, as described in the **Claims and appeals** chapter.
- The Independent Review Organization will be made up of individuals appointed by the AMP administrator and will not include any employee of the company, Mayo Clinic, or a third-party administrator of the AMP. The Independent Review Organization will review any relevant medical files that were reviewed or generated by Mayo Clinic, as well as any additional materials you submit, and will consider various factors, including alternative courses of treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures, and the potential benefit the transplant would have.
- If the Independent Review Organization determines that the transplant and related course of treatment are medically necessary, the Independent Review Organization will approve an exception to pursue a transplant outside of Mayo Clinic, under regular medical benefits.
  - Claims will be covered at 75% for network providers after you meet the annual deductible.
  - If you are enrolled in the Premier Plan, Contribution Plan, or Saver Plan, and your work location is other than central Florida, Dallas/Fort Worth, or northwest Arkansas, claims are covered at 50% of the maximum allowable charge if you use a non-network provider, even after you've reached your out-of-pocket maximum. You are responsible for your 50% share plus any charges above the maximum allowable charge. The amount you pay for out-of-network services applies toward your network deductible until it is met, and also applies to your out-of-network annual deductible. Your network deductible applies toward your annual out-of-pocket maximum. (Note that services provided by non-network providers are not covered in the Premier Plan, Contribution Plan, or Saver Plan in central Florida, Dallas/Fort Worth, or northwest Arkansas, or in any of the local plan options, except in cases of emergency.)
  - The Plan does not cover the cost of travel or lodging or provide a daily allowance for such transplants.

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Transplant denials by Mayo Clinic are not subject to review under this process if Mayo Clinic's decision is based on a determination that the transplant is not appropriate because you refuse to comply with medical restrictions or requirements, including weight loss, smoking cessation, alcohol cessation, social support, or similar factors. Transplant-related claims where treatment has already been rendered are decided under the regular medical claims and appeals procedures found in the **Claims and appeals** chapter.

Pediatric transplant recipients under age 19

- Pediatric transplant recipients under age 19 (except for cornea and intestinal transplants) must undergo a pre-transplant review and, upon request by Mayo Clinic, an evaluation by Mayo Clinic.
- Once a Mayo review or visit is complete, if transplant services are sought at a facility other than Mayo Clinic, transplant claims will be considered at 75% for network providers after you meet the annual deductible.
- If your medical plan option provides coverage for non-network providers, claims are covered at 50% of the maximum allowable charge if you use a non-network provider, even after you reach your out-of-pocket maximum. You are responsible for your 50% share plus any charges above the maximum allowable charge. The amount you pay for out-of-network services applies toward your network deductible until it is met, and also applies to your out-of-network annual deductible. Your network deductible applies toward your annual out-of-pocket maximum. (Note that services provided by non-network providers are not covered in the Premier Plan, Contribution Plan, or Saver Plan in central Florida, Dallas/Fort Worth, or northwest Arkansas, or in any of the local plan options, except in cases of emergency.)
- Travel, lodging, and a daily allowance are provided only if the transplant is performed at Mayo Clinic.

Transplant donor expenses

- Eligible transplant donor expenses with respect to a living donor are covered when the recipient is an AMP participant who is eligible for transplant coverage and the living donor's medical plan or insurance provider does not pay for transplant donor charges or expenses.
- Eligible transplant donor expenses with respect to travel and lodging benefits must be arranged by a transplant coordinator. It is your responsibility to provide contact information for the transplant benefit administrator to the eligible transplant donor, prior to appointments.

- Covered donor charges are paid at the same benefit level as the recipient according to transplant guidelines, up to 120 days post-transplant.
- Cadaver organ acquisition and procurement expenses are covered only when the expenses are part of the provider's contracted rate with the Plan's third-party administrator.

CORNEA AND INTESTINAL TRANSPLANTS

Cornea and intestinal transplants are not included in the Centers of Excellence transplant program and can be performed at the network facility of your choice, according to these terms:

- Claims are covered at 75% for network providers after you meet the annual deductible.
- If your medical plan option provides coverage for non-network providers, claims are covered at 50% of the maximum allowable charge if you use a non-network provider, even after you've reached your out-of-pocket maximum. You are responsible for your 50% cost share plus any charges above the maximum allowable charge. The amount you pay for out-of-network services applies toward your network deductible until it is met, and also applies to your out-of-network annual deductible. Your network deductible applies toward your annual out-of-pocket maximum. (Note that services provided by non-network providers are not covered in the Premier Plan, Contribution Plan, or Saver Plan in central Florida, Dallas/Fort Worth, or northwest Arkansas, or in any of the local plan options, except in cases of emergency.)
- No travel, lodging, or daily allowance is provided for these transplants.

WEIGHT LOSS SURGERY BENEFIT

Certain weight loss surgeries are covered under the AMP Centers of Excellence program, subject to specific criteria, including but not limited to:

- Services must be provided by a physician and facility designated by the AMP.
- If you wish to use the weight loss surgery benefit you must be enrolled for medical benefits in the AMP for at least 12 months. If you are enrolled in the eComm PPO Plan or an HMO, you are not eligible for weight loss surgery benefits, but if you later become covered under one of the AMP options, your time enrolled in the eComm PPO Plan or an HMO will count toward the 12-month waiting period. If you are not enrolled in one of the AMP options, any time enrolled in critical illness insurance or accident insurance will not count toward the 12-month waiting period. If you terminate coverage for any reason and reenroll, your prior time enrolled for coverage will count toward the 12-month waiting period.
- You must be willing to travel to the designated facility at your own expense (travel reimbursement is not provided).
- You must be at least 18 years of age.
- You must have either a body mass index (BMI) of 40 or greater, *or* a BMI of 35 or greater and at least one obesity-related comorbidity factor (type 2 diabetes, hypertension, cardiovascular disease, etc.).
- You must agree to comply with all requirements for the duration of the weight loss surgery treatment.

If you had a previous laparoscopic adjustable gastric band procedure for weight loss purposes, and now need surgical removal based on medical complications, you can apply for the weight loss surgery benefit to be evaluated by a Centers of Excellence facility to determine if you would be an appropriate candidate for a conversion to a covered weight loss surgery, during or in conjunction with the removal of the gastric band. You will be required to provide documentation demonstrating that you met the above-mentioned clinical criteria for bariatric surgery prior to the original lap band procedure.

Coverage for weight loss surgery is provided at the network benefit level; after you meet your annual deductible for eligible network expenses, the Plan pays 75% and you pay 25%. If you meet the requirements stated above and your doctor recommends weight loss surgery, call your health care advisor at the number on your plan ID card to obtain a request form, which must be completed by you and your physician. You must send the completed request form to Contigo Health (formerly Health Design Plus) at the address listed on the form. A claim is considered filed when Contigo Health (formerly Health Design Plus) receives the request form. The claim is determined under the procedures for pre-service claims described in the **Claims and appeals** chapter.

When limited benefits apply to the AMP

Some services are subject to specific restrictions and limitations in addition to annual deductible and coinsurance/copayment requirements. If you have a question on the coverage of a particular service, contact the third-party administrator at the number on your plan ID card.

The limitations and restrictions described below are in addition to other AMP rules, including deductibles, coinsurance/copayments, and exclusions. Consideration

may be given for additional coverage when authorized by your nurse care manager, as described in the **Care management** section.

Refer also to **What is not covered by the Associates' Medical Plan**, later in this chapter.

Ambulance: Coverage of ambulance or air ambulance transportation is limited to the nearest hospital or nearest treatment facility capable of providing care, and only if such transportation is medically necessary as compared to other transportation methods of lower cost and safety.

The Plan covers ambulance or air ambulance transportation between health care facilities if the treatment to be provided at the second facility is medically necessary and not available at the initial facility.

The Plan covers ambulance and air ambulance transportation from a hospital to a hospice facility (including to a residence where hospice care will be provided).

Ambulance charges for the sole convenience of the participant, caregiver, or provider are not covered.

Birth control/contraceptives: Prescribed FDA-approved contraceptive methods for women and female sterilization are covered under women's preventive care, including but not limited to:

- Diaphragms: fitting and supply
- Cervical cap: fitting and supply
- Intrauterine device (IUD): fitting, supply, and removal (including copper or with progestin)
- Birth control pills (including the combined pill, progestin-only, and extended/continuous use)
- Birth control patch
- Vaginal ring
- Injection (e.g., Depo-Provera) given by a physician or nurse every three months
- Implantable contraception (e.g., Implanon)
- Plan B, when prescribed
- Ella, when prescribed
- Female sterilization (including surgery and surgical sterilization implant)
- Vaginal sponge, when prescribed
- Female condom, when prescribed
- Spermicide, when prescribed.

The AMP covers generic contraceptives only when prescribed by a physician (and brand-name contraceptives when medically necessary). If your attending physician believes a brand-name contraceptive is medically necessary, you may file a claim for coverage of the brand-name drug.

Services and/or devices that are not included in the contraceptive benefit are:

- Abortion
- Prescription abortifacient medication, including but not limited to RU-486
- Male sterilization **See page 330**
- Over-the-counter birth control methods that are not prescribed, including but not limited to Plan B, spermicides, condoms, vaginal sponges, basal thermometers, and ovulation predictor kits.

Clinical trials: Approved clinical trials are covered under limited circumstances. Routine patient costs associated with participation in Phases I–IV of approved clinical trials to treat cancer or other life-threatening conditions, as determined by the third-party administrator and required by law. These costs are subject to the AMP's applicable deductibles and limitations and do not include costs of the investigational item, device, or service, items provided for data collection, or services that are inconsistent with established standards of care.

Durable medical equipment (DME)/home medical supplies: DME that satisfies all of the following criteria is covered, except as stated under **DME not covered** on the next page.

DME is equipment that:

- Can withstand repeated use
- Is used mainly for a medical purpose rather than for comfort or convenience
- Generally is not useful in the absence of an illness or injury
- Is related to a medical condition and prescribed by a physician
- Is appropriate for use in the home, and
- Is determined to meet medical criteria for coverage to diagnose or treat an illness or injury, help a malformed part of the body to work well, help an impaired part of the body to work within its functional parameters, or keep a condition from becoming worse.

Coverage is also provided for home medical supplies, such as ostomy supplies, wound-care supplies, tracheotomy supplies, and orthotics. Supplies must be prescribed by a medical doctor (M.D.) or doctor of osteopathy (D.O.) to be covered. Surgical stockings are limited to 12 stockings per calendar year.

To be covered, a doctor must include a diagnosis, the type of equipment needed, and expected time of usage. Examples of DME include wheelchairs, hospital-type beds, and walkers. If equipment is rented, the total benefit may not exceed the purchase price at the time rental begins.

Repair of DME is covered when all the following are met:

- The patient owns the equipment
- The required repairs are not caused by the patient's misuse or neglect of the equipment
- The expense of repair does not exceed the expense of purchasing new equipment, and
- The equipment is not covered by warranty.

If patient-owned DME is being repaired, up to one month's rental for that piece of DME is covered. Payment is based on the type of replacement device provided, but will not exceed the rental allowance for the equipment under repair.

DME not covered: Motor-driven scooters, invasive implantable bone growth stimulators (except in the case of spinal surgeries), sitz bath, seat lift, rolling chair, vaporizer, urinal, ultraviolet cabinet, whirlpool bath equipment, bed pan, portable paraffin bath, heating pad, heat lamp, steam/hot/cold packs, devices that measure or record blood pressure, and other such medical equipment or items determined to be not medically necessary.

Foot care: For nonsurgical foot care in connection with treatment for the following conditions, the AMP allows a total of three provider visits per calendar year:

- Bunions
- Corns or calluses
- Flat, unstable or unbalanced feet
- Metatarsalgia
- Hammertoe
- Hallux valgus/claw toes, or
- Plantar fasciitis.

Services must be prescribed by a medical doctor (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.).

Open-cutting surgical care (including removal of nail roots) and nonsurgical care due to metabolic and peripheral vascular disease are not subject to the calendar-year limit.

Orthotic devices for the feet may be covered if prescribed by a qualified doctor and custom-molded under the doctor's supervision, subject to the calendar-year limit described above. Orthopedic shoes prescribed by a doctor are limited to two shoes per calendar year.

Gender dysphoria treatment: Medically necessary services for treatment of gender dysphoria are covered:

- Gender reassignment surgery, including both male to female surgery and female to male surgery
- Hormone replacement therapy, including laboratory testing to monitor hormone therapy, and
- Psychotherapy visits.

Gender reassignment surgery is covered only if you are age 18 or older. Cosmetic treatment of gender dysphoria is not covered.

Home nursing care: In-home private-duty professional nursing services are covered if provided by a state-approved licensed vocational nurse (L.V.N.), licensed practical nurse (L.P.N.), or registered nurse (R.N.). Services cannot be rendered by a relative or by someone in the same household as the patient. Home nursing care benefits are payable up to a maximum of 100 visits per calendar year. A visit is defined as two hours or less.

Hospice care: Hospice care is an integrated program providing comfort and support services for the terminally ill. Hospice care is covered if you have an estimated life expectancy of 12 months or less, as attested by the physician treating the illness. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual, and respite care for the terminally ill person, and support for immediate family members, including partners, while the covered person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.

Inpatient and outpatient hospice care are covered up to 365 days per illness. Participants may continue to receive treatment and participate in approved clinical trials while obtaining hospice services. Coverage for additional days may be available if determined to be medically necessary.

Infertility treatment: Services for the diagnosis and correction of an underlying condition of infertility are covered. Refer to **What is not covered by the Associates' Medical Plan** later in this chapter for a list of non-covered infertility services.

International business travel medical coverage: The company provides international business medical insurance through an insurance policy from GeoBlue. If you participate in the Saver Plan you are not eligible to make HSA contributions for any month in which you are traveling on company business outside the U.S. and are covered under the GeoBlue policy, which provides health benefit coverage for associates traveling internationally on business. You are encouraged to consult with your tax advisor if you have questions about the amount to reduce your contributions based on your individual circumstances.

Nutritional counseling: Nutritional counseling for children is covered if it is medically necessary for a chronic disease (e.g., PKU, Crohn's disease, celiac disease, galactosemia, etc.) in which dietary adjustment has a therapeutic role when prescribed by a physician and furnished by a provider (e.g., a registered dietician, licensed nutritionist, or other qualified licensed health professional) recognized under the AMP. Benefits are limited to three visits per condition per

year. See the **Preventive care program** section for additional benefits related to nutritional and obesity counseling for adults and children.

Off-label use of cancer chemotherapy injectable drugs: These drugs are covered when medically necessary, recommended by one of the following three drug compendia, and not recommended against by one or more of the same compendia (appropriate to the date of service):

- *American Hospital Formulary Service (AHFS) Drug Information*
- Clinical Pharmacology Online, or
- National Comprehensive Cancer Network (consensus) or category 1 (the recommendation is based on high-level evidence and there is uniform NCCN consensus) or category 2A (the recommendation is based on lower-level evidence and there is uniform NCCN consensus).

If you or your physician are unsure about the Plan's coverage for any type of prescription drug, verify coverage details by calling the third-party administrator of your medical plan at the number on your plan ID card. You can also call OptumRx at **844-705-7493**.

Off-label use of non-cancer chemotherapy injectable drugs: These drugs are covered when medically necessary and recommended under one of the following drug compendia (appropriate to the date of service):

- *American Hospital Formulary Service (AHFS) Drug Information*, or
- Clinical Pharmacology Online.

The Plan does not cover any drug determined by the FDA to be contra-indicated or not advisable. Coverage for FDA-approved drugs is subject to the AMP's applicable requirements and limitations.

Oral treatment: Charges for care of teeth and gums are covered when submitted by a doctor or dentist, including but not limited to:

- Prescriptions
- Emergency room services for mouth pain
- Treatment of fractures/dislocations of the jaw resulting from an accidental injury
- Accidental injury to natural teeth up to one year from the date of the accident (does not include injuries resulting from biting or chewing; those may be covered under the dental plan)
- Dental procedures necessitated by either severe disease (including but not limited to cancer) or traumatic event, as long as the dental service is medically necessary and the service is incidental to and an integral part of service covered under AMP medical benefits. Examples of services include, but are not limited to, the extraction of teeth prior to or following chemotherapy or radiation therapy of the head and neck. Treatment of oral tissues related to chemotherapy must be supported by documentation of a direct link between the destroyed bone or gums and the chemotherapy.
- Non-dental cutting procedures in the oral cavity
- Medical complications that are the result of a dental procedure, or
- Expenses for dental services performed in a hospital setting, including facility and professional charges, for extensive procedures that prevent an oral surgeon from providing general anesthesia in an office setting, or for circumstances that limit the ability of the oral surgeon to provide services in an office setting. Such circumstances include, but are not limited to, situations in which the covered person is:
  - A child under age 4
  - Between the age of 4 and 12, when either:
    - Care in a dental office has been attempted unsuccessfully and usual methods of behavior modification have not been successful; or
    - Extensive amounts of care are required, exceeding four appointments.
  - An individual with one of the following medical conditions, requiring hospitalization or general anesthesia for dental treatment:
    - Respiratory illness
    - Cardiac conditions
    - Bleeding disorders
    - Severe disability (including but not limited to cerebral palsy, autism, developmental disability)
    - Other severe disease (including but not limited to cancer or neurological disorder), or
    - Compromised airway.
  - An individual of any age whose condition requires extensive procedures that prevent an oral surgeon from providing general anesthesia in the office setting.

Outpatient physical/occupational therapy: Charges for outpatient physical/occupational therapy are covered when services are:

- Prescribed by a medical doctor (M.D.), doctor of osteopathy (D.O.), or doctor of podiatric medicine (D.P.M.), and
- Provided by a licensed physical therapy provider or licensed occupational therapy provider or by one of the types of doctors listed above.

This benefit is payable to a maximum of 20 visits for physical therapy and 20 visits for occupational therapy per calendar year. Additional visits may be covered if deemed appropriate by the care manager.

Pregnancy benefits: Pregnancy expenses are covered the same as any other medical condition. (Eligible prenatal services are covered under the preventive care program.)

Benefits are paid for pregnancy-related expenses of dependent children. The newborn is covered only if the newborn is a covered dependent of the covered associate. See **How to change your elections due to a status change event** in the **Eligibility and enrollment** chapter for information on enrolling a newborn for coverage.

Prostate-specific antigen (PSA) tests: Covered only when conducted as part of a clinical diagnosis.

Prosthetics: Prosthetic devices (such as artificial limbs) are covered if medically necessary and prescribed by a physician, subject to the terms of the third-party administrators. Replacement prostheses are allowed only with a change of prescription. A licensed prosthetician must perform replacements of artificial limbs.

Rehabilitative care: Inpatient and/or day rehabilitation is covered to a maximum of 120 days per condition for the following clinical groups if clinical criteria are met:

- Stroke
- Spinal cord injury
- Brain injury
- Congenital deformity
- Neurological disorders
- Amputation
- Severe or advanced osteoarthritis involving two or more weight-bearing joints
- Rheumatoid, other arthritis
- Systemic vasculitis with joint inflammation
- Major multiple trauma, or
- Burns.

Specialty care: Medical care commonly provided at the following types of facilities is covered if you are admitted to this level of care subsequent to an eligible acute care hospital confinement:

- Extended care facility
- Long-term acute care specialty facility
- Subacute care facility
- Skilled nursing facility, or
- Transitional care facility.

Benefits are limited to a maximum of 60 calendar days per disability period. Successive periods of confinement due to the same or related causes are considered one disability period unless separated by a complete recovery.

Speech therapy: Therapy of up to 60 visits per calendar year is covered when:

- Prescribed by a medical doctor (M.D.) or doctor of osteopathy (D.O.), and
- Provided by a licensed speech therapist.

Initial and ongoing plans of treatment and progress reports may be requested from the prescribing doctor. To be covered, speech therapy must be for a residual speech impairment resulting from:

- A cerebral vascular accident
- Head or neck injury
- Partial or complete paralysis of voice cords or larynx
- Head or neck surgery, or
- Congenital and severe developmental speech disorders.

Video visits: Video visits are covered for participants enrolled in the AMP only when provided through the Doctor On Demand service. See **Telehealth video visits** earlier in this chapter for information.
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Vision services: Diagnosis and treatment of injury or disease of the eye, including but not limited to diabetic retinopathy, glaucoma, and macular degeneration, are covered. Charges for routine eye care, including but not limited to vision analysis, eye examinations, or eye surgeries for nearsightedness or correction of vision, are not covered, except for vision screening for children covered under preventive care guidelines.

Weight loss treatment: Weight loss surgery is covered only under the Centers of Excellence program when you meet specific eligibility guidelines and clinical criteria. Weight loss treatments, including but not limited to medications, diet supplements, and surgeries outside the scope of the Centers of Excellence program, are not covered. See the **Centers of Excellence** section of this chapter for information about weight loss surgery.

What is not covered by the AMP

In addition to the exclusions and limitations listed in the **When limited benefits apply to the AMP** section of this chapter, the following list represents services not covered by the AMP. Network discounts do not apply to these services.

If you are enrolled in the Saver Plan, you may be able to use your HSA funds for these and other qualified medical expenses. For information, contact your HSA administrator.

If you have a question regarding whether a service is covered under the Plan, call the third-party administrator at the number on your plan ID card or see the inside back cover of this book for contact information.

Acupuncture

Administrative services and interest fees: Charges for the completion of claim forms, missed appointments, additional charges for weekend or holiday appointments, interest fees, collection fees, or attorney fees.

Alternative/nontraditional treatment (including homeopathy, naturopathy, hypnosis, and massage therapy).

Autopsy

Beyond the scope of licensure or unlicensed: Services rendered by a non-credited or a non-licensed physician, health care worker or institution, or services rendered beyond the scope of such person or entity's license.

Biofeedback

Breast reconstruction/reduction: Any expenses or charges resulting from breast enlargement (augmentation), including implant insertion and implant removal, whether male or female, are not covered except when the implant is removed as the result of implant damage or rupture. Replacement of a damaged or ruptured implant is not covered unless the original implant was placed for conditions eligible to be paid by the Plan.

Any expenses or charges resulting from breast reductions, implantations, or total breast removal, whether male or female, are not covered, unless directly related to treatment of a mastectomy, as provided by law (see **Women's Health and Cancer Rights Act of 1998** later in this chapter), or unless an AMP medical review determines the procedure is medically necessary.

Chiropractic care: Spinal manipulation, joint manipulation, or soft-tissue manipulation, regardless of the type of provider performing the service, except that participants enrolled in the Mercy Local Plans for Arkansas, Oklahoma, Southwest Missouri, and St. Louis have limited coverage when services are performed by a network provider.

Copays and/or discounts, deductibles and/or coinsurance

Cosmetic health services or reconstructive surgery: Except for congenital abnormality, services covered by law (see **Women's Health and Cancer Rights Act of 1998** later in this chapter), or conditions resulting from accidental injuries, tumors, or diseases.

Custodial or respite care: Care or services provided in a facility or home to maintain a person's present state of health, which cannot reasonably be expected to significantly improve.

Drugs, items, and equipment not FDA-approved

Educational services: Including any services for learning and educational disorders (which include but are not limited to reading disorders, alexia, developmental dyslexia, dyscalculia, spelling disorders, and other learning difficulties).

Elective inpatient and outpatient stays or services outside the U.S.

Expenses related to missed appointments, review or storage of your health care information or data

Experimental, investigational, and/or treatments and services that are not medically necessary: Experimental and/or investigational medical services are those defined as experimental and/or investigational according to protocols established by your third-party administrator. For Centers of Excellence services, the Centers of Excellence third-party administrator makes this determination.

Extracorporeal shock wave therapy: For plantar fasciitis and other musculoskeletal conditions.

Government compensation: Charges that are compensated for or furnished by local, state, or federal government, or any agency thereof, unless payment is legally required.

Health and behavior assessment/intervention: Evaluation of psychosocial factors potentially affecting physical health problems and treatments, except for behavioral assessments outlined under the preventive care program.

Hearing devices: Charges for routine hearing tests and hearing aids, except for hearing screening for children, covered under preventive care guidelines.

HMO copays

Illegal occupation, assault, felony, riot, or insurrection: Charges for medical services, supplies, or treatments that result from or occur while being engaged in an illegal occupation, commission of an assault, felony, or criminal offense (except for a moving violation), or participation in a riot or insurrection.

Infertility services: Treatment by artificial means for the purpose of creating a pregnancy. Assistive reproductive technology (ART) and other non-covered services include but are not limited to:

- Infertility prescription drugs
- Charges to reverse a sterilization procedure
- Charges for, or related to, the services of a surrogate mother, egg donor, or sperm donor, and
- In-vitro fertilization, GIFT, ZIFT, IVC, gamete intra-cryopreservation, frozen embryo transfer, and artificial insemination, including all related charges.

Judgments/settlements

Late claims: Charges received more than 18 months past the date of service. See **Filing a medical claim** later in this chapter for information about coordination of benefits. In the event a participant establishes that a claim was filed within the stated time period, but the claim was mistakenly filed with the company or any third-party administrator of the Plan, that time shall not count toward the filing period above.

Marital, family, or relationship counseling: Or counseling to assist in achieving more effective intra- or interpersonal development.

Military-related injury or illness: Including injury or illness related to, or resulting from, acts of war, declared or undeclared.

Neurofeedback

Nonaccredited/nonlicensed providers or institutions

Non-covered services:

- Services not specifically included as a benefit in this Summary Plan Description
- Services provided after exceeding the benefit maximum for specified services
- Services for which you are responsible for payment, such as non-covered out-of-network charges
- Charges for services above the contracted rates to providers, or
- Charges for medical records.

Out-of-pocket expenses

Over-the-counter medications and equipment: Except for specific preventive care medications. See **The pharmacy benefit** chapter for more information.

Personal care items: Primarily for personal comfort or convenience, including but not limited to diapers, bathtub grabbers, handrails, lift chairs, over-bed tables, bedboards, incontinence pads, ramps, snug seats, recreational items, home improvements and home appliances, spas, wigs, and knee braces for sports.

Services provided by a member of the patient's family

Services provided by a government entity while incarcerated

Sexual dysfunction services and pharmaceuticals: Including therapy, treatment, or pharmaceuticals for the treatment of sexual dysfunction, except for sexual dysfunction resulting from an accidental injury or treatment for an illness or condition (e.g., erectile dysfunction resulting from a prostatectomy or spinal cord injury).

Sports/school physicals: Charges for physical examinations performed for the purpose of clearing an individual for participation in a sport or school activity.

Surrogate parenting: Whether paying for another's services or serving as a surrogate.

Talking aids: Assistive talking devices, including special computers or devices designed to assist in therapy treatment to enhance motor and/or psychological abilities.

Termination of pregnancy: Charges for procedures, services, drugs, and supplies related to abortions or termination of pregnancy are not covered, except when the health of the mother would be in danger if the fetus were carried to term, the fetus could not survive the birthing process, or death would be imminent after birth.

Travel and lodging, except as specified under Centers of Excellence benefits

Vitamins: Charges for nonprescription vitamins (whether oral or injectable), minerals, nutritional supplements, or dietary supplements, except as outlined in the **Preventive care program** section of this chapter.

Walmart Care Clinic/Walmart Health: Charges for nonpreventive services, except where the Walmart Care Clinic or Walmart Health is considered a network provider or for lab services provided outside the clinic by an external vendor.

Work hardening or similar vocational programs

Workers' compensation: Treatment of any compensable injury, as defined by applicable workers' compensation law, regardless of whether or not you file a timely claim for workers' compensation benefits.

Filing a medical claim

If you use a network provider, the provider will generally file the claim for you. If you see a non-network provider, you may need to file a claim. If you need to file a claim, it should include the following information:

- Patient's name
- Provider's name, address, and tax identification number
- Associate's insurance ID (see your plan ID card)
- Date of service
- Amount of charges
- Medical procedure codes (these should be found on the bill), and
- Diagnosis.

Claim forms are located on **One.Walmart.com**. You must file within 18 months from date of service or your claim will be denied. Claims are determined under the time frames and requirements outlined in the **Claims and appeals** chapter. See your plan ID card for the correct address to mail your claim. Failure to mail your claim to the correct address may result in the denial of your claim.

When you incur medical expenses and file a claim, or a claim is filed on your behalf, benefits are paid directly to the provider for network services. Payment to the provider discharges the AMP's obligation to you for the benefit.

If your plan provides coverage for non-network providers and you use a non-network provider, payment may be made directly to you upon your showing proof of payment in full to the provider. You are responsible for your 50% share of the maximum allowable charge, plus any amount above the maximum allowable charge. As a convenience to you, payment may also be made to a non-network provider if you expressly authorize such payment. Your provider, whether network or non-network, may not pursue appeals on your behalf unless you designate your provider as your

authorized representative, as described in the **Claims and appeals** chapter. The AMP prohibits the assignment of any benefit or any legal claim or cause of action (whether known or unknown). Note that any direct payment to a provider is undertaken by the AMP solely for your convenience.

You have the right to appeal a claim denial, as described in the **Claims and appeals** chapter.

If you have coverage under more than one medical plan

The AMP has the right to coordinate with other plans under which you are covered so the total medical benefits payable do not exceed the level of benefits otherwise payable under the AMP. "Other plans" refers to the following types of medical and health care coverage:

- Coverage under a governmental program provided or required by statute, including no-fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation
- Group insurance or other coverage for a group of individuals, including coverage under another employer plan or student coverage obtained through an educational institution
- Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans
- Any coverage under governmental plans, such as Medicare or TRICARE, but not including a state plan under Medicaid or any governmental plan when, by law, its benefits are secondary to those of any private insurance, nongovernmental program, and
- Any private or association policy or plan of medical expense reimbursement that is group or individual rated.

When you are covered by more than one plan, one of the plans is designated the primary plan. The primary plan pays first and ignores benefits payable under other plans when determining benefits. Any other plan is designated as a secondary plan that pays benefits after the primary plan. A secondary plan reduces its benefits by the amount of benefits payable under "other plans" and may limit the benefits it pays.

You must follow the primary insurance terms in order for the AMP to pay as secondary payer.

These rules apply whether or not a claim is made under the other plan. If a claim is not made, benefits under the AMP will be delayed or denied until an explanation of benefits is received showing a claim made with the primary plan.

The AMP does not coordinate as a secondary payer for any copays you pay with respect to another plan or with respect to prescription drug claims or transplants (except where the other plan is Medicare).

If you reside in a state where automobile no-fault coverage, personal injury protection coverage, or medical payment coverage is mandatory, that coverage is primary and the AMP is secondary. The AMP reduces benefits for an amount equal to the state's mandatory minimum requirement.

- The Plan has first priority with respect to its right to reduction, reimbursement, and subrogation.
- The Plan does not coordinate benefits with an HMO or similar managed care plan where you pay only a copayment or fixed dollar amount.
- The Plan does not coordinate with any other plan other than Medicare with respect to a covered transplant.

HOW THE AMP COORDINATES WITH OTHER PLANS

	Example 1	Example 2	Example 3
If another plan pays primary at:	80%	80%	0%
And the AMP's payment is:	75%	100%	75%
The AMP's total benefit is:	0%	20%	75%

DETERMINING WHICH PLAN IS PRIMARY

A plan without a coordinating provision is always primary. The AMP has a coordinating provision. If all plans have a coordinating provision, the following provisions apply:

- The AMP always is the secondary payer to any motor vehicle policy available to you, including personal injury protection or no-fault coverage. If the AMP pays benefits as a result of injuries or illnesses you sustain and another party (e.g., an insurance company) bears primary responsibility for your covered medical expenses, the AMP has a legal right to reimbursement of benefits. See the **Claims and appeals** chapter for more information.
- The plan covering the participant for whom the claim is made, other than as a dependent, pays first and the other plan pays second.
- If the plan participant is covered under a retiree medical plan that includes a coordination of benefits provision, that provision governs.
- For dependent children's claims, the plan of the parent whose birthday occurs earlier in the calendar year is primary.
- When the birthdays of both parents are on the same day, the plan that has covered the dependent for the longer period of time is primary.
- When the parents of a dependent child are divorced or separated, or the domestic partnership or legal relationship is terminated, and the parent with custody has not remarried, that parent's plan is primary.

- When the parent with custody has remarried, or entered into a domestic partnership with another individual, that parent's plan is primary, the stepparent's plan pays second and the plan of the parent without custody pays last.
- When there is a court decree that establishes financial responsibility for the health care expenses of the child, the plan that covers the parent with financial responsibility is primary.
- If these rules do not establish an order of benefit determination, the plan that has covered the participant for whom the claim is made for the longest period of time is primary.
- If you are covered under a right of continuation coverage pursuant to federal or state law (for example, COBRA) and you are also covered under another plan that covers you as an employee, member subscriber, or retiree (or as that person's dependent), the latter plan is primary and the continuation coverage is secondary. If the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule does not apply.

IF YOU OR A DEPENDENT IS COVERED UNDER MEDICAID

If you or your dependent is a participant in the AMP and also covered under Medicaid, the AMP pays before Medicaid. The AMP does not take the Medicaid coverage into account for purposes of enrollment or payment of benefits.

If, while you are covered under Medicaid, benefits are required to be paid by the Plan, but are first paid by the state plan, payment by the Plan will be made as required by any applicable state law which provides that payment will be made to the state.

IF YOU OR A DEPENDENT IS ELIGIBLE FOR OR ENROLLED IN MEDICARE

If you are enrolled in Medicare Part D, you are not eligible to enroll in the AMP. If your dependent is enrolled in Medicare Part D and you are not, you are eligible to enroll in a Walmart medical plan, but your dependent would not be eligible for such coverage.

In general, the Social Security Act requires that AMP be the primary payer if you or your dependent is eligible for or enrolled in Medicare Part A, or Parts A and B, and meet one of the following criteria:

- You are employed by the company and are age 65 or older
- You are employed by the company and your spouse/partner is age 65 or older
- You are an active participant or COBRA participant entitled to Medicare on the basis of end-stage renal disease, but only for the first 30-month period of eligibility for Medicare coverage (whether or not actually enrolled in Medicare throughout this period)
- You are under age 65 and are entitled to Medicare due to disability and are covered under the AMP due to being employed by the company, or
- Your dependent is under age 65 and is entitled to Medicare due to his or her disability and is covered under the AMP due to your being employed by the company.

The AMP is secondary if you or your dependent is enrolled in Medicare and meets one of the following criteria:

- You or your dependent is a COBRA participant, except in the case of Medicare enrollment due to end-stage renal disease, for which the AMP is primary for the first 30-month period of eligibility for Medicare coverage, or
- You or your dependent is an active participant or COBRA participant enrolled in Medicare due to end-stage renal disease, after the 30-month coordination period with Medicare is exhausted.

IF YOU ARE AGE 65 OR OLDER AND AN ACTIVE ASSOCIATE

If you are still working for the company, you may continue your coverage under the AMP. If you also have Medicare, the AMP is generally primary and Medicare is secondary. File your claim with the AMP first.

You may also elect to end your coverage under the AMP and choose Medicare as your primary coverage. If you choose Medicare as your primary coverage, you may not elect the AMP as your secondary plan.

LEGALLY MANDATED AUTOMOBILE PERSONAL INJURY OR MEDICAL PAYMENT COVERAGE

If you reside in a state where automobile no-fault coverage, personal injury protection coverage, or medical payment coverage is mandatory, that coverage is primary and the AMP takes secondary status. The AMP reduces benefits for an amount equal to, but not less than, the state's mandatory minimum requirement.

Break in coverage

There may be occasions in which you must make special arrangements to pay your medical premiums to avoid a break in coverage. These situations occur most commonly if you are on a leave of absence or if your paycheck is not sufficient to pay your full share of the cost of coverage (such as after a reduction in hours). Depending on your circumstances, failure to make your premium payments by the due date may result in an interruption in the payment of any benefit claims and/or a break in coverage.

For details on the impact a break in coverage may have, and on how to make personal payments to continue your coverage, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

When coverage ends

Your coverage ends on your last day of employment, or when you are no longer eligible under AMP terms. Dependent coverage ends when your coverage ends or when a dependent is no longer an eligible dependent (as defined in the **Eligibility and enrollment** chapter). You and/or your enrolled dependents may be eligible for continued coverage through the Consolidated Omnibus Reconciliation Act of 1985, as amended (COBRA). See the **COBRA** chapter for details.

If you leave the company and are rehired

If you terminate employment and return to work for the company within 13 weeks, you will automatically be reenrolled in your previous coverage (or the most similar coverage offered under the AMP). If you return within 30 days, your annual deductible, out-of-pocket maximum and HRA (if applicable) will not reset. If you return after 30 days but within 13 weeks, your annual deductible, out-of-pocket maximum and HRA (if applicable) will reset and you will be responsible for meeting the new deductible and out-of-pocket maximum in their entirety. You will have 60 days after resuming employment to drop or otherwise change the coverage in which you were automatically reenrolled.

If you return reenroll after 13 weeks, you will be treated as a new associate and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you drop coverage and reenroll

If you drop coverage and reenroll within 30 days, you will automatically be reenrolled in your previous coverage (or the most similar plans offered under the AMP). The annual deductible and waiting periods will not reset.

If you drop coverage and reenroll after 30 days, you will be treated as a new associate and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

IF A DEPENDENT IS DROPPED FROM COVERAGE AND REENROLLED

If your dependent child is dropped from coverage and then determined to be eligible for coverage within 30 days, the dependent will automatically be reenrolled in the same coverage you elect for yourself. The annual deductible and waiting periods will not reset.

If your dependent regains eligibility and is reenrolled after 30 days, they will be treated as a newly eligible dependent. The associate may enroll them for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

Other information about the medical plan

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 requires that all group medical plans that provide medical and surgical benefits with respect to mastectomy must provide coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage will be subject to the otherwise applicable annual deductibles and coinsurance/copayment provisions under the Plan. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. For additional information, call People Services at **800-421-1362**.

A NOTE ABOUT MATERNITY ADMISSIONS

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

The pharmacy benefit

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The pharmacy benefit

Keep you and your eligible dependents in good health with your pharmacy benefit. It's automatically included with your medical plan.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Find a Walmart or Sam's Club pharmacy	Go to **One.Walmart.com** or **OptumRx.com/Walmart**	
Find an OptumRx network pharmacy	Go to **OptumRx.com**	Call OptumRx at **844-705-7493**
Get the list of covered brand-name drugs	Go to **One.Walmart.com** or **OptumRx.com/Walmart**	

What you need to know about the pharmacy benefit

- You are covered under the pharmacy benefit if you are enrolled in any of the medical plan options available under the Associates' Medical Plan (AMP). If you are enrolled in an HMO plan or the eComm PPO Plan, your pharmacy benefits are provided through your medical plan.
- Any reference to a "network pharmacy" refers to a Walmart or Sam's Club pharmacy or OptumRx pharmacy, including Walmart and OptumRx mail-order pharmacies.
- If your work location is five miles or less from a Walmart or Sam's Club pharmacy, you must use a Walmart or Sam's Club pharmacy for pharmacy benefits to be paid. Benefits are generally not payable if you use another network pharmacy (including an OptumRx network pharmacy).
- If your work location is more than five miles from a Walmart or Sam's Club pharmacy and you have medical coverage under the Premier Plan, Contribution Plan, or Saver Plan, you have the option to fill prescriptions at an OptumRx network pharmacy, in addition to a Walmart or Sam's Club pharmacy.
- If you have medical coverage under a local plan option, you must use a Walmart or Sam's Club pharmacy (including through mail order) for benefits to be payable, regardless of the distance to a Walmart or Sam's Club pharmacy from your work location.
- If you have a chronic condition such as diabetes, asthma, or arthritis and require the same or similar prescriptions on a regular basis, you may want to consider the mail-order option.
- Specialty drugs may be purchased from Walmart Specialty Pharmacy. Optum Specialty Pharmacy is also an option.

The pharmacy benefit

The pharmacy benefits covers eligible prescriptions from both retail and mail-order network pharmacies. You are eligible for prescription coverage on the date your medical coverage is effective.

To obtain eligible pharmacy benefits, simply present your plan ID card at a Walmart or Sam's Club pharmacy. If you are covered under the Premier Plan, Contribution Plan, or Saver Plan and your work location is more than five miles from a Walmart or Sam's Club pharmacy, you may also purchase drugs at any OptumRx network pharmacy. When using mail order, you can use Walmart or Sam's Club mail-order pharmacy regardless of your work location or medical plan. A form is available on **One.Walmart.com**. OptumRx home delivery pharmacy is also an option.

Under certain limited circumstances you can fill prescriptions at an OptumRx network pharmacy even if your work location is within five miles of a Walmart or Sam's Club Pharmacy.

No pharmacy benefits are paid if you use a non-network pharmacy, except as provided in this chapter.

Visit **One.Walmart.com** to find information about:

- Walmart or Sam's Club pharmacies
- Pharmacies in the OptumRx network
- Mail-order network pharmacies
- Covered generic, brand-name, and specialty drugs, and
- Preventive medications.

You can also call OptumRx at **844-705-7493**.

WHEN PRESCRIPTIONS CAN BE FILLED AT ANY NETWORK PHARMACY

If you have medical coverage under the Premier Plan, Contribution Plan, or Saver Plan and your work location is more than five miles from a Walmart or Sam's Club pharmacy, you may use any network pharmacy to fill your prescriptions. (If you have medical coverage under a local plan option, you must use a Walmart or Sam's Club pharmacy, regardless of the distance to a Walmart or Sam's Club pharmacy from your work location.)

You may also have prescriptions filled at any OptumRx network pharmacy in certain limited circumstances, including:

- If a covered drug is out of stock and not available at a Walmart or Sam's Club pharmacy for an extended time (as defined by the AMP)
- If a covered drug is unavailable at a Walmart or Sam's Club pharmacy
- If an emergency prescription fill is needed outside Walmart or Sam's Club pharmacy hours

NOTE: Certain restrictions apply to filling prescriptions for narcotics and other controlled substances.

For information on other exceptions and steps you must take, call OptumRx at **844-705-7493**.

How the pharmacy benefit works

The pharmacy benefit covers only prescription drugs specifically listed on the pharmacy benefit's formulary, which is a list of generic and brand-name medications maintained by OptumRx. You can view an abbreviated list on **One.Walmart.com** or you can call OptumRx at **844-705-7493** for a full list. If you don't see your drug on the list, call OptumRx to see if it is on the formulary.

The pharmacy benefit provides discounted prices on generic and brand-name drugs that are covered on the formulary and filled at an eligible network pharmacy. If, at the time your prescription is filled, the discounted price available is lower than your copay, you will be charged the lower amount, which may include a dispensing fee.

Premier Plan, Contribution Plan, and local plan participants: You pay the required copay or coinsurance out of your own pocket when you purchase your prescription drugs. See the **Pharmacy benefits** chart on the next page for details about copays and coinsurance. (If you are covered under the Contribution Plan, HRA funds cannot be used to purchase prescriptions.) Your copays are applied toward your medical plan's annual out-of-pocket maximum. Once you meet your annual out-of-pocket maximum, eligible prescriptions are paid at 100% for the rest of the calendar year.

Saver Plan participants: You pay the full price for your prescription drugs until you meet the Saver Plan's network annual deductible. Once you meet your network annual deductible, you pay the required copay or coinsurance listed in the **Pharmacy benefits** chart. (The exceptions are medications on the OptumRx list of approved preventive medications, which are not subject to the Saver Plan's network annual deductible. See **Preventive medications not subject to the Saver Plan's network annual deductible** later in this chapter for details.) Your copays are applied toward the Saver Plan's annual out-of-pocket maximum. Once you meet your annual out-of-pocket maximum, eligible prescriptions are paid at 100% for the rest of the calendar year.

Refer to the **Pharmacy benefits** chart on the next page for details about copays and coinsurance.

PHARMACY BENEFITS
See page 330 *for updated terms replacing the chart below.*

Generic drugs Up to 30-day supply 31- to 60-day supply 61- to 90-day supply	 $4 copay $8 copay $12 copay	**Filling your prescriptions** • Present your plan ID card at a Walmart or Sam's Club pharmacy. • If you are covered under the Premier Plan, Contribution Plan, or Saver Plan and your work location is more than 5 miles from a Walmart or Sam's Club pharmacy, you may also purchase drugs at an OptumRx network retail pharmacy. (Note, however, that supplies of generic drugs for greater than 30 days may be purchased only at a Walmart or Sam's Club pharmacy.) • Prescription refills are available after 75% of your previous prescription has been used. • See **When prescriptions can be filled at an OptumRx network pharmacy** on the previous page for additional information.
Brand-name drugs Up to a 30-day supply	Greater of $50 or 25% of allowed cost	
Specialty drugs *Available only at Walmart Specialty Pharmacy or Optum Specialty Pharmacy*	Greater of $50 or 20% of allowed cost	

Under the Saver Plan: The charges listed above apply after the Saver Plan's network annual deductible has been met, with the exception of medications that are on the OptumRx list of approved preventive medications, which are not subject to the deductible. See **Preventive medications not subject to the Saver Plan's network annual deductible** later in this chapter for details.

When purchasing mail-order drugs:
- You may purchase mail-order prescriptions through a Walmart/Sam's Club mail-order pharmacy, regardless of your work location or medical plan. OptumRx home delivery pharmacy is also an option.
- Your cost for a 90-day supply is three times the cost of a 30-day supply purchased at a Walmart or Sam's Club pharmacy, as listed above.
- For brand-name drugs, supplies of more than 30 days must be purchased through mail order.

TYPES OF DRUGS

To be covered, prescription drugs must be on the pharmacy benefit's formulary, which is a list of generic and brand-name medications that have been tested for quality and effectiveness and are believed to be a necessary part of a quality treatment program. The formulary is reviewed quarterly and can change.

The pharmacy benefit has a closed formulary. This means that your prescription drugs, whether they fall under the generic, brand-name or specialty drug category, must be included on the formulary for pharmacy benefits to be paid.

Generic drug: A generic drug is a lower-cost equivalent of a brand-name drug. When a generic equivalent becomes available, the brand-name drug will no longer be covered. Generic equivalents work like the brand-name drug in dosage, strength, performance, and use, and must meet the same quality and safety standards. All generic drugs must be reviewed by the United States Food and Drug Administration (FDA). For more information, visit **One.Walmart.com**.

Brand-name drug: A covered brand-name drug is a drug manufactured by a single manufacturer that has been evaluated for safety and effectiveness when compared to similar drugs treating the same condition and identified for inclusion on the covered brand-name drug list.

Specialty drug: Specialty drugs are used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Specialty drugs require an enhanced level of service, whether administered by a health care professional, self-injected, or taken orally. (Medications used to treat diabetes are not considered specialty medications.)

CONTRACEPTIVES FOR WOMEN

The AMP covers all FDA-approved contraceptive methods, including over-the-counter (OTC) variations for women, as required by the Affordable Care Act. The AMP covers certain FDA-approved generic contraceptives (and brand-name contraceptives when medically necessary) at 100%, with no deductible, for women who are capable of bearing a child, when the drug is prescribed by a physician. If your attending physician believes a brand-name contraceptive is medically necessary, you may file a claim for coverage of the brand-name drug. See **Filing a pharmacy benefit claim** at the end of this chapter.

See page 330 *for updates to the prescription drug benefit.*

PREVENTIVE MEDICATIONS NOT SUBJECT TO THE SAVER PLAN'S NETWORK ANNUAL DEDUCTIBLE

For Saver Plan participants, certain preventive medications are covered under the Saver Plan before you meet the Plan's network annual deductible. Prescription drugs that can keep you from developing a health condition are called "preventive medications." If you are taking prescribed drugs for certain health issues, such as high blood pressure, high cholesterol, etc., you may be eligible to get these medications at no cost before you meet your Saver Plan's network annual deductible.

PREVENTIVE OVER-THE-COUNTER MEDICATIONS

The AMP covers certain generic over-the-counter (OTC) preventive care medications at 100% when they are prescribed by a physician and purchased at network pharmacies. You will need to present your plan ID card and a prescription from your physician at the time of purchase. Covered OTC preventive care medications are those required under the Affordable Care Act. If your physician believes a brand-name preventive OTC medication is medically necessary rather than a generic, the physician can file an appeal with OptumRx for coverage of the brand-name drug, or you can file a claim for the brand-name drug under the procedures listed in the **Filing a pharmacy benefit claim** section of this chapter.

Some common preventive OTC medications identified by the United States Preventive Services Task Force (USPSTF) are listed in the **Preventive over-the-counter medications** chart below. For a current list of covered preventive care OTC medications, go to **One.Walmart.com** or call OptumRx at **844-705-7493**.

PREVENTIVE OVER-THE-COUNTER MEDICATIONS Recommended by the U.S. Preventive Services Task Force (USPSTF)	
Oral fluoride	By prescription when appropriate for children 6 months to 6 years of age
Folic acid	By prescription for all women planning or capable of pregnancy
Generic aspirin	By prescription for adults age 45 to 59 who have 10% or greater 10-year cardiovascular disease risk, are not at increased risk for bleeding, have life expectancy of at least 10 years and are willing to take low-dose aspirin for at least 10 years; low-dose aspirin (81mg/d) by prescription after 12 weeks of gestation in pregnant women at high risk for preeclampsia
Bowel prep agents	By prescription when appropriate for a screening colonoscopy for adults over age 50

MEDICATIONS THAT REQUIRE PRIOR AUTHORIZATION

Prior authorization is required before some medications can be covered by the AMP. OptumRx may ask your physician to provide additional information. This is called a "coverage authorization."

After OptumRx receives the required information, it will notify you and your physician (usually within two business days) to confirm whether coverage is authorized. If it is determined that the prescription is not a covered benefit under the AMP, it will not be paid. You may appeal this decision, as described in the **Claims and appeals** chapter. If you choose to fill the prescription without prior authorization, you must pay the full retail cost, even if the prescription would have been authorized if you had waited. The amount paid will not be applied toward your out-of-pocket maximum.

For questions about prior authorizations, call OptumRx at **844-705-7493**.

MEDICATIONS WITH QUANTITY LIMITS

Certain medications have limits on the quantity you can receive per prescription, based on FDA dosage guidelines. A list of these medications can be found on **One.Walmart.com**.

Prescriptions for quantities greater than the FDA-approved quantity are not covered under the AMP. If you choose to fill the prescription, you must pay the full retail cost.

What is not covered by the pharmacy benefit

Medications not covered by the pharmacy benefit include but are not limited to:

- Compound medication, which consists of two or more ingredients that are measured, prepared, or mixed according to a prescription order. Select compounded ingredients will not be covered. These may include ingredients that are not approved by the FDA or are available over-the-counter.

- Over-the-counter drugs (with the exception of insulin, when a state does not require a prescription for it, and those covered as part of the preventive care benefit under the Affordable Care Act, when a prescription is provided). See **Preventive over-the-counter medications** earlier in this chapter for more information.
- Prescriptions filled at a pharmacy other than a Walmart or Sam's Club pharmacy (except as noted).
- Prescriptions filled by a pharmacy that is not an eligible pharmacy for your medical plan option.
- Prescription drugs with over-the-counter equivalents.
- Prescription drugs purchased through a pharmacy discount program.
- Drugs for which prior authorization has not been secured, in cases where prior authorization is required.
- Prescription drug claims that are reduced, subsidized, or paid by another health plan, insurance provider, or pharmacy discount program. The AMP does not coordinate benefits for pharmacy claims.

This list is not meant to be an all-inclusive list of excluded benefits. For questions about excluded benefits, call OptumRx at **844-705-7493**.

Pharmacy discounts for prescriptions not covered

If a prescription is covered by the pharmacy benefit, the appropriate copay or coinsurance will apply. However, if the prescription is covered under the AMP but ineligible for coverage under the pharmacy benefit (e.g., it is being filled too soon or is prescribed for off-label use), the prescription will not be covered by the pharmacy benefit and the pharmacy discount described in this section.

Discounts, coupons, pharmacy discount programs, debit cards, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug discounts/coupons provided to pharmacies when you fill a prescription) do not count toward the medical plan's annual out-of-pocket maximum. In addition, if you have coverage under the Saver Plan, such charges do not count toward the Saver Plan's network annual deductible.

If you are enrolled in the AMP, you are eligible for a pharmacy discount on certain drugs not covered by the pharmacy benefit. The discount varies depending on the drug prescribed. Prescriptions purchased with the retail pharmacy discount do not count toward your network annual deductible or out-of-pocket maximum.

To use the pharmacy discount, present your plan ID card to the pharmacy when you pick up your prescription. If the prescription is not covered by the pharmacy benefit, the retail pharmacy will automatically discount the cost of the drug.

For information, contact OptumRx at **844-705-7493**.

Filing a pharmacy benefit claim

When you fill a prescription at an eligible network pharmacy, you do not need to file a claim. However, if you are unable to use your card at a network pharmacy or if you disagree with the amount you must pay, you can file a claim with OptumRx. Your claim must be submitted in writing within 18 months of the date you had the prescription filled (or attempted to have it filled). If the prescription is an eligible prescription, it will be paid in accordance with the terms of the pharmacy benefit.

Call OptumRx at **844-705-7493** for a claim form, or visit **One.Walmart.com**. Claims are processed according to the terms described in the **Claims and appeals** chapter.

If your claim is denied, you have a right to appeal. Appeals are processed according to terms described in the **Claims and appeals** chapter.

Privacy and security

When you purchase prescription drugs through a Walmart or Sam's Club pharmacy or an OptumRx network pharmacy, your personal and medical information is kept confidential. All network pharmacies are covered by and adhere to applicable state and federal regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which protects the privacy of personal health information. Walmart values the trust that our associates place in us. Earning that trust is in accordance with our core value of respect for the individual. For more information, see **HIPAA notice of privacy practices** in the **Legal information** chapter.

Health savings account (HSA)

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Health savings account for Saver Plan participants

If you are enrolled in the Saver Plan and want to save money on qualified medical expenses, the HSA is a great option. Your HSA contributions are tax-free and the company will match them dollar-for-dollar, up to set limits. Your account balance earnings are also tax-free and, as the money grows from year to year, you can use it to pay for current or future medical expenses.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Establish an account or change your contribution amount	Log on to **One.Walmart.com** or **Workday** for Jet associates	Call People Services at **800-421-1362**
Access your HSA	Log on to **MyHealthEquity.com** If you are logging in for the first time as a member and have not already established a user ID and password, click the "Begin Now" button.	Call HealthEquity at **866-296-2860** HealthEquity is the HSA administrator and custodian.
Get a list of qualified medical expenses (I.R.C.§ 213(d)) Get information on contribution limits, eligibility and tax reporting responsibilities associated with an HSA	**irs.gov**	Call HealthEquity at **866-296-2860** or contact your tax advisor

What you need to know about the HSA

- You must be enrolled in the Saver Plan to open and contribute to an HSA through this program.
- Walmart will match on a pretax basis each dollar you contribute, up to the matching limit.
- The HSA allows you to pay for qualified medical expenses (as defined by the IRS) with tax-free dollars.
- If you accept the HSA's terms and conditions, pass the customer identification process, and take the necessary steps to open your account, you will receive a welcome kit at your home address. Your account will be considered open on the effective date of your Saver Plan coverage.
- You are not eligible to make HSA contributions for any month in which you travel on Walmart business outside the U.S. and are covered under the GeoBlue policy, which provides health benefits for associates traveling internationally on business. Consult your tax advisor if you have questions about the amount to reduce your contributions based on your individual circumstances.
- The health savings account is offered through HealthEquity.

HSA advantages: tax breaks and Walmart contributions

If you're enrolled in the Saver Plan, the HSA offers you:

- Walmart contributions to your HSA to match your pretax contributions, dollar-for-dollar up to the matching limit.
- The ability to contribute pretax dollars to the account through payroll deductions.
- The ability to pay for qualified medical expenses with tax-free dollars through the account, including easy access to the money in your account using the debit card you will receive. You can also access the funds in your account by logging in to **MyHealthEquity.com**.

HealthEquity is the HSA administrator/custodian with which Walmart has contracted to receive HSA contributions from Walmart's payroll. To receive the Walmart contribution to your HSA or make pretax contributions through payroll deduction, you must maintain an open account with HealthEquity and continue medical coverage through the Saver Plan. If you have an HSA with another custodian, Walmart will not provide the Walmart contribution to your account or allow you to make pretax contributions through payroll deduction for that HSA.

Interest earnings and capital gains on the balance in your account are not taxed during the period in which the funds remain in your account. In addition, all HSA funds withdrawn for qualified medical expenses are tax-free.

You have investment opportunities for your account balance once that balance reaches a certain amount. Investments are not guaranteed or FDIC-insured.

The balance in your HSA rolls over from year to year, increasing your savings for future medical expenses. You own the balance in your account, and can save it, invest it in funds offered through your custodian, or spend it on qualified medical expenses.

NOTE: State tax law with respect to HSAs may differ from federal tax law in certain states, including California and New Jersey. Please consult your tax advisor or HealthEquity if you have questions about either the federal or state tax implications of a health savings account.

HSA eligibility

You must be a Saver Plan participant to contribute to an HSA through this program.

Even if you are enrolled in the Saver Plan, you cannot contribute to an HSA if:

- You are covered under any other health plan that is not a qualified high-deductible health plan, including a general purpose health care flexible spending account (FSA) or health reimbursement account (HRA). Exceptions include some disease-specific coverage; dental, vision, long-term care, and disability coverage; accident policies such as critical illness insurance and accident insurance, and others.
- You are enrolled in Medicare.
- You are enrolled in Medicaid.
- You are covered under TRICARE.
- You have received medical services from the U.S. Department of Veterans Affairs during the preceding three months, other than benefits for preventive care or a service-connected disability. Mere eligibility for Veterans Affairs benefits does not disqualify you from contributing to an HSA.
- You have received medical services at an Indian Health Service (IHS) facility during the preceding three months.
- You can be claimed as a dependent on another person's tax return.

Other restrictions may apply. For further information, please call HealthEquity at **866-296-2860**.

Your dependent's status does not affect your ability to contribute to an HSA. For example, your covered spouse/partner's Medicare status will not affect your ability to contribute to an HSA.

If you are a Saver Plan participant and also enrolled in critical illness insurance, you're not eligible for the major organ transplant rider under that coverage due to IRS guidance suggesting that such coverage would be viewed as non-high-deductible plan coverage.

You are responsible for determining if you are eligible for an HSA.

During the Plan year, you may be required to confirm account eligibility to continue contributions (for example, if you become Medicare-eligible because of your age, you may be asked to verify that you have not enrolled in Medicare). In certain cases, Medicare enrollment can be retroactive (such as if you delay your enrollment past age 65) and, if that occurs, you will also lose eligibility to make HSA contributions retroactively. If you are eligible for, or are enrolling in, Medicare, you should carefully evaluate your participation in the HSA to avoid penalties for excess contributions.

The Saver Plan is a qualified high-deductible health plan (HDHP) subject to ERISA and to requirements of federal law that allow you to contribute to an HSA. Walmart does not, however, insure the health savings account described in this chapter. It is Walmart's intention to comply with U.S. Department of Labor guidance specifying that an HSA is not subject to ERISA when the employer's involvement with the HSA is limited. Accordingly, the HSA is not established or administered by Walmart or the Associates' Health

and Welfare Plan. Instead, the HSA is established by the associate during the enrollment process and administered by HealthEquity.

If you have non-high-deductible health plan coverage through Walmart or any other employer (e.g., your eligible spouse/partner's employer), including a general purpose flexible spending account (FSA) or a Health Reimbursement Account (HRA), you are generally ineligible to make HSA contributions (but you can enroll in the Saver Plan). There are exceptions to this rule for "limited purpose" FSAs/HRAs, which can be used for dental or vision coverage only, or for "post-deductible" FSAs/HRAs, which provide coverage only after you satisfy the deductible under an HDHP. For information, contact HealthEquity by phone at **866-296-2860** or online at **MyHealthEquity.com**.

You are not eligible to make HSA contributions for any month in which you are traveling on Walmart business outside the U.S. and are covered under the GeoBlue policy, which provides health benefit coverage for Walmart associates traveling internationally on business. Consult your tax advisor if you have questions about the amount to reduce your contributions based on your individual circumstances.

If you make or receive an ineligible contribution to your HSA, excise taxes may apply unless you remove the contribution by certain deadlines. For more information about Medicare, HSA eligibility, or how to correct ineligible contributions, contact your tax advisor or review IRS Publication 969, *Health Savings Accounts and Other Tax-Favored Health Plans*. You can also call **800 Medicare** (**800-633-4227**), or visit **Medicare.gov**.

Opening your HSA

When you enroll online in the Saver Plan, you choose the amount you want to contribute to your account through payroll deductions. You may change your contribution amount at any time. See **Setting up or changing your contribution amount** later in this chapter.

You'll receive a welcome kit at your home address directly from HealthEquity, the HSA custodian, generally within the following time frames:

- By the end of December if you enroll during Annual Enrollment, or
- Within two to three weeks after your HSA is opened if you enroll at any other time.

Your debit card will be included within the welcome kit. Activate your debit card online at **MyHealthEquity.com** or by calling HealthEquity at **866-296-2860**.

No payroll withholding or employer contributions will be deposited to your HSA until it is open. Your account will not be considered open until you have successfully passed the customer identification process required to open an HSA. If HealthEquity requires additional information to complete this process, it will contact you.

If any payroll withholding or employer contribution is made before your account is open, the custodian will hold your contribution and deposit it into your HSA when it is open. If your account is not opened within a reasonable amount of time, the funds withheld from your pay will be refunded to you through your payroll check (less applicable payroll taxes) and reported as wages on your Form W-2. The employer contribution, if any, will be returned to Walmart.

For questions about your account status, welcome kit, or debit card, call HealthEquity at **866-296-2860** or go online to **MyHealthEquity.com**.

Once HealthEquity confirms that your account is open and you have completed your HSA deductions selection online, your contributions to the account and Walmart's matching contributions will begin the following pay period. See **When company contributions are made** later in this chapter.

If you do not open your HSA by December 1 of the Plan year, you will forfeit your right to the company's contributions for that year, even if you are covered by the Saver Plan during that year.

For purposes of company funding and payroll deductions, you must select HealthEquity as your HSA custodian when you enroll. You may move your funds to another HSA custodian at any time, but Walmart will provide company funding and support ongoing payroll deductions only for HSAs established with HealthEquity.

HSA FEES

The company pays the monthly maintenance fees if you are enrolled in the Saver Plan and your HSA custodian is HealthEquity.

The company does not pay overdraft fees, excess contribution fees, or lost card fees. If you are enrolled in COBRA, terminate employment with the company, otherwise become ineligible for AMP coverage, or are no longer enrolled in the Saver Plan, all associated fees become your responsibility. These fees will be deducted automatically from your HSA balance if any of these events occur. Call HealthEquity at **866-296-2860** to learn about the fees for various HSA services. It is your responsibility to check your HSA balance prior to using funds to pay for services. Current rate and fee schedules are available online at **MyHealthEquity.com**. The fee schedule is also included in the welcome kit.

Contributions to your HSA

Once you open your HSA, Walmart may make contributions to your account as follows (as long as your account is open and you are enrolled in the Saver Plan):

- Walmart matches your pretax contributions dollar-for-dollar, up to the matching limit described in the chart below.
- You may make pretax contributions to the account through payroll deductions in any amount (of $5 or more each pay period) up to the legal limit, taking into account Walmart's contributions. For administrative purposes, contributions are generally based annually on 25 pay periods.
- In addition to making contributions by payroll deduction, you can contribute money directly to your HSA by mailing a check to HealthEquity, or by electronic funds transfer (EFT) once you have linked a personal bank account on the HealthEquity website. Any such contributions count toward the contribution limit stated in the chart below. These personal contributions are made on an after-tax basis and are not eligible for the Walmart matching contribution. Walmart does not track your after-tax HSA contributions; you bear the responsibility of making sure you do not exceed the annual contribution limit.
- If your requested HSA contribution for a specific pay period exceeds the amount of your paycheck after deductions, no contribution or company match will be made to your HSA for that pay period.
- With respect to your final paycheck, your HSA salary reductions and corresponding employer match may be reduced because of state law restrictions on salary reduction or because your requested HSA contribution exceeds the net amount of your payroll check after deductions.

If you experience a status change event and switch from associate-only coverage to family coverage under the Saver Plan during the year, Walmart will increase its matching contribution to correspond with the matching contribution limit for family coverage. If you switch from family coverage to associate-only coverage during the year, the matching contributions that the company made prior to the change will not be reduced. If this results in your having contributions in your account above the annual maximum contribution allowed under IRS guidelines, the excess contributions must be withdrawn by the tax-filing deadline to avoid additional taxes.

ANNUAL CONTRIBUTION LIMITS

By law, the maximum annual contribution that can be made to your account, including both the company's contributions and your contributions (pretax and after-tax), is:

- For 2020, $3,550 for individual coverage, or
- For 2020, $7,100 for family coverage.

See page 331

The annual maximum contribution is the total contribution from all sources (payroll contributions by the associate and/or the company and personal contributions).

These amounts are indexed annually by the federal government and are subject to change each year.

YOUR CONTRIBUTIONS AND THE COMPANY'S CONTRIBUTIONS TO THE HSA

Your Saver Plan network annual deductible	Company matching contribution: $1 for $1 up to	2020 maximum annual contribution (associate and company contributions combined)*
$3,000 (associate-only coverage)	$350	$3,550
$6,000 (family coverage)	$700	$7,100
*If you are age 55 or over by December 31, 2020, you can contribute an additional $1,000 in 2020.		**See page 331** *for 2021 contribution limits.*

If two associates who are legally married are both eligible to contribute to individual HSAs, the contribution limit for 2020 for both accounts combined is based on the maximum amount that can be contributed for a family: $7,100. Note, however, if either of the associates is age 55 or older in 2020, the total combined contribution is increased by $1,000 for each associate age 55 or older.

If two associates are in a relationship that meets the definition of eligible dependent but is other than a legal marriage, and they have family coverage, each associate is eligible to contribute to an individual HSA up to the maximum family contribution limit of $7,100 (provided that neither associate can be claimed as a tax dependent on any individual's federal tax return). If either associate is age 55 or older in 2020, the maximum contribution is increased by $1,000 for each associate.

It's important to monitor contributions to your HSA — there are adverse tax consequences if your contributions exceed the annual limit set by the federal government. Changes in coverage during the year or enrollment after the beginning of the year can affect your contribution limits. If you become aware during the year that combined contributions to your HSA exceed the annual limit, you can withdraw the excess contribution and the related interest earnings before your income tax return for the year is due (including extensions). For assistance and information, call HealthEquity at **866-296-2860**.

EARNING INTEREST ON YOUR HEALTH SAVINGS ACCOUNT

The balance in your HSA earns interest. For interest rate information on your account, contact HealthEquity at **866-296-2860** or go online to **MyHealthEquity.com**. Your current interest earned along with the interest rate schedule is available on your monthly statements.

WHEN COMPANY CONTRIBUTIONS ARE MADE

Walmart will match dollar-for-dollar the amount that you contribute through payroll deduction each pay period, up to the matching limit for your coverage, as shown in the chart titled **Your contributions and the company's contributions to the HSA**. The company deposits this contribution, along with any contribution you make through payroll deduction, into your HSA shortly after each payroll deduction period ends.

SETTING UP OR CHANGING YOUR CONTRIBUTION AMOUNT

You may change your contribution amount online at any time during the year on a going-forward basis.

To set up or change your contribution amount, log on to **One.Walmart.com** or **Workday** for Jet associates and select "Online Enrollment." Contact People Services at **800-421-1362** if you need help setting up your payroll deductions.

NOTE: Once you make the maximum annual contribution (as stated in the chart on the previous page), your payroll contributions automatically cease. It is your responsibility to make a new contribution decision at the next Annual Enrollment for the following calendar year.

IF YOU ARE AGE 55 OR OLDER

If you are age 55 or older, you can make additional "catch up" contributions to your HSA by payroll deduction, just like your regular contribution. For 2020, the catch-up contribution limit is $1,000. Call HealthEquity at **866-296-2860** for information.

If you also cover your spouse under the Saver Plan and your spouse is age 55 or older, he or she may also be eligible to open a second HSA and contribute catch-up contributions. The contribution limit for 2020 for both accounts combined is based on the maximum amount that can be contributed for a family: $7,100. If either you or your spouse is age 55 or older in 2020, the total combined contribution is increased by $1,000 for each participant age 55 or older. The company does not contribute funds or pay any fees associated with an HSA for your dependent spouse.

If you cover an eligible partner under the Saver Plan and that individual is other than a spouse, you and your partner are each eligible to contribute to individual HSAs up to the maximum family contribution limit of $7,100 (provided that neither party can be claimed as a tax dependent on any individual's federal tax return). If either associate or partner is age 55 or older in 2020, the maximum contribution is increased by $1,000 for each participant age 55 or older. The company does not contribute funds or pay any fees associated with an HSA for your dependent partner.

Call HealthEquity at **866-296-2860** for information on opening an HSA for your eligible spouse/partner.

Paying qualified medical expenses through your HSA

See page 331 *for updated information on eligible expenses.*

When you have an eligible medical expense, you can decide whether to pay out of your pocket or use the funds in your HSA. Some people use their HSA for current expenses, while others prefer to use the HSA as an account for future health care expenses. Eligible expenses include health plan deductibles and coinsurance, most medical care and services, dental and vision care, and prescription drugs. In addition, amounts paid for over-the-counter drugs are qualified expenses if the drugs are prescribed by a doctor. (This requirement does not apply to insulin.) These expenses must not already be covered by your medical plan, and health insurance premiums generally do not qualify. Refer to IRS Publications 969 and 502 at **irs.gov** for information about qualified medical expenses. You can also find information about qualified medical expenses on **One.Walmart.com** and **MyHealthEquity.com**.

THE HSA AND YOUR INCOME TAX RETURN

The funds in your HSA belong to you, but any money used for nonqualified medical expenses is subject to federal income tax as well as a 20% penalty if you are under age 65. Make sure you save your receipts and other records to show that you used your HSA funds for eligible expenses. Remember that you are responsible for the tax consequences associated with contributions to and withdrawals from your HSA. Consult your tax advisor if you have questions about your HSA and taxes.

Investing your HSA

Once your account reaches a minimum balance of $1,000, you can invest any amount over that balance in a selection of over 20 investment funds available through HealthEquity. Review the funds and learn more at **MyHealthEquity.com** under “Investments.”

If you leave the company or are no longer enrolled in the Saver Plan

The funds in your HSA belong to you as the account holder, even if you enroll in COBRA, change medical plans, change jobs, or leave the company. In these events, all fees associated with the account become your responsibility.

Closing your HSA

All funds in your HSA belong to you. You may use these funds for qualified medical expenses on a tax-free basis now and in the future. If you do not choose to maintain the account, call HealthEquity at **866-296-2860** for information on closing your account.

The dental plan

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The dental plan

The dental plan covers a wide range of services, with no deductible for preventive or orthodontics. Plus, when you use network dentists, you'll save money while protecting one of your biggest assets—your smile.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get a listing of Delta Dental network dentists	Go to **One.Walmart.com** or **deltadentalar.com**	Call Delta Dental at **800-462-5410** or People Services at **800-421-1362**
Get answers to questions about your dental claims and to contact Delta Dental Customer Service	Go to **deltadentalar.com** and select "Login/Register" to create your account	Call Delta Dental at **800-462-5410**
Get a claim form if you use a nonparticipating dentist	Go to **One.Walmart.com** or **deltadentalar.com**	

What you need to know about the dental plan

- If you are an eligible associate, you may purchase dental coverage to assist with preventive, basic, and major dental care as well as with orthodontia expenses. See the **Eligibility and enrollment** chapter for information on eligibility.
- Delta Dental administers the dental plan benefit.
- Once you meet the dental plan's annual deductible, the dental plan pays benefits of up to $2,500 per covered person per calendar year and a lifetime maximum orthodontia benefit of $1,500 per covered person. The annual deductible does not apply for preventive and diagnostic services or orthodontia.
- Dental plan coverage must remain in effect for two full calendar years.
- Orthodontia is covered after a 12-month waiting period.
- If you have medical coverage with the Associates' Medical Plan (AMP), both the dental and medical information are on your plan ID card. If you are enrolled in an HMO or if you have dental-only coverage, you will receive a Delta Dental ID card. Your ID cards will be mailed to your home address.

Your dental plan

The dental plan is available to you if you are an hourly or management associate. Coverage is also available to your eligible dependents, with the exception of spouses/partners of part-time associates, temporary associates, and part-time truck drivers. The dental plan is administered through Delta Dental.

Once you enroll in the dental plan, your coverage must remain in effect for two full calendar years. You can add or remove a dependent during Annual Enrollment or due to a status change event, but you must maintain a minimum of associate-only coverage for two full calendar years.

CHOOSING A COVERAGE LEVEL

When you enroll in the dental plan, you also select the eligible family members you wish to cover:

- Associate only
- Associate + spouse/partner (except for part-time hourly associates, temporary associates, or part-time truck drivers)
- Associate + child(ren), or
- Associate + family (except for part-time hourly associates, temporary associates, or part-time truck drivers).

For information on dependent eligibility and when dependents can be enrolled, see the **Eligibility and enrollment** chapter.

The dental plan benefit is self-insured, which means benefits are not paid by an insurance company. Claims are processed by Delta Dental of Arkansas.

How the dental plan works

The dental plan covers four types of dental services:

- **Preventive and diagnostic care** coverage includes oral examinations and cleanings and related services. You do not have to meet the annual deductible before the dental plan covers these services. Charges you incur for preventive and diagnostic care, if any, do not apply toward your deductible.
- **Basic care** coverage includes fillings, non-surgical periodontics, and root canal therapy, and begins after you meet the annual deductible.
- **Major care** coverage includes surgical periodontics, crowns and dentures and begins after you meet the annual deductible.
- **Orthodontia** coverage begins after an individual has been covered under the dental plan for 12 months; you do not have to meet the annual deductible before receiving orthodontia benefits. Charges you incur for orthodontia care do not apply toward your deductible.

NOTE: The 12-month waiting period for orthodontia coverage is waived for localized associates and their covered dependents.

COVERAGE UNDER THE DENTAL PLAN			
Annual deductible Waived for preventive and diagnostic care and orthodontia care	$75 per person/$225 maximum per family		
Maximum benefit Does not apply to orthodontia care	$2,500 per covered person per calendar year		
	Delta Dental PPO dentists	**Delta Dental Premier dentists**	**Non-network dentists**
Preventive and diagnostic care Charges (if any) do not count toward annual deductible	100% covered; no annual deductible applies	80% covered;* no annual deductible applies	80% of maximum plan allowance; no annual deductible
	*In areas served by an insufficient number of PPO dentists, as determined by facility location, services are covered at 100%. Go to **One.Walmart.com** for details.		
Basic care Including fillings, non-surgical periodontics, and root canal therapy	80% of maximum plan allowance after annual deductible is met		
Major care Including surgical periodontics, crowns, and dentures	50% of maximum plan allowance after annual deductible is met		
Orthodontia (12-month wait) Charges do not count toward annual deductible or maximum benefit	80% of maximum plan allowance up to $1,500 lifetime maximum orthodontia benefit per person; no annual deductible applies		

After you meet the annual deductible (if applicable) and complete any applicable waiting period, the dental plan pays a percentage of the maximum plan allowance (MPA) for covered expenses.

MAXIMUM PLAN ALLOWANCE (MPA)

The MPA is the maximum amount the dental plan pays for covered dental services. The MPA applies to network and out-of-network dental services.

For covered network services, the MPA is that portion of a provider's charges covered by the dental plan as determined by the provider's contract with Delta Dental of Arkansas. Network providers agree to accept an amount negotiated by Delta Dental for covered services as payment in full, subject to applicable deductible and coinsurance amounts.

For covered out-of-network services, the MPA is limited to the allowance set by Delta Dental in its discretion and utilizing such methods or benchmarks Delta Dental may choose to employ. If you see an out-of-network dental provider, the dental plan pays a percentage based on the lesser of the MPA or the provider's actual billed charges for a covered procedure. If the provider's billed charges exceed the Plan's MPA, you are responsible for paying 100% of the difference. For additional information, call Delta Dental at **800-462-5410**.

KNOW WHAT YOU'LL OWE: GET A PRETREATMENT ESTIMATE

You are not required to get pre-approval of any dental treatments. But by having your dentist submit a proposed treatment plan, you can learn how much you can expect the dental plan to pay for a procedure or course of treatment before the work is done. It is recommended that a proposed treatment plan be submitted for treatment expected to cost $800 or more. Delta Dental will provide a pretreatment estimate of the amount that will be covered and may suggest an alternate treatment plan if part of your dentist's treatment plan is ineligible for coverage.

To get a pretreatment estimate, ask your dentist to complete a regular dental claim form and check the "predetermination" box. The form should be mailed to:

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, Arkansas 72231-5965

Delta Dental's pretreatment estimate is not a guarantee of payment. You still must file a claim for the services rendered, as set out in the **Claims and appeals** chapter.

SAVE MONEY BY USING NETWORK DENTISTS

As a dental plan participant, you can use any dentist and receive benefits for covered expenses under the Plan. You will save money and time, however, when you use Delta Dental dentists. Providers contracted with Delta Dental's Premier and PPO networks agree to accept the dental plan's maximum plan allowance as payment in full for a covered procedure, so you pay no more than the dental plan's applicable coinsurance percentage (after you meet any applicable annual deductible). In addition, Delta Dental's network providers also provide participants with discounted prices. When you see a Delta Dental PPO provider, you may be able to save more because PPO providers have agreed to accept reduced fees for covered procedures when treating Delta Dental participants. You may save time because network dentists will often file your claims for you.

The Delta Dental PPO network is an extensive nationwide network of dentists, but is not as widely available as the Delta Dental Premier network. Refer to the chart entitled **Coverage under the dental plan** earlier in this chapter for details on how coverage terms for preventive and diagnostic care may differ based on the availability of PPO dentists in your area. To find a Delta Dental PPO or Delta Dental Premier dentist, see **Dental plan resources** at the beginning of this chapter.

IT PAYS TO USE NETWORK DENTISTS		
	Delta Dental Premier dentists and PPO dentists	**Non-network dentists**
Dentist files claim forms for you	Yes	No
Dentist accepts maximum plan allowance as payment in full, subject to annual deductible and coinsurance	Yes	No
Dentist offers discounted prices for Delta Dental participants	Yes	No

Filing a dental claim

If you use a Delta Dental network dentist, your dentist will often file the claim for you. If you use a non-network dentist, you may need to file a claim. The dentist may be paid directly from the dental plan if the dentist is a Delta Dental network dentist. If you use a non-network dentist, the payment will be made to you.

Mail your claim to:

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, Arkansas 72231-5965

You or your dental provider must file a claim in accordance with the claims procedure within 18 months from date of service or your claim will be denied. Not following the claims procedure described in the **Claims and appeals** chapter, such as failure to mail your claim to the correct address, may result in the denial of your claim.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial.

IF YOU HAVE COVERAGE UNDER MORE THAN ONE DENTAL PLAN

If you or a family member have coverage under the dental plan and are also covered under another dental plan (for example, your spouse/partner's company plan), coordination of benefits may apply. The dental plan has the right to coordinate with other plans you are covered under so the total dental benefits payable will not exceed the level of benefits otherwise payable under the dental plan. Coordination of benefits procedures and plans referred to as "other plans" are described in **If you have coverage under more than one medical plan** in **The medical plan** chapter.

What is covered under the dental plan

The dental plan covers the services listed in this section, subject to some limitations. If you have questions about what is covered under the dental plan, call Delta Dental at **800-462-5410**.

PREVENTIVE AND DIAGNOSTIC CARE

Preventive and diagnostic care are covered without having to meet the annual deductible.

Bitewing X-rays: Limited to four per calendar year. Combined with panoramic X-ray if done by same provider on same day and processed as a full mouth series.

Cleaning (dental prophylaxis): One prophylaxis, including cleaning, scaling and polishing of the teeth, is covered twice during a calendar year. Two additional cleanings are allowed during a pregnancy and up to three months following delivery. Two additional cleanings are allowed for heart disease, diabetes, and periodontal disease. Additional periodontal maintenance allowed for periodontal disease.

Fluoride treatment: Covered once in any consecutive 12-month period for participants under age 19.

Full-mouth debridement: Limited to once per lifetime.

Full-mouth series or panoramic X-rays: Limited to one procedure in any consecutive 60-month period. A full-mouth series is any combination of 14 or more periapical and/or bitewing X-rays taken on the same date. If the combination of separately billed intraoral images (i.e., bitewings and periapicals) equals or exceeds the number of films allowed for a full mouth series, the charges for the images will be combined and deemed to comprise a full mouth series. A benefit is paid only if no other full mouth series or panoramic radiographic image has been paid during the preceding 60 consecutive months.

Oral evaluations: Benefits are payable as follows:

- **Routine oral evaluation:** Two evaluations covered during a calendar year.
- **Comprehensive detailed oral evaluation or periodontal evaluation:** Initial comprehensive oral evaluation are payable subject to the routine oral evaluation time limitations. Subsequent oral evaluations submitted by the same provider within three years are processed as routine oral evaluations.

Emergency evaluations performed by dentists are not subject to the calendar year restriction.

Periapical X-rays: Covered as needed.

Preventive resin restoration: Covered for first and second permanent molars with unrestored occlusal surface for participants under age 19. Limited to one treatment per tooth every five years.

Pulp vitality tests: Covered if same provider does no other definitive procedure the same day.

Risk assessment: Covered once every three-year period for children age 3 through age 19.

Sealant repair: Covered for first and second permanent molars with unrestored occlusal surface for participants under age 16. Not covered during the first 24 months of the initial placement of the sealant. Limited to one treatment per tooth every 24 months. Not covered when the tooth has previously received a preventive resin restoration.

Sealants: Covered for first and second permanent molars with unrestored occlusal surface for participants under age 16. Limited to one treatment per tooth per lifetime. Not covered when the tooth has previously received a preventive resin restoration.

Space maintainers: Covered for participants age 13 and under. Limited to one appliance per space (quad/arch) extraction site in any consecutive 60-month period. Repair or replacement of a space maintainer is not covered.

BASIC CARE

After you meet the annual deductible, the Plan pays 80% of the maximum plan allowance for basic care.

Amalgam and composite resin fillings: Benefits are payable once per tooth surface in any consecutive 24-month period.

Endodontics: Includes pulp therapy and root canal therapy. See **Root canal therapy** in **Major care** below.

Extractions: Nonsurgical extractions are covered once per tooth.

Nonsurgical periodontics: Provided once per quadrant in any consecutive 24-month period.

Occlusal orthotic device (TMJ appliance): Benefits are payable once every five years. Adjustments within six months are not covered. One adjustment covered per year thereafter.

Periodontal maintenance: Periodontal maintenance is covered only if done 30 days or more after the completion of surgical or nonsurgical periodontal treatment. Thereafter, periodontal maintenance is allowed up to four times per calendar year. This benefit is combined with any routine cleanings performed during the same calendar year with a combined limitation of four for that year.

MAJOR CARE

After you meet the annual deductible, the Plan pays 50% of the maximum plan allowance for major care.

Anesthesia/general anesthetics and IV sedation: Covered only when provided in the following circumstances:

- The patient suffers from a medical condition that prevents him or her from holding still (including but not limited to dystonia, Parkinson's disease, autism)
- The patient is under age 4, or
- In connection with certain covered oral surgical procedures.

Complete and partial removable dentures and partial fixed bridges: Covered when the denture or bridge is the professionally accepted, standard course of treatment.

- Includes replacement or addition of teeth to dentures, partials or fixed bridgework.
- When alternate treatment plans are available, the dental plan covers the professionally accepted, standard course of treatment. For example, a bridge is allowed only when a partial denture will not suffice. See **Alternative treatment** plans in **Limited benefits** later in this chapter.
- Complete and partial or removable dentures are not payable for patients under the age of 16.
- A denture that replaces another denture or fixed bridge, or a fixed bridge that replaces another fixed bridge, is covered only if the existing denture, partial denture or fixed bridge is at least five years old and cannot be repaired.

Crowns, cast restorations, inlays, onlays, and veneers: Covered only when the tooth cannot be restored by amalgam or composite resin filling.

- Replacement is not covered unless the existing crown, cast restoration, inlay, onlay, or veneer is more than five years old and cannot be repaired.

  NOTE: Accidents as a result of biting or chewing are not an exception to the five-year wait for crown replacements.
- For participants under age 12, benefits for crowns on vital teeth are limited to resin or stainless steel crowns, unless there is a history of root canal therapy or recession of the pulp.
- Treatment is determined according to the alternate treatment plan limitation. See **Alternative treatment plans** in **Limited benefits** later in this chapter.

Implants: Surgical placement of an implant body is covered once in every five-consecutive-year period.

- The abutment to support a crown is covered once in every five-consecutive-year period.
- An implant or abutment-supported retainer is covered once in every five-consecutive-year period.
- An implant maintenance procedure is covered once in any 12-consecutive-month period.
- Implant removal is covered once in a lifetime per tooth. Implants are not payable for patients under the age of 16.

Occlusal adjustment (limited): Covered only if done 180 days or more after completion of initial restorative, prosthodontic and implant procedures that include the occlusal surface.

Oral surgery: Surgical extractions and extractions of wisdom teeth, including preoperative and postoperative care, except for those services covered under the Associates' Medical Plan. Oral sedation and/or nitrous oxide (analgesia) are not covered. If oral surgery is performed in a hospital setting, the dental plan covers oral surgeon fees for such services for covered individuals not enrolled in the Associates' Medical Plan.

Outpatient or inpatient hospital costs and additional fees charged by the dentist for hospital treatment: See **Hospital charges in What is not covered under the dental plan** later in this chapter.

Root canal therapy: Includes bacteriological cultures, diagnostic tests, local anesthesia, and routine follow-up care. Payable once per tooth.

- Therapeutic pulpotomy is payable once per tooth until age 21.
- Retreatment of a previous root canal is allowed once in a consecutive 24-month period.

Surgical periodontics: Treatment of the gums — osseous surgery/soft tissue graft, provided in the same area once in any consecutive 36-month period.

ORTHODONTIA

After you have been a participant in the dental plan for 12 months, you are eligible for orthodontia assistance for yourself (the associate). Each of your covered dependents must also participate in the dental plan for 12 months before becoming eligible for orthodontia assistance. If you terminate coverage for any reason and reenroll, your prior time enrolled for coverage will count toward the 12-month waiting period. (The 12-month wait is waived for localized associates and their covered dependents.)

If the dentist submits a statement at the beginning of a period of orthodontic treatment showing a single charge for the entire treatment, benefits are paid in the following manner:

- The dentist receives an initial payment of up to $150
- A prorated portion of the remainder is paid every three months based on the estimated period for treatment and on continued eligibility, and
- The amount and number of payments are subject to change if the charge or treatment period changes.

The dental plan covers only orthodontic treatment that begins after the covered individual becomes eligible for orthodontia assistance. Active orthodontic treatment is deemed started on the date the active appliances are first placed. Active orthodontic treatment is deemed completed on the earlier of:

- The date on which treatment is voluntarily discontinued, or
- The date on which the active bands or appliances are removed.

If an individual has had orthodontia treatment prior to becoming eligible for orthodontia assistance under the dental plan, treatment is available only if five years have elapsed since the completion or discontinuance of that orthodontic treatment plan.

Repair or replacement of an orthodontic appliance is not covered.

There are certain orthodontia assistance benefits that are not covered. See **What is not covered under the dental plan** later in this chapter.

Limited benefits

Alternative treatment plans: When alternative treatment plans are available, the dental plan covers the professionally accepted, standard course of treatment.

Transfer of treatment: If you transfer from the care of one dentist to another during the course of treatment, or if more than one dentist renders services for one dental procedure, the dental plan pays no more than the amount it would have paid if only one dentist had rendered services.

What is not covered under the dental plan

The dental plan does not pay benefits for all types of services. To determine if a service is covered, call Delta Dental or submit a pretreatment estimate of benefits form. Services that are not covered by the plan include, but are not limited to, the following:

Accidental injury to sound, natural teeth: Expenses for treatment of accidental injury to sound, natural teeth may be covered under the medical plan. This exclusion does not apply to accidental injuries as a result of biting or chewing; these charges may be covered under the dental plan.

Beyond the scope of licensure or unlicensed: Services rendered by a dentist beyond the scope of their license, or any services provided by an unlicensed dentist.

Bridgework: Repair or recementing of bridgework during the first six-month post-delivery period, and such services received more often than once every five years.

Cosmetic purposes: Services performed for cosmetic purposes or to correct congenital, hereditary, or developmental malformations. This exclusion does not apply to orthodontic services for the correction of malposed teeth.

Dentures: Repair or relining of dentures during the first six-month post-delivery period, and such services received more often than once every five years for repairs and once every three years for relines and rebases.

Elective non-emergency dental services outside the U.S.

Elective non-necessary services: Services that are not dentally necessary or that do not meet generally accepted standards of care for treating the particular dental condition, including decoration, personalization or inscription of any tooth, device, appliance, crown, or other dental work.

Experimental or investigational: Charges for treatment or services, including hospital care, that are experimental, investigational, or inappropriate, under protocols established by Delta Dental.

Governmental agency: Services provided or paid for by any governmental agency or under any governmental program or law, except charges for legally entitled benefits under applicable federal laws.

Hospital charges: Services performed in a hospital or outpatient hospital setting, including but not limited to provider and facility charges. This exclusion does not apply to oral surgeon fees for participants not enrolled in the Associates' Medical Plan, subject to terms of the dental plan.

Occlusal guards: Devices serving to minimize effects of bruxism (grinding) or other occlusal factors. This exclusion does not apply to occlusal orthotic devices to treat TMJ disorders.

Oral sedation: Oral sedation and/or nitrous oxide (analgesia).

Orthodontia care: Services in connection with treatment for the correction of malposed teeth during the first 12 consecutive months that a participant is covered under the dental plan.

Periodontal splinting: Charges for complete occlusal adjustments or stabilizing the teeth through the use of periodontal splinting.

Permanent restorations: Charges for bases, liners, and anesthetics used in conjunction with permanent restorations (fillings).

Prescription drugs and medicines: Written for dental purposes.

Prosthetics, duplicates: Duplicate prosthetic devices or appliances.

Retainers: Separate charges for retainers (appliances intended to retain orthodontic relationship) or habit appliances to address harmful behaviors such as thumb-sucking or tongue-thrusting.

Services undertaken prior to effective date or during the waiting period for orthodontia services: Charges for courses of treatment, including prosthetics and orthodontics, which are begun prior to the effective date of coverage or before you are eligible to receive benefits for orthodontia services.

Surgical corrections: Charges for services related to the surgical correction of:

- Temporomandibular joint dysfunction (TMJ)
- Orofacial deformities, and
- Specified oral surgery procedures covered by the Associates' Medical Plan.

Tooth structure: Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth.

OTHER CHARGES NOT COVERED

- Any procedure performed for a temporary purpose
- Charges in excess of the maximum plan allowance
- Extraoral grafts
- Hypnosis or acupuncture
- Oral hygiene instruction and dietary instruction
- Plaque control programs
- Services covered by the Associates' Medical Plan
- Services for which there is no charge
- Teledentistry
- Any other services not specifically listed as covered
- Charges covered by workers' compensation or employers' liability laws
- Services provided by a member of the participant's family, or
- Charges incurred as a result of war.

Break in coverage

There may be occasions in which you must make special arrangements to pay your dental premiums to avoid a break in coverage. These situations occur most commonly if you are on a leave of absence or if your Walmart paycheck is not sufficient to pay your full share of the cost of coverage (such as after a reduction in hours). Depending on your circumstances, failure to make your premium payments by the due date may result in an interruption in the payment of any benefit claims and/or a break in coverage.

For details on the impact a break in coverage may have, and on how to make personal payments to continue your coverage, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

When dental coverage ends

Your coverage ends on your last day of employment or when you are no longer eligible under the terms of the Plan. Dependent coverage ends when your coverage ends or when a dependent is no longer an eligible dependent (as defined in the **Eligibility and enrollment** chapter). All benefits cease on the date coverage ends, except for completion of operative procedures in progress at the time coverage ends. "Operative procedures" are limited to individual crowns, dentures, bridges, and implants, and are considered "in progress" only if all procedures for commencement of lab work are completed and all operative procedures are completed within 45 days of termination. The dental plan does not pay benefits if you or a covered dependent receive benefits for these post-termination expenses from another plan. You and/or your enrolled dependents may be eligible for continued coverage through the Consolidated Omnibus Reconciliation Act of 1985, as amended (COBRA). See the **COBRA** chapter for information regarding COBRA continuation coverage.

If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be reenrolled for the same coverage you had prior to leaving the company (or the most similar coverage offered under the Plan). If your break is 30 days or less, the annual deductible and waiting period for orthodontia assistance will not reset. If your break is greater than 30 days, your annual deductible and waiting period for orthodontia assistance will reset. If your break is greater than 30 days but less than 13 weeks, and you have already maintained coverage under the Plan for a minimum of two years, you will have 60 days after resuming work to drop or otherwise change the coverage in which you were automatically reenrolled.

If you return to work after 13 weeks, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you drop coverage and reenroll

If you drop coverage and reenroll within 30 days, you will automatically be reenrolled for the same coverage you had (or the most similar coverage offered under the Plan). In this case, the annual deductible and waiting period for orthodontia assistance will not reset.

If you drop coverage and reenroll after 30 days, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

IF A DEPENDENT IS DROPPED FROM COVERAGE AND REENROLLED

If a dependent child is dropped from coverage and then determined to be eligible for coverage within 30 days, the dependent will automatically be reenrolled in the same coverage you elect for yourself. The annual deductible and waiting periods for orthodontia assistance will not reset.

If your dependent regains eligibility and is reenrolled after 30 days, they will be treated as a newly eligible dependent. The associate may enroll them for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

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The vision plan

The vision plan helps you pay for routine eye exams, lenses, frames, and contact lenses, so you can see clearly for years to come.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Locate a Walmart Vision Center or Sam's Club Optical provider	Go to **One.Walmart.com**	
For detailed information about vision plan coverage or to locate a VSP network provider	Go to **vsp.com** and enter your member number	Call VSP at **866-240-8390**
Get the cost for vision plan coverage	Go to **One.Walmart.com**	Call People Services at **800-421-1362**

What you need to know about the vision plan

- Coverage under the vision plan is separate from the medical plan, which generally does not cover charges for routine eye care. If you are interested in coverage for vision services not covered by the medical plan, you must enroll separately in the vision plan.
- You may see any Walmart Vision Center, Sam's Club Optical, or VSP network provider for care and receive the same level of benefits. No benefits are available if you see a non-network provider.
- You may purchase contact lenses online at **WalmartContacts.com** or **SamsClubContacts.com**. VSP coordinates the amount of your purchase eligible for coverage. Go to **vsp.com** or call VSP at **866-240-8390** for details about the contact lens benefit.
- If you have access to an HMO plan that offers vision coverage, compare the HMO's benefits and the benefits offered by the vision plan and decide which option best meets your needs.
- If you have medical plan coverage with the Associates' Medical Plan (AMP), the VSP phone number will appear on your plan ID card. If you are enrolled in an HMO or if you enroll for vision coverage only or dental and vision coverage only, you will receive a VSP ID card, which will be mailed to your home address.

The vision plan

Walmart offers the vision plan to help you pay for routine eye care. The vision plan is administered through VSP. You may access care under the vision plan through a Walmart Vision Center or Sam's Club Optical facility, or through a provider in VSP's nationwide network. Vision plan coverage is available to you if you are an hourly or management associate. Coverage is also available to your dependents, with the exception of spouses/partners of part-time associates, temporary associates, and part-time truck drivers.

CHOOSING A COVERAGE LEVEL

When you enroll in the vision plan, you also select the eligible family members you wish to cover:

- Associate only
- Associate + spouse/partner (except for part-time hourly associates, temporary associates, or part-time truck drivers)
- Associate + child(ren), or
- Associate + family (except for part-time hourly associates, temporary associates, or part-time truck drivers).

For information on dependent eligibility and when dependents can be enrolled, see the **Eligibility and enrollment** chapter.

How the vision plan works

The vision plan covers a routine eye exam once every calendar year, lenses once every calendar year, frames once every calendar year, or contact lenses once every calendar year. The vision plan pays benefits for prescription contact lenses or prescription eyeglasses. If you choose contact lenses, you will not be eligible for lenses or frames again until the next calendar year. Benefits are paid as shown in the chart below. Walmart providers and VSP network providers have agreed to provide their services to covered associates for a prearranged fee; all you pay is the applicable copay and the cost of any non-covered or elective items. VSP pays the rest directly to the provider. No benefits are paid for services at a provider that is neither a Walmart/Sam's Club provider nor a VSP network provider.

Additional charges. Charges for any of the following items are your responsibility. Call VSP at **866-240-8390** for more information.

- Blended lenses
- Oversize lenses
- Photochromic or tinted lenses other than Pink 1 or 2 allowance
- Laminated lenses
- High-index lenses

VISION PLAN BENEFITS			
	Walmart Vision Center	**Sam's Club Optical**	**VSP network providers**
Routine exam copay Once every calendar year	$4 *Limitations apply for low-vision testing or supplemental testing for individuals whose vision problems are not correctable with regular lenses.*		
Materials copay	$4 *Applies with purchase of frames or lenses (but not contact lenses). Copay is charged only once when frames and lenses are purchased together.*		
Progressive lens copay	$55		
Lenses • Single vision • Lined bifocal • Lined trifocal • Lenticular • Progressive multifocal	100% covered after copay *Standard lenses are covered after applicable copay. Check with your optical team for lenses offered under benefit.*		
Frames Once every calendar year	$130 allowance *Charges above the frame allowance are your responsibility.*		
Contact lenses Once every calendar year In lieu of glasses	$130 contact lens allowance *Fitting and evaluation fee up to $60 may apply. Charges above the contact lens allowance are your responsibility.*		
NOTE: Sales taxes may apply and will reduce the vision benefit.			

- Anti-reflective coating
- Color coating
- Mirror coating
- Optional cosmetic processes
- Low vision care
- Cosmetic lenses, and
- Frames or contacts that cost more than your allowance.

How to use the plan

Follow these steps for your vision care.

STEP 1	To find a Walmart Vision Center or Sam's Club Optical provider, go to **One.Walmart.com**; to find a provider in the VSP network, call **866-240-8390** or go to **vsp.com** and enter your member number.
STEP 2	When you make an appointment, identify yourself as a VSP member and give the office your name and date of birth, plus the patient's name (if different). The provider's office contacts VSP to verify your eligibility.
STEP 3	At your visit, pay your copay and any other required amount directly to the Walmart Vision Center or Sam's Club Optical or VSP network provider. The provider's office arranges for reimbursement and handles any other administrative tasks required.

What is not covered

Some expenses are not covered under the vision plan, including:

- Charges for eye exams, lenses, or frames that:
  - you are not legally obligated to pay for or for which no charge would be made in the absence of vision coverage
  - exceed plan maximums
  - are not necessary according to accepted standards of ophthalmic practice, or not ordered or prescribed by the attending physician or optometrist
  - do not meet accepted standards of ophthalmic practice, including charges for experimental or investigational services or supplies
  - are received as a result of eye disease, defect, or injury due to an act of declared or undeclared war
  - are for any condition, disease, ailment, or injury arising out of and in the course of employment compensable under a workers' compensation or employers' liability law and were ordered before the patient became eligible for coverage or after coverage ends
  - are received free from any governmental agency by compliance with laws or regulations enacted by any federal, state, municipal, or other governmental body
  - are paid for by another insurance plan (see **If you have coverage under more than one vision plan** later in this chapter), or
  - are payable under any health care program supported in whole or in part by federal funds or any state or political subdivision.
- Medical or surgical treatment or supplies
- Professional services or eyewear connected with orthoptics, vision training, subnormal vision aids, aniseikonic lenses and tonography, and other services/materials not covered by the vision plan
- Replacement of broken lenses or frames after one year from purchase
- Replacement of lost lenses or frames unless the patient is otherwise eligible under the frequency provisions, as detailed in the **Vision plan benefits** chart on the previous page
- Service contract fees
- Plano lenses (nonprescription lenses less than .50 diopter)
- Services from any non-network providers — i.e., any provider that is not affiliated with a Walmart Vision Center or Sam's Club Optical, or that is not a VSP network provider.

Breakage and loss of eyewear

If you're covered under the vision plan and you damage your eyewear within one year of purchase, you can return to your network provider for replacement or repair. Some warranties on eyewear may be longer than one year; check with your eyewear provider for details.

Lost eyewear is not covered under the vision plan.

Filing a vision claim

When you use the vision plan, claims for services are generally not required; see **How to use the plan** for a description of payment arrangements. When it's necessary to file a claim — for example, if you are newly enrolled in the vision plan when you see a provider and your personal information is not yet on file with VSP — return to the provider after your information is in the system and ask the provider to file the claim on your behalf. Claims are processed according to the terms described in the **Claims and appeals** chapter.

IF YOU HAVE COVERAGE UNDER MORE THAN ONE VISION PLAN

If you or a family member have coverage under the vision plan and are also covered under another vision plan (for example, your spouse/partner's company vision plan), coordination of benefits may apply. The vision plan has the right to coordinate with other plans under which you are covered so the total vision benefits payable will not exceed the level of benefits otherwise payable under the vision plan. Under the vision plan, "other plans" refers only to other plans administered by VSP. There is no coordination-of-benefits provision with vision coverage providers other than VSP. Plans referred to as "other plans" are described in **If you have coverage under more than one medical plan** in **The medical plan** chapter.

Break in coverage

There may be occasions in which you must make special arrangements to pay your vision premiums to avoid a break in coverage. These situations occur most commonly if you are on a leave of absence or if your Walmart paycheck is not sufficient to pay your full share of the cost of coverage (such as after a reduction in hours). Depending on your circumstances, failure to make your premium payments by the due date may result in an interruption in the payment of any benefit claims and/or a break in coverage.

For details on the impact a break in coverage may have, and on how to make personal payments to continue your coverage, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

If you have received covered vision services prior to your leave, any applicable benefit frequency limitation under the vision plan (i.e., eyeglass frames every calendar year) will continue to apply after your return.

When vision coverage ends

Your coverage ends on your last day of employment or when you are no longer eligible under the terms of the Plan. Dependent coverage ends when your coverage ends or when a dependent is no longer an eligible dependent (as defined in the **Eligibility and enrollment** chapter). You and/or your enrolled dependents may be eligible for continued coverage through the Consolidated Omnibus Reconciliation Act of 1985, as amended (COBRA). See the **COBRA** chapter for information regarding COBRA continuation coverage.

If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be reenrolled for the same coverage you had prior to leaving the company (or the most similar coverage offered under the Plan). If your break is greater than 30 days but less than 13 weeks, you will have 60 days after resuming work to drop or otherwise change the coverage in which you were automatically reenrolled.

If you return to work after 13 weeks, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you drop coverage and reenroll

If you drop coverage and reenroll within 30 days, you will automatically be reenrolled for the same coverage you had (or the most similar coverage offered under the Plan).

If you drop coverage and reenroll after 30 days, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you have received covered vision services prior to your absence, any applicable benefit frequency limitation under the vision plan (i.e., eyeglass frames once every calendar year) will continue to apply after your return.

IF A DEPENDENT IS DROPPED FROM COVERAGE AND REENROLLED

If a dependent child is dropped from coverage and then determined to be eligible for coverage within 30 days, the dependent will automatically be reenrolled in the same coverage you elect for yourself.

If your dependent regains eligibility and is reenrolled after 30 days, they will be treated as a newly eligible dependent. The associate may enroll them for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

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COBRA

If you and/or your covered dependents lose medical, dental, or vision coverage because of a qualifying event, a federal law known as "COBRA" may allow you to continue that coverage for a set period of time at your own expense.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Contact People Services within 60 calendar days of a divorce, legal separation, termination of a relationship with a partner, or ineligibility of dependents		Call People Services at **800-421-1362** or provide notification in writing to: **Walmart People Services** **508 SW 8th Street** **Bentonville, Arkansas 72716-3500**
Contact WageWorks, the COBRA administrator, for questions regarding eligibility, enrollment, premiums, and notification of a second qualifying event	Go to **mybenefits.wageworks.com**	Call **800-570-1863**

What you need to know about COBRA

- "COBRA," which stands for Consolidated Omnibus Budget Reconciliation Act of 1985, may apply if a "qualifying event" occurs that would otherwise cause you or a covered dependent to lose medical, dental, or vision coverage. Qualifying events are described in this chapter. The Plan extends COBRA continuation coverage to you and all your covered dependents.
- For medical, dental, and vision benefits, COBRA continuation coverage can continue up to 18 or 36 months, depending on the qualifying event. The 18 months can be extended to 29 months under certain circumstances when a disability is involved.
- If you experience a qualifying event and become eligible for COBRA benefits, your Resources for Living benefits automatically continue for 18 months from the date of the qualifying event (or the maximum duration for which you would be eligible for COBRA coverage). You do not have to enroll in COBRA coverage to continue your Resources for Living benefits.
- The Plan contracts with WageWorks, a third-party administrator, to administer COBRA. References to COBRA in this section are to the Plan's continuation coverage, which may be more favorable to participants and dependents than the continuation coverage legally required under COBRA.
- There are strict notification rules and time limits for enrolling in COBRA continuation coverage, as described in this chapter. Please read this chapter carefully—failure to adhere to these rules can result in the loss of your right to elect COBRA continuation coverage. If you have any questions or need assistance with enrollment, please call **800-570-1863**.

COBRA continuation coverage

If medical, dental, or vision coverage under the Plan ends for you or your eligible dependents, you and/or your eligible dependents may be able to continue your coverage under the Plan's continuation coverage provisions, which comply with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

An event that makes you and/or your eligible dependents eligible for COBRA continuation coverage is called a "qualifying event," such as termination of employment or loss of benefits eligibility. Under COBRA, each person who would lose coverage after a qualifying event is considered a "qualified beneficiary." Each qualified beneficiary has an independent right to elect COBRA continuation coverage.

You must have had medical, dental, or vision coverage under the Plan on the day before the date of your qualifying event to be eligible for COBRA coverage, unless coverage ended during a leave of absence, as described on this page. You may choose a lesser coverage level or select an alternate medical plan, if applicable. COBRA continuation coverage applies to medical, dental, and vision coverage; it does not apply to other benefits described in this *Associate Benefits Book*.

If you change medical plans when you elect COBRA coverage, your annual deductible and out-of-pocket maximum will reset, and you will be responsible for meeting the new deductible and out-of-pocket maximum in their entirety.

If you have HMO coverage at the time of your qualifying event and the state where you live has more favorable coverage continuation rules than federal COBRA, the HMO generally follows state rules. For eComm PPO Plan participants, the eComm PPO Plan also follows state rules. For information on state continuation rights, contact your HMO provider or the eComm PPO Plan, as applicable.

IF YOU ARE ON LEAVE OF ABSENCE

Generally, if your leave ends and you do not return to work, you and any eligible dependents who were enrolled in medical, dental, or vision coverage under the Plan during your leave will be offered COBRA, which will run from the date following your employment termination date.

If you and any eligible dependents were enrolled in medical, dental, or vision coverage under the Plan on the day before your leave began but you dropped coverage during your leave or your coverage was canceled due to nonpayment of premiums during the leave, you will still be offered COBRA when your employment terminates. If you elect COBRA coverage, it will run from the date following your employment termination date. This means that if you or any eligible dependent elects COBRA at the end of a leave of absence during which coverage was dropped or canceled, the elected COBRA coverage will not be effective retroactive to the date coverage was dropped or canceled, but will be effective on the date following your employment termination date.

COBRA qualifying events

You are eligible for COBRA if your medical, dental, or vision coverage ends because:

- Your employment with Walmart ends for any reason, or
- You are no longer eligible for medical coverage because the number of hours you regularly work for Walmart has decreased, making you ineligible for coverage under the Plan.

Your spouse or partner is eligible for COBRA if coverage for the spouse or partner ends for any of the following reasons:

- Your employment with Walmart ends for any reason
- Your spouse or partner is no longer eligible for medical, dental, or vision coverage because the number of hours you regularly work for Walmart has decreased, making them ineligible for coverage under the Plan
- You and your spouse divorce or legally separate
- You and your partner no longer meet the definition of having a "partnership" for purposes of the Plan (refer to the **Eligibility and enrollment** chapter for the definition of "partner").
- You enroll in Medicare benefits Part D, causing your medical coverage to terminate (you must contact People Services by calling **800-421-1362** within 60 days of enrolling in Medicare Part D), or
- You die.

Your eligible dependent other than a spouse or partner is eligible for COBRA if coverage for the dependent ends for any of the following reasons:

- Your employment with Walmart ends for any reason
- Your eligible dependent is no longer eligible for medical, dental, or vision coverage because the number of hours you regularly worked for Walmart has decreased, making them ineligible for coverage under the Plan

- You enroll in Medicare benefits Part D, causing your medical coverage to terminate. (You or your eligible dependent must contact People Services by calling **800-421-1362** within 60 days of enrolling in Medicare Part D.)
- Your dependent child no longer meets eligibility requirements (e.g., the end of the month in which a dependent turns age 26), or
- You die.

NOTIFICATION

In general, Walmart will notify WageWorks, the Plan's third-party administrator for COBRA, if you or your dependents become eligible for COBRA continuation coverage because of your death, termination of employment, or a reduction in hours of employment that makes you ineligible for coverage under the Plan. Walmart will generally make this notification to the COBRA administrator within 30 days after the qualifying event.

Under the law, you or your eligible dependent is responsible for notifying People Services of your divorce, legal separation, termination of your relationship with a partner, or a child becoming ineligible due to loss of dependent status. You must also notify People Services if you enroll in Medicare Part D. The notification must be made within 60 days after the qualifying event (or the date on which coverage would end because of the qualifying event, if later). You or your eligible dependent can provide notice on behalf of yourself as well as any eligible dependent affected by the qualifying event. Provide notice of the qualifying event to People Services by calling **800-421-1362** or writing to:

Walmart People Services
508 SW 8th Street
Bentonville, Arkansas 72716-3500

The notice must include the following information:

- Name and address of the covered associate
- Type of qualifying event
- Date of qualifying event
- Name of dependent losing coverage, and
- Address of the dependent losing coverage (if different from the covered associate's address).

If you do not contact People Services within the 60-day period, you will lose your right to elect COBRA continuation coverage. To protect your family's rights, let People Services know about any changes in addresses of family members. You should keep a copy of any notices you send to People Services and/or WageWorks for your records.

Federal law places responsibility upon you or your eligible dependent to notify People Services within 60 calendar days after the later of the date of a divorce, legal separation, termination of your relationship with a partner, or a child becoming ineligible due to loss of dependent status, or the date on which coverage under the Plan is terminated as a result of one of these events. If you or your eligible dependent do not notify People Services within 60 days, your dependent will not be eligible for COBRA.

You or your eligible dependent must also notify the COBRA administrator by phone or in writing of a second qualifying event or Social Security disability in order to extend the period of COBRA coverage. Other forms of notice will not bind the Plan. If notice is not provided by phone or in writing of a second qualifying event or extension request within 60 days from the later of the date of the second qualifying event or the date on which you lost (or will lose) coverage as a result of a second qualifying event, COBRA continuation rights will expire on the date that your or your eligible dependent's initial COBRA coverage period expires.

COBRA ENROLLMENT

Within 14 days after the COBRA administrator receives notification that a qualifying event has occurred, the COBRA administrator, on behalf of the Plan, will send a COBRA election notice to you and your eligible dependent at your last known address. The election notice describes your right to continue medical, dental, or vision coverage under COBRA. (If you do not receive this notification, please contact People Services.) To receive COBRA continuation coverage, you must elect such coverage through the COBRA administrator within 60 calendar days from the date you lose coverage or the date of the election notice, if later. To enroll, you must complete and mail your COBRA election notice or go online at **mybenefits.wageworks.com**. If you elect COBRA, notify the COBRA administrator of any change of address. Refer to **Paying for COBRA coverage** on the next page for information on making COBRA payments. If you need assistance, call **800-570-1863**.

NOTE: You may be asked to provide documentation of the qualifying event.

You and each of your eligible dependents have independent election rights. You may elect COBRA coverage for all of your family members who lose coverage because of the qualifying event. A parent or legal guardian may elect COBRA coverage on behalf of a minor eligible dependents. A child born to or placed for adoption with you while you are on COBRA also has COBRA rights.

COBRA is provided subject to the eligibility requirements for continuation coverage for you and your eligible dependents under the law and the terms of the Plan. To the extent permitted by law, the Plan Administrator will retroactively terminate your COBRA coverage if you are later determined to be ineligible.

Instead of electing COBRA coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace or Medicaid. You may also be eligible for a 30-day "special enrollment period" in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer). You may also have the same special enrollment right at the end of your COBRA coverage if you take COBRA coverage for the maximum time available to you. Some of these options may cost less than COBRA continuation coverage. You can learn more about your options at **healthcare.gov**.

STATUS CHANGE EVENTS WHILE ON COBRA CONTINUATION COVERAGE

After the COBRA election period, you or your eligible dependent may not change the elected COBRA coverage without a status change event outside Annual Enrollment or a subsequent qualifying event. For information about status change events, see **Status change events** in the **Eligibility and enrollment** chapter. If a status change event occurs (such as if a child is born), you must notify the COBRA administrator within 60 calendar days of the event. Supporting documentation may be required. You will have the right to make changes to your coverage during any Annual Enrollment while you are on COBRA.

Unless otherwise provided in the Plan, if you add a spouse or partner or other eligible dependent due to a status change event while on COBRA, each person must individually meet any applicable benefit waiting period (for example, for transplant coverage or weight loss surgery) and is subject to any applicable Plan limitations. If you change medical plans due to a status change event, your annual deductible and out-of-pocket maximum will reset, and you will be responsible for meeting the new deductible and out-of-pocket maximum in their entirety. If you change from the Contribution Plan to another plan, your HRA balance under the Contribution Plan will be forfeited.

If you are covered as a dependent and you experience a qualifying event that affects your status as a dependent and makes you eligible for your own continuation coverage under COBRA, you will receive credit toward your deductible and out-of-pocket maximum under the Associates' Medical Plan for expenses incurred as a covered dependent, unless you change plan options as described above. You will also receive credit toward any waiting periods.

In the event of a status change, you or your eligible dependent may change benefit coverage to another benefit tier under the Plan only if the change in coverage is consistent with the status change event.

If you move to a new location and this affects your medical coverage (i.e., moving from an HMO area to a non-HMO area), you will have 60 calendar days from the date you notify the COBRA administrator of the address change to select a different plan. If you do not submit your selections within 60 days, you may automatically be enrolled in a predetermined plan.

Paying for COBRA coverage

You and/or your eligible dependents are responsible for both the associate portion of the premium and the portion previously paid by the company, plus a 2% administrative fee (50% administrative fee in cases of the 11-month disability extension, as described later in this chapter). The letter sent to you and your eligible dependents following notice of a qualifying event will include the monthly premium cost for COBRA coverage.

Initial COBRA premium: Your first payment is due 45 days after you elect COBRA and must cover the cost of COBRA coverage from the day following the qualifying event through the end of the month before the month in which you make your first payment. (For example, assume your employment terminates on Sept. 30, and you lose coverage on Sept. 30. You elect COBRA on Nov. 15. Your initial premium payment should equal the premiums for October and November and is due on or before Dec. 30, which is the 45th day after the date of your COBRA election. Ongoing premiums are due the first day of each month, with a 30-day grace period. So your December payment must be received no later than Dec. 31, the end of the 30-day grace period for the December coverage period.)

If your initial premium payment is not made in the allowed time frame, you will not be eligible for COBRA coverage.

Continuing premiums: Monthly premiums are due on the first day of each month following the due date of the initial premium. If you make your payment on or before the first day of each month, your COBRA coverage under the Plan will continue for that month without any break.

You are allowed a 30-day grace period from the premium due date before coverage is canceled. However, if you make your payment later than the first day of the month, your coverage will be suspended and any claims incurred, including pharmacy benefits, will not be paid until coverage is paid through the current month. If you do not pay this premium, you will be responsible for claims incurred. If the 30th day falls on a weekend or holiday, you have until the first business day following to have your payment postmarked or paid.

As a courtesy, the COBRA administrator will send you a COBRA premium payment invoice, unless you make your payments by Automated Clearing House (ACH) debit, in which case you will not receive an invoice. Premium payments are due regardless of your receipt of a payment invoice. If you pay by mail, attach your payment to the invoice and mail it to:

WageWorks
P.O. Box 660212
Dallas, Texas 75266-0212

To pay online, log on to **mybenefits.wageworks.com**. To pay by phone, call **800-570-1863**.

If your COBRA coverage is canceled due to nonpayment of premiums, your COBRA coverage will end on the last day for which you paid your full COBRA premium on time, and it will not be reinstated.

If you do not want to continue coverage, you may cancel COBRA coverage at any time by ceasing to pay the premiums. No further action is required.

How long COBRA coverage may last

The maximum duration of your COBRA coverage depends on the qualifying event making you eligible for COBRA coverage, as shown in the chart below.

MAXIMUM DURATION OF COBRA COVERAGE

Event	Associate	Dependents
• Your employment with the company ends for any reason • You are no longer eligible for coverage under the Plan due to a reduction in hours	18 months from the date of the event	18 months from the date of the event
• Your death • Your marital (or partnership) status changes • Dependent(s) no longer meets eligibility requirements (e.g., turns age 26)	Not applicable	36 months from the date of the event
You enroll in Medicare less than 18 months prior to your termination of employment or reduction in hours	18 months from the date of termination of employment or reduction in hours	Up to 36 months from the date the associate enrolled in Medicare
You enroll in Medicare Part D	Not applicable	36 months from the date the associate enrolled in Medicare Part D
Disability extension is obtained	29 months from the date of the original qualifying event	29 months from the date of the original qualifying event
Second qualifying event — you must notify the COBRA administrator within 60 days of the second qualifying event or the date of loss of coverage, if later	Not applicable	Up to 36 months from the date of the original qualifying event

IF YOU ARE ENTITLED TO MEDICARE

If you are eligible for Medicare Parts A and/or B and terminate employment with the company (or lose coverage under the Plan), be aware that if you do not enroll in Medicare Parts A and/or B during the Medicare special enrollment period, you may have to wait until the next Medicare annual enrollment period to enroll in Medicare Parts A and/or B and may have to pay a higher Medicare premium when you do enroll. The eight-month special enrollment period runs from the date that you are no longer employed by the company (or lose coverage under the Plan, whichever occurs first), even if you elect COBRA continuation coverage (e.g., following termination of employment). For additional information, refer to Medicare's *Medicare & You* handbook, published annually. The handbook can be obtained directly from Medicare by calling **800-633-4227** or from the Medicare website at **medicare.gov**.

Entitlement to Medicare means you are eligible for and enrolled in Medicare. If you become entitled to Medicare less than 18 months before a qualifying event due to termination of employment or reduction in hours, your eligible dependents can elect COBRA for a period of not more than 36 months from the date you became eligible for Medicare.

If you are entitled to Medicare prior to your COBRA election date, you or your eligible dependents must notify the COBRA administrator at **800-570-1863** of your Medicare status in order to ensure your maximum coverage period is properly calculated.

IF YOU OR AN ELIGIBLE DEPENDENT IS DISABLED

If you're a qualified beneficiary who has COBRA coverage because of termination of employment or a reduction in hours, you and each enrolled member of your family may be entitled to an extra 11 months of COBRA coverage if you or other enrolled members of your family become disabled. (That is, you can get up to a total of 29 months of COBRA coverage.) The 29-month COBRA coverage period begins on the date after your termination of employment or reduction in hours of employment that makes you ineligible for coverage under the Plan. The disability extension applies only if all of the following conditions are met:

- The Social Security Administration determines that you or your eligible dependent is disabled
- The disability exists at any time within the first 60 calendar days of COBRA coverage and lasts at least until the end of 18-month period of COBRA continuation coverage, and
- You and/or your eligible dependent notifies the COBRA administrator of the Social Security Administration's disability determination by submitting a copy of the Social Security Administration disability determination Notice of Award letter to the COBRA administrator within your initial 18-month COBRA period and within 60 days of the later of:
  - The date of your qualifying event
  - The date of your Social Security Administration disability determination Notice of Award, or
  - The date on which you and/or your eligible dependent loses coverage under the Plan as a result of the qualifying event.

In the absence of an official Notice of Award from Social Security, the Plan may accept other correspondence from the Social Security Administration if that correspondence explicitly includes all information the Plan needs to grant the extension and is submitted to the COBRA administrator within the time frames listed above.

If you and/or your eligible dependent qualify for the disability extension, a new invoice will be mailed to you and/or your eligible dependent before the end of the initial 18-month COBRA coverage period, unless you make your payments by Automated Clearing House (ACH) debit, in which case you will not receive an invoice. Contact the COBRA administrator for details about paying premiums during a disability extension.

The COBRA premium for the 19th through the 29th month of COBRA coverage generally is the amount you were paying before the qualifying event, plus the amount the company was paying, plus a 50% administrative fee, or 150% of the full premium amount.

However, if the disability extension applies, but the disabled qualified beneficiary family member is not enrolled in COBRA coverage, the COBRA premium for the covered family members for the extended period is limited to 102% of the full premium amount. You or your eligible dependent must notify the COBRA administrator no later than 30 days after the Social Security Administration determines that you or your eligible dependent is no longer disabled.

IF YOU HAVE A SECOND QUALIFYING EVENT WHILE ON COBRA

While you (the associate) cannot receive an extension of COBRA coverage due to a second qualifying event, your eligible dependent who has COBRA coverage due to your termination of employment or reduction in hours may receive COBRA coverage for up to a total of 36 months if a

second qualifying event occurs during the original 18-month continuation coverage period (or during the 29-month coverage period, in the event of a disability extension).

The following can be second qualifying events:

- Your death
- Your divorce, legal separation, or termination of a relationship with a partner
- Your child is no longer eligible for medical, dental, or vision coverage (e.g., a dependent turns age 26), or
- Your enrollment in Medicare Part D.

If a second qualifying event occurs while your eligible dependent has COBRA coverage, their COBRA coverage may last up to 36 months from the date of the first qualifying event that made you (the associate) eligible for COBRA coverage.

To receive the extension of the COBRA coverage period, you or your eligible dependents must notify the COBRA administrator of the second qualifying event within 60 calendar days of the date of the event or loss of coverage following the event, if later. If the COBRA administrator is not notified of the second qualifying event during the 60-day period, your eligible dependents cannot get the COBRA coverage extension and the coverage will be terminated as of the date your initial COBRA period expired.

When COBRA coverage ends

COBRA coverage usually ends after the 18-month, 29-month, or 36-month maximum COBRA coverage period. See **How long COBRA coverage may last** in this chapter to find out which maximum COBRA coverage period applies to you.

COBRA coverage may be terminated before the end of the 18th, 29th, or 36th month if:

- The company no longer provides medical, dental, or vision coverage to any associates
- After the initial 45-day payment period you do not make a COBRA payment within 30 calendar days of the due date (if the 30th day falls on a weekend or non-postal delivery day, you have until the next business day to have your payment postmarked or paid)
- You or your eligible dependent becomes covered by another group health, dental, or vision plan after electing COBRA coverage
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, terminates as of the later of (a) the first day of the month that is more than 30 days after a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled, or (b) the end of the coverage period that applies without regard to the disability extension), or
- You or your eligible dependent submits a fraudulent claim or fraudulent information to the Plan.

FILING AN APPEAL

You have the right to appeal an enrollment or eligibility status decision related to your COBRA coverage. See **Appealing an enrollment or eligibility status decision** in the **Claims and appeals** chapter for more information.

Resources for Living®

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Resources for Living®

Resources for Living (RFL) gives you confidential counseling and well-being information. It's available at no cost to you and your family members from your date of hire. Call a professional counselor anytime for help with stress management, family relationships, career issues, and other daily challenges. RFL also has lots of information and help with childcare, eldercare, education, finances, wellness, and more.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Speak with a counselor or work-life specialist to identify resources and solutions for everyday needs		Call **800-825-3555**
Access articles, tools, and resources across a wide range of topics	Go to **One.Walmart.com** or **rfl.com**: User ID: **Walmart** Password: **Associate**	
Access monthly healthy living tips and webinars on a variety of topics	Go to **One.Walmart.com** or **rfl.com**: User ID: **Walmart** Password: **Associate**	

What you need to know about Resources for Living

- RFL is available 24 hours a day, seven days a week, 365 days a year.
- You and your household members can find counseling, information, and work-life assistance.
- There is no cost to you for RFL benefits. You are automatically enrolled in RFL as of your date of hire.

Using Resources for Living (RFL)

If you are a U.S. associate, you, your household family members, and your benefit-eligible dependents are automatically enrolled in RFL as of your first day of employment. You can call RFL any time at **800-825-3555** or log into **rfl.com** to find tools for:

- Stress management
- Budgeting and saving money
- Legal assistance
- Relationships at home and in the workplace
- Emotional and physical well-being
- Family life and more

RFL provides access to services and support by telephone, televideo, face-to-face counseling, videos, webinars, web-based articles, and through a resource team that can help support your everyday needs and well-being.

RFL counseling services

Whether you need help working through an issue or just someone to talk to, RFL offers you support. You can call and get help with:

- Managing stress
- Coping with depression, anxiety, or substance misuse
- Building healthy relationships with family, friends, and co-workers
- Balancing the demands of work and home life
- Working through emotionally difficult situations

You or your eligible family members can talk to an RFL counselor by telephone, televideo, or face-to-face. Just call RFL toll-free at **800-825-3555** for support. If your situation calls for face-to-face behavioral counseling, you can receive up to three sessions per issue per year, at no cost.

RFL legal and financial services

RFL gives you access to legal and financial experts. Whether you're creating a budget or a will, RFL can help. RFL's specialists can help you:

- Meet your financial goals and save for the future
- Explore your options related to legal issues
- Create a personal budget
- Make your money go further
- Pay down debt
- Recover from identify theft, and more

You can receive a half-hour consultation for each legal or financial issue or a one-hour consultation for each identity-theft issue, at no cost to you. Note that this service does not provide assistance in situations involving employment law.

RFL daily life assistance

You can reach out to RFL for help in meeting the demands of work and home life. Call for help with everyday needs such as:

- Care for your child or an older adult
- Military resources
- Pet care
- Adoption resources
- Home repair services
- Support groups
- Educational options and resources for children and adults
- Accessing tools to support your well-being, including healthy eating, exercise, improved sleep, and stress management

RFL's work-life consultants can help you find options for meeting your needs and research details like cost, services, and availability.

CALLING RFL

Call **800-825-3555** for personalized support at any time. Services are available in English and Spanish (other languages available upon request). Calls are confidential, except as required by law.

RFL ON THE WEB

Visit **rfl.com** for articles, webinars, tools, and resources on a variety of topics to help you live well. To log on to **rfl.com**, enter the following:

User ID: **Walmart**
Password: **Associate**

You can also access **rfl.com** by clicking on the single sign-on link found on the RFL page of **One.Walmart.com**.

When RFL benefits end

If you experience a qualifying event and become eligible for COBRA benefits, your Resources for Living benefits automatically continue for 18 months from the date of the qualifying event (or the maximum duration for which you would be eligible for COBRA coverage). You do not have to enroll in COBRA coverage to continue your Resources for Living benefits.

Filing a claim for RFL benefits

You do not have to file a claim for RFL benefits. You may access the RFL website or contact RFL by phone at any time. However, if you have a question about your benefits, or disagree with the benefits provided, you may contact People Services at **800-421-1362** or file a claim by writing to the following address:

People Services
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Claims and appeals are determined under the time frames and requirements set out in the procedures for filing a claim for medical benefits, as described in the **Claims and appeals** chapter.

Critical illness insurance

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Allstate Benefits regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company, the underwriting company and subsidiary of The Allstate Corporation.

Critical illness insurance

If you and your dependents sign up for critical illness insurance, you'll be eligible for a direct lump-sum cash benefit to help pay for expenses related to covered critical illnesses.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get detailed information	Go to **One.Walmart.com** or **AllstateBenefits.com/Walmart**	Call Allstate Benefits at **800-514-9525**

What you need to know about critical illness insurance

- You may purchase critical illness insurance to assist you and your family in the event a covered individual is diagnosed with certain serious illnesses.
- You may elect coverage amounts of $5,000, $10,000, $15,000, or $20,000.
- If a covered individual is diagnosed with a covered condition, critical illness insurance pays a percentage of the coverage amount in a lump sum, based on the nature of the condition.
- Proof of Good Health is not required for any level of coverage.
- The Certificate of Insurance available online at **One.Walmart.com** or **AllstateBenefits.com/Walmart** provides detailed information about critical illness insurance, in addition to the highlights available in this chapter.

Critical illness insurance

Critical illness insurance provides a direct benefit if you or any covered dependents are diagnosed with a covered illness or disease. The policy pays benefits regardless of, and in addition to, any other insurance you may have.

Coverage is available in $5,000 increments up to a maximum of $20,000 with no Proof of Good Health required.

Critical illness insurance is available to you if you are an hourly or management associate. Coverage is also available to your dependents, with the exception of spouses/partners of part-time associates, temporary associates, and part-time truck drivers.

CHOOSING A COVERAGE LEVEL

When you enroll for critical illness insurance, you also select the eligible family members you wish to cover:

- Associate only
- Associate + spouse/partner (except for part-time hourly associates, temporary associates, and part-time truck drivers)
- Associate + child(ren), or
- Associate + family (except for part-time hourly associates, temporary associates, and part-time truck drivers).

For information on eligibility and when you can enroll, see the **Eligibility and enrollment** chapter.

The cost for coverage is based on the coverage amounts you choose, the eligible dependents you choose to cover, your age, and whether you (and/or your covered spouse/partner) are eligible for tobacco-free rates.

If you have associate-only or associate + spouse/partner coverage and you (or your spouse/partner) give birth to a child, your newborn child will be automatically covered for 60 days after birth. You must change your election to associate + child(ren) or associate + family if you wish to continue covering your child after 60 days. See the **Eligibility and enrollment** chapter for information on when and how you may change your election.

Critical illness benefits

Benefits are payable if you are diagnosed with one of the conditions listed below. Coverage must be effective before the date of diagnosis for an illness or disease to be covered under the policy.

The following benefits are payable at 100% of the coverage amount you elect:

- Invasive cancer
- Alzheimer's disease (requires loss of three activities of daily living [ADLs])
- Coronary artery bypass surgery
- End-stage renal failure
- Heart attack
- Stroke
- Parkinson's disease (requires loss of two ADLs)
- Complete loss of hearing (due to illness)
- Loss of sight in one eye or both eyes (due to illness)
- Quadriplegia (due to illness)
- Paraplegia (due to illness)
- Loss of at least one foot, hand, arm, or leg (due to illness)
- Benign brain tumor
- Coma (lasting seven days) due to illness, or
- Major organ transplant (see note below).

If you undergo a major organ transplant, as specified in the major organ transplant rider found in the Certificate of Insurance, you will receive 100% of the coverage amount you elect. If you are enrolled in the Saver Plan, you are not eligible for the major organ transplant rider included in critical illness insurance.

The following benefits are payable at less than 100% of the coverage amount you elect:

- Carcinoma in situ: 25% of coverage amount
- Complete loss of one or more fingers and/or one or more toes (due to illness): 25% of coverage amount
- Transient ischemic attacks (TIAs): 25% of coverage amount
- Aneurysm (ruptured or dissecting): 25% of coverage amount
- Specified diseases: 50% of coverage amount
  - Addison's disease
  - Amyotrophic lateral sclerosis (Lou Gehrig's disease)
  - Cerebrospinal meningitis (bacterial)
  - Cerebral palsy
  - Cystic fibrosis
  - Diphtheria
  - Encephalitis
  - Huntington's chorea
  - Legionnaires' disease (confirmation by culture or sputum)
  - Malaria
  - Multiple sclerosis
  - Muscular dystrophy
  - Myasthenia gravis
  - Necrotizing fasciitis
  - Osteomyelitis
  - Poliomyelitis
  - Rabies
  - Sickle cell anemia
  - Systemic lupus
  - Systemic sclerosis (scleroderma)
  - Tetanus, or
  - Tuberculosis.

The benefits described above generally will be paid only once, upon the initial occurrence of each critical illness identified above (or, in the instance of invasive cancer, for the particular form of cancer). However, if you have a recurrence of heart attack, stroke, coronary artery bypass surgery, invasive cancer, carcinoma in situ, rabies, ruptured or dissecting aneurysm, benign brain tumor, or coma, the plan will pay a recurrence benefit of 100% of the coverage amount, provided the recurrence occurs 180 days after the prior occurrence (or, in the case of a recurrence of the same cancer, provided you were symptom-free and treatment-free during the 180 days after the prior occurrence).

Other benefits payable include:

- Ambulance: $250 for ground ambulance or $2,000 for air ambulance if a covered person requires ambulance transportation to a hospital or emergency center due to a covered illness.
- Post-traumatic stress disorder (PTSD): $100 for each day a covered person receives counseling for PTSD; payable once per day per covered person and limited to six days per coverage year
- Skin cancer benefit: $500 upon positive diagnosis of skin cancer (basal cell carcinoma and squamous cell carcinoma) by a licensed Doctor of Medicine certified by the American Board of Pathology to practice pathological anatomy, or an osteopathic pathologist, based on microscopic examination of skin biopsy samples. This benefit is not paid for malignant melanoma (which is covered under the invasive cancer benefit). It also does not include any conditions which may be considered precancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; nonmalignant melanoma; moles; or similar diseases or lesions. Payable only once per covered person each calendar year.
- National Cancer Institute (NCI) evaluation and Walmart Centers of Excellence evaluation: when evaluated for determining the appropriate treatment of a previously diagnosed covered illness, $500 for evaluation; $250 for transportation and lodging if the center is more than 100 miles from your home. Payable once for each initial occurrence or recurrence of a covered illness.
- Lodging benefit: $60 per day when you or a covered family member receive treatment for a covered illness on an outpatient basis at a treatment facility more than 100 miles from your or your covered family member's home. 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.
- Transportation benefit: $0.50 per mile for personal vehicle, up to $1,500, or up to $1,500 round-trip transportation for coach fare on a common carrier. Transportation must be required for treatment of a covered critical illness at a hospital (inpatient or outpatient), radiation therapy center, chemotherapy or oncology clinic, or any other specialized freestanding treatment facility. If the treatment is for a covered child and common carrier travel is necessary, the benefit will be paid for up to two adults to accompany the child. This benefit will not be paid if the covered person lives within 100 miles of the treatment facility.

Your Certificate of Insurance will contain complete information on the benefits payable. To obtain a copy, visit **One.Walmart.com** or **AllstateBenefits.com/Walmart**. You can also call Allstate Benefits at **800-514-9525** for a copy.

When your critical illness insurance coverage begins

If you enroll during Annual Enrollment, your coverage becomes effective on January 1 of the next year.

If you enroll outside of Annual Enrollment, your coverage becomes effective on the date of your status change event or the end of your eligibility waiting period, whichever is later. No benefit is payable for any disease diagnosed before your effective date of coverage. If you should die before your effective date, no critical illness insurance benefit will be paid to your beneficiary(ies).

Your critical illness insurance begins whether or not you are actively at work, as long as you have reported for your first day of work and enrolled for the benefit. See the **Eligibility and enrollment** chapter for details.

Naming a beneficiary

If you die while covered under critical illness insurance, your beneficiary(ies) will receive any benefits due at the time of your death.

You must name a beneficiary(ies) to receive your critical illness insurance benefit if you die. Do this by going to **One.Walmart.com** or **Workday** for Jet associates. Note that only beneficiary designations made online are accepted.

You can name anyone you wish. If the beneficiary(ies) you list with Walmart differs from the beneficiary(ies) named in your will, the list that Walmart has prevails.

The following information is needed for each beneficiary you name:

- Name
- Current address and phone number
- Relationship to you
- Social Security number
- Date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you,

that beneficiary's interest will end, and will be shared equally by any remaining beneficiaries unless your beneficiary form states otherwise.

You can name a minor as a beneficiary; however, Allstate Benefits may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult an attorney or an estate planner before naming a minor as a beneficiary.

You (the associate) are automatically assigned as the primary beneficiary of your dependent's critical illness coverage. If you and your dependent die at the same time, benefits will be paid to your dependent's estate or at Allstate Benefits' option to a surviving relative of the dependent.

CHANGING YOUR BENEFICIARY

You can change your beneficiary(ies) at any time on **One.Walmart.com** or **Workday** for Jet associates. Any change in beneficiary must be completed and submitted to Walmart before your death and can be submitted only by you, the covered associate.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to your surviving family member(s) in the following order:

1. Your spouse/partner; if not surviving, then
2. Your children, in equal shares; if not surviving, then
3. Your parents, in equal shares; if not surviving, then
4. Your siblings, in equal shares; if not surviving, then
5. Your estate.

Be sure to keep your beneficiary information up to date. Proceeds go to whoever is listed on your beneficiary form with Walmart, regardless of your current relationship with that person, unless state law says otherwise. You can change your beneficiary(ies) at any time on **One.Walmart.com** or **Workday** for Jet associates.

Filing a claim

Within 60 days of the occurrence or commencement of any covered critical illness, or as soon as reasonably possible, send a notice of claim to:

Allstate Benefits
Attn: Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488

You may also provide notice of claim as follows:

Online: **AllstateBenefits.com/mybenefits**
By phone: **800-514-9525**
By fax: **877-423-8804**

Be sure to provide the following information for the covered person:

- Name
- Social Security number, and
- Date the covered illness began.

You may request a claim form from Allstate Benefits or visit **One.Walmart.com**, **Workday** for Jet associates, or **AllstateBenefits.com/Walmart** to obtain a copy. If you do not receive a claim form within 15 days of your request, you may send a notice of the claim to Allstate Benefits by providing Allstate Benefits with a statement of the nature and extent of the loss.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You or your beneficiary has the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

When benefits are not paid

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

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

Break in coverage

There may be occasions in which you must make special arrangements to pay your critical illness insurance premiums to avoid a break in coverage. These situations occur most commonly if you are on a leave of absence or if your Walmart paycheck is not sufficient to pay your full share of the cost of coverage (such as after a reduction in hours). Depending on your circumstances, failure to make your premium payments by the due date may result in an interruption in the payment of any benefit claims and/or a break in coverage.

For details on the impact a break in coverage may have, and on how to make personal payments to continue your coverage, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

When coverage ends

Your critical illness insurance coverage ends on the earliest of the following:

- At termination of your employment
- Upon failure to pay your premiums
- On your date of death
- On the last day of an approved leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company.

Critical illness insurance coverage for your spouse/partner ends:

- On the date your insurance coverage ends
- On the last day of the pay period when your job status changes to part-time, temporary, or part-time truck driver
- On the date your spouse/partner loses eligibility, such as upon a valid decree of divorce or termination of partnership, or
- On your spouse/partner's death.

Critical illness insurance coverage for your dependent child(ren) ends:

- On the date your insurance coverage ends
- On the date your dependent child loses eligibility, or
- On your dependent child's death.

CONTINUATION OF COVERAGE AT TERMINATION

If your coverage under critical illness insurance terminates as described earlier in this section, you may continue to receive critical illness insurance directly from Allstate Benefits through portability coverage. To receive portability coverage, you must notify Allstate Benefits that you wish to continue coverage and send the first premium within 60 days of the date your coverage under critical illness insurance terminates.

The premiums for portability coverage are due in advance of each month's coverage, on the first day of the calendar month. The premiums are set at the same rate in effect under critical illness insurance for active associates with the same coverage.

For more information, please contact Allstate Benefits at **800-514-9525**.

WHEN YOUR DEPENDENT BECOMES INELIGIBLE

Any eligible dependent covered under critical illness insurance at the time such coverage terminates may also receive portability coverage, under the terms described above. Contact Allstate Benefits at **800-514-9525** for information.

If you leave the company and are rehired

If you leave the company and then return to work within 13 weeks, you will automatically be reenrolled for the same coverage plan you had prior to leaving the company (or the most similar coverage offered under the Plan).

If your break is greater than 30 days but less than 13 weeks, you will have 60 days after resuming work to drop or otherwise change the coverage in which you were automatically reenrolled.

If you return to work after 13 weeks, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you drop coverage and reenroll

If you drop coverage and reenroll within 30 days, you will automatically be reenrolled for the same coverage you had prior to dropping coverage (or the most similar coverage offered under the Plan).

If you drop coverage and reenroll after 30 days, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

IF A DEPENDENT IS DROPPED FROM COVERAGE AND REENROLLED

If your dependent child is dropped from coverage and then determined to be eligible for coverage within 30 days, the dependent will automatically be reenrolled in the same coverage you elect for yourself.

If your dependent regains eligibility and is reenrolled after 30 days, they will be treated as a newly eligible dependent. The associate may enroll them for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

Accident insurance

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Allstate Benefits regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company, the underwriting company and subsidiary of The Allstate Corporation.

Accident insurance

This insurance helps you if you're in an accident away from work. If the accident is covered, this can help you pay for things like immediate care treatment, hospitalization, physical therapy, transportation, and lodging. Benefits are paid directly to you unless you want to have them paid to the provider.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get detailed information	Go to **One.Walmart.com** or **AllstateBenefits.com/Walmart**	Call Allstate Benefits at **800-514-9525**

What you need to know about accident insurance

- You may purchase accident insurance to assist you and your family if a covered individual has a covered accident that requires medical care.
- Accident insurance pays a set benefit in a lump sum, based on the nature of the accident and the care required.
- Proof of Good Health is not required for any level of coverage.
- Coverage is provided through Allstate Benefits. The Certificate of Insurance available online at **One.Walmart.com** or **AllstateBenefits.com/Walmart** provides detailed information about accident insurance, in addition to the highlights available in this chapter.

Accident insurance

Accident insurance provides benefits to you if you or any covered dependent receives covered treatment related to an off-the-job accident. The benefits under this policy are not reduced by any other benefits you may receive.

Accident insurance is available to you if you are an hourly or management associate. Coverage is also available to your dependents, with the exception of spouses/partners of part-time associates, temporary associates, and part-time truck drivers.

CHOOSING A COVERAGE LEVEL

When you enroll for accident insurance, you also select the eligible family members you wish to cover:

- Associate only
- Associate + spouse/partner (except for part-time hourly associates, temporary associates, and part-time truck drivers)
- Associate + child(ren), or
- Associate + family (except for part-time hourly associates, temporary associates, and part-time truck drivers).

For information on eligibility and when you can enroll, see the **Eligibility and enrollment** chapter.

The cost for coverage is based on the eligible dependents you choose to cover.

If you have associate-only or associate + spouse/partner coverage and you (or your spouse/partner) give birth to a child, your newborn child will be automatically covered for 60 days after birth. You must change your election to associate + child(ren) or associate + family if you wish to continue covering your child after 60 days. See the **Eligibility and enrollment** chapter for information on when and how you may change your election.

Accident insurance benefits

Accident insurance provides benefits if you or a covered dependent seeks medical treatment or is hospitalized as a result of a covered accident that happens off the job. An accident generally is a covered accident if it occurs while you (or your covered family member) are not working at any job for pay or benefits and is the result of a sudden, unforeseen, and unexpected event that results in injury and occurs without the injured person's intent. Certain accidents are not covered. See **When benefits are not paid** later in this chapter for more information.

For a complete list of benefits and the amounts payable, visit **One.Walmart.com** or **AllstateBenefits.com/Walmart**.

Accident insurance will pay a benefit if you receive particular services in connection with a covered off-the-job accident. See the chart on the next page for details regarding services for which accident insurance pays a benefit.

SERVICE	BENEFIT AMOUNT	LIMITATIONS
Immediate care (physician fees, x-rays, and emergency room)	$120 per covered accident	Services must be received within 30 days of covered accident.
Follow-up treatment (not covered under physical therapy)	$50 per follow-up treatment after emergency treatment paid under immediate care, up to 6 treatments	Follow-up visits must occur within 30 days of the initial covered treatment. Benefit paid for only one treatment per day.
Physical therapy (not covered by follow-up treatment)	$50 per day, up to 10 days	Therapy must begin within 30 days of covered accident or discharge from hospital and be received within six months of covered accident or discharge.
Initial hospitalization	$1,500 payable the first time a covered person is hospitalized for at least 24 hours; $2,250 if admitted directly to a hospital intensive care unit	Hospitalization must begin within 30 days of the covered accident. Payable only once per hospitalization per calendar year.
Hospital confinement	Daily benefit of $300 for a continuous hospital confinement for at least 18 hours, up to 365 days	Hospitalization must begin within 30 days of covered accident. Not payable on same day rehabilitation benefit is paid.
Intensive care unit (ICU) confinement	$900 per day, up to 15 days	Confinement must begin within 30 days of covered accident.
Step-down ICU confinement	$200 per day, up to 15 days	Must be confined to step-down intensive care unit for at least 18 hours.
Rehabilitation unit confinement (after hospitalization)	$100 per day confined to rehabilitation unit	Payable up to 30 days per continuous period of confinement; maximum of 60 days. Not payable for days in which hospital confinement benefit is paid.
Major diagnostic exams	$400 for CT scan, MRI, or EEG	One payment per calendar year.
Appliance to aid personal locomotion or mobility	$200 for crutches, wheelchair, leg brace, back brace, walker, and CAM boot walker	Payable once per covered accident.
Prosthesis	$1,000	Payable once per covered accident. Not payable for hearing aids, wigs, or dental aids (including false teeth).
Ambulance	$250 for ground ambulance or $2,000 for air ambulance	Transportation by ambulance must occur within 72 hours of covered accident.
Blood, plasma, and/or platelets	$100	Not payable for immunoglobulins. Payable once per covered accident.
Transportation for treatment at a non-local hospital	$400 per round trip; additional $400 if dependent child is receiving treatment	Payable for up to three roundtrips per year. Not payable for ambulance transportation.
Family lodging for confinement at a non-local hospital	$100 per night for an immediate family member of covered person, up to 30 days	Payable only during the days the covered person is confined to the non-local hospital.

Accident insurance also pays a benefit if the following specific injuries are sustained in a covered accident:

INJURY	BENEFIT AMOUNT	LIMITATIONS
Dislocation	$188–$3,750, depending on joint dislocated	Payable for up to two dislocations per accident. Certain treatments may result in a lesser benefit.
Burns	$100–$10,000 depending on degree of burn and size of affected area	If proof of loss does not specify size of burn, the lowest benefit amount will be paid. Treatment by a physician must occur within 72 hours of the covered accident.
Skin grafts	50% of benefit amount under burns	Paid in addition to the burn benefit.
Eye injury	$250 for surgical repair; $50 for removal of foreign body	For services performed by a physician.
Lacerations	$25–$400, depending on the size of the laceration	If proof of loss does not specify size of laceration, the lowest benefit amount will be paid. Treatment must occur within 72 hours of the covered accident.
Fractures	$375–$3,750, depending on location of fracture; 25% for chip fractures or other fractures not corrected by open or closed repair	For fractures corrected by open or closed repair as a result of covered accident. Payable for no more than two fractures per covered accident.
Concussions (brain)	$50	As a result of covered accident.
Emergency dental services	$50 for broken teeth extracted; $150 for broken teeth repaired with crowns	Payable once per covered accident.
Coma	$10,000	Coma must persist at least seven days. Medically induced comas are excluded.
Surgical procedures	$350–$1,400, depending on surgical procedure	Must be performed within one year of covered accident. Miscellaneous surgery is payable once per 24 hours even though more than one surgery or procedure may be performed.

Your Certificate of Insurance will contain complete information on the benefits payable. To obtain a copy, visit **One.Walmart.com** or **AllstateBenefits.com/Walmart**. You can also call Allstate Benefits at **800-514-9525** for a copy, which will be provided at no cost to you.

When your accident insurance coverage begins

If you enroll during Annual Enrollment, your coverage becomes effective on January 1 of the next Plan year.

If you enroll outside of Annual Enrollment, your coverage becomes effective on the date of your status change event or the end of your eligibility waiting period, whichever is later. If you should die before your effective date, no accident insurance benefit will be paid to your beneficiary(ies).

Your accident insurance begins whether or not you are actively at work, as long as you have reported for your first day of work and enrolled for the benefit. See the **Eligibility and enrollment** chapter for details.

Naming a beneficiary

If you die while covered under accident insurance, your beneficiary(ies) will receive any benefits due at the time of your death.

You must name a beneficiary(ies) to receive your accident insurance benefit if you die. You may do this by going to **One.Walmart.com** or **Workday** for Jet associates. Note that only beneficiary designations made online are accepted.

You can name anyone you wish. If the beneficiary(ies) you list with Walmart differs from the beneficiary(ies) named in your will, the list that Walmart has prevails.

The following information is needed for each beneficiary:

- Name
- Current address and phone number
- Relationship to you
- Social Security number
- Date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you, that beneficiary's interest will end, and will be shared equally by any remaining beneficiaries unless your beneficiary form states otherwise.

You can name a minor as a beneficiary; however, Allstate Benefits may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult an attorney or an estate planner before naming a minor as a beneficiary.

Be sure to keep your beneficiary information up to date. Proceeds go to whoever is listed on your beneficiary form on file with Walmart, regardless of your current relationship with that person, unless state law requires otherwise.

You (the associate) are automatically assigned as the primary beneficiary of your dependent's accident coverage. If you and your dependent die at the same time, benefits will be paid to your dependent's estate or at Allstate Benefits' option to a surviving relative of the dependent.

CHANGING YOUR BENEFICIARY

You can change your beneficiary(ies) at any time on **One.Walmart.com** or **Workday** for Jet associates. Any change in beneficiary must be completed and submitted to Walmart before your death and can be submitted only by you, the covered associate.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to your surviving family member(s) in the following order:

1. Your spouse/partner; if not surviving, then
2. Children, in equal shares; if not surviving, then
3. Parents, in equal shares; if not surviving, then
4. Siblings, in equal shares; if not surviving, then
5. Your estate.

Be sure to keep your beneficiary information up to date. Proceeds go to whoever is listed on your beneficiary form with Walmart, regardless of your current relationship with that person, unless state law says otherwise. You can change your beneficiary(ies) at any time on **One.Walmart.com** or **Workday** for Jet associates.

Filing a claim

Within 60 days of the occurrence or commencement of any covered accident, or as soon as reasonably possible, send a notice of claim to:

Allstate Benefits
Attn. Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488

You may also provide notice of claim as follows:

Online: **AllstateBenefits.com/mybenefits**
By phone: **800-514-9525**
By fax: **877-423-8804**

Provide the following information for the covered person:

- Name
- Social Security number, and
- Date the covered accident occurred.

You may request a claim form from Allstate Benefits or visit **One.Walmart.com** or **AllstateBenefits.com/Walmart** to obtain a copy. If you do not receive a claim form within 15 days of your request, you may send a notice of the claim to Allstate Benefits by providing Allstate Benefits with a statement of the nature and extent of the loss.

You will be required to provide written proof of your claim to Allstate. Generally, you should provide written proof related to your claim within 90 days of the service or loss, or as soon as reasonably possible after the loss if it is not possible to provide it within 90 days. In any event, you generally must provide any required proof of the claim to Allstate within 15 months, or your claim will be denied.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You or your beneficiary has the right to appeal a claim denial.

When benefits are not paid

Benefits are not paid for a loss that is caused by or occurs as a result of:

- An injury that results from an accident that occurs while working at any job for pay or benefits
- An injury incurred prior to your effective date of coverage
- Any act of war, whether or not declared, or participation in a riot, insurrection or rebellion
- Suicide, or any attempt at suicide, whether sane or insane
- Any injury sustained while you or your covered family member are under the influence of alcohol or any narcotic, unless administered upon the advice of a physician
- Dental or plastic surgery for cosmetic purposes, except when such surgery is required to treat an injury or correct a disorder of normal bodily function that was caused by an injury
- 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
- Committing or attempting to commit an assault or felony
- Driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway, or
- Any injury incurred while a covered person is an active member of the military, naval, or air forces of any country or combination of countries. Upon notice and proof of service in such forces, Allstate Benefits will return the prorated portion of the premium paid for any period of such service.

Break in coverage

There may be occasions in which you must make special arrangements to pay your accident insurance premiums to avoid a break in coverage. These situations occur most commonly if you are on a leave of absence or if your Walmart paycheck is not sufficient to pay your full share of the cost of coverage (such as after a reduction in hours). Depending on your circumstances, failure to make your premium payments by the due date may result in an interruption in the payment of any benefit claims and/or a break in coverage.

For details on the impact a break in coverage may have, and on how to make personal payments to continue your coverage, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

When coverage ends

Your accident insurance coverage ends on the earliest of the following:

- At termination of your employment
- Upon failure to pay your premiums
- On your date of death
- On the last day of an approved leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company.

Accident insurance coverage for your spouse/partner ends:

- On the date your accident insurance coverage ends
- On the last day of the pay period when your job status changes to part-time, temporary, or part-time truck driver
- On the date your spouse/partner loses eligibility, such as upon a valid decree of divorce or termination of partnership, or
- On your spouse/partner's death.

Accident insurance coverage for your dependent child(ren) ends:

- On the date your accident insurance coverage ends
- On the date your dependent child loses eligibility, or
- On your dependent child's death.

CONTINUATION OF COVERAGE AT TERMINATION

If your coverage under accident insurance terminates as described earlier in this section, you may continue to receive accident insurance directly from Allstate Benefits through portability coverage. To receive portability coverage, you must notify Allstate Benefits that you wish to continue coverage and send the first premium within 60 days of the date your coverage under accident insurance terminated.

The premiums for portability coverage are due in advance of each month's coverage, on the first day of the calendar month. The premiums are set at the same rate in effect under accident insurance for active associates with the same coverage.

For more information, please contact Allstate Benefits at **800-514-9525**.

WHEN YOUR DEPENDENT BECOMES INELIGIBLE

Any eligible dependent covered under accident insurance at the time such coverage terminated may also receive portability coverage, under the terms described on the previous page. Contact Allstate Benefits at **800-514-9525** for information.

If you leave the company and are rehired

If you leave the company and then return to work within 13 weeks, you will automatically be reenrolled for the same coverage plan you had prior to leaving the company (or the most similar coverage offered under the Plan).

If your break is greater than 30 days but less than 13 weeks, you will have 60 days after resuming work to drop or otherwise change the coverage in which you were automatically reenrolled.

If you return to work after 13 weeks, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you drop coverage and reenroll

If you drop coverage and reenroll within 30 days, you will automatically be reenrolled for the same coverage you had prior to dropping coverage (or the most similar coverage offered under the Plan).

If you drop coverage and reenroll after 30 days, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

IF A DEPENDENT IS DROPPED FROM COVERAGE AND REENROLLED

If your dependent child is dropped from coverage and then determined to be eligible for coverage within 30 days, the dependent will automatically be reenrolled in the same coverage you elect for yourself.

If your dependent regains eligibility and is reenrolled after 30 days, they will be treated as a newly eligible dependent. The associate may enroll them for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

Company-paid life insurance

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Company-paid life insurance

Life insurance is automatically provided by Walmart at no cost to you. So you can rest easy knowing your loved ones will have financial help if the unthinkable happens.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Change your beneficiary designation	Go to **One.Walmart.com** or **Workday** for Jet associates	Beneficiary changes cannot be made over the phone
• Get more coverage details • Request an accelerated benefit • Get details about continuing your insurance		Call Prudential at **877-740-2116**
File a claim		Call Prudential at **877-740-2116**

What you need to know about company-paid life insurance

- If you are a full-time hourly or management associate, Walmart provides you with life insurance coverage at no cost to you (for details about eligible job classifications, see the **Enrollment and eligibility dates by job classification** charts in the **Eligibility and enrollment** chapter). No enrollment is necessary, and Proof of Good Health is not required.
- Your coverage amount is equal to your annualized rate of pay, including overtime and bonuses, during the one-year period prior to your death, rounded to the nearest $1,000, to a maximum of $50,000.
- An early payout due to terminal illness is available.
- Coverage is provided through The Prudential Insurance Company of America (Prudential).
- This policy is term life insurance. It has no cash value.

Company-paid life insurance

If you are a full-time hourly or management associate, Walmart provides you with life insurance coverage at no cost to you (for details about eligible job classifications, see the **Enrollment and eligibility dates by job classification** charts in the **Eligibility and enrollment** chapter). No enrollment is necessary.

Your company-paid coverage amount is equal to your annualized rate of pay, including overtime and bonuses, during the one-year period prior to your death, rounded to the nearest $1,000, to a maximum of $50,000.

Naming a beneficiary

To ensure your company-paid life insurance benefit is paid according to your wishes, you must name a beneficiary(ies). You may do this by going to **One.Walmart.com** or **Workday** for Jet associates. Note that only beneficiary designations made online are accepted.

You can name anyone you wish. If the beneficiary(ies) you list with Walmart differs from the beneficiary(ies) named in your will, the list that Walmart has prevails. If you have not designated a beneficiary(ies) under the company-paid life insurance benefit, payment will be made to your surviving family members as described under **If you do not name a beneficiary** later in this chapter.

The following information is needed for each beneficiary:

- Name
- Current address and phone number
- Relationship to you
- Social Security number
- Date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you, that beneficiary's interest will end, and will be shared equally by any remaining beneficiaries unless your beneficiary form states otherwise. If you and a beneficiary die in the same event and it cannot be determined who died first, the beneficiary will be treated as having died before you.

You can name a minor as a beneficiary; however, Prudential may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult an attorney or an estate planner before naming a minor as a beneficiary. If you name a minor as a beneficiary, funeral expenses cannot be paid from the minor's beneficiary proceeds.

CHANGING YOUR BENEFICIARY

You can change your beneficiary(ies) at any time on **One.Walmart.com** or **Workday** for Jet associates. Any change in beneficiary must be completed and submitted to Walmart before your death and can be submitted only by you, the covered associate.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to surviving family members in the following order:

1. Spouse or partner of the deceased; if not surviving, then
2. Children in equal shares; if not surviving, then
3. Parents in equal shares; if not surviving, then
4. Siblings in equal shares; if not surviving, then
5. Your estate.

Be sure to keep your beneficiary information up to date. Proceeds go to whoever is listed on your beneficiary form with Walmart, regardless of your current relationship with that person, unless state law says otherwise. You can change your beneficiary(ies) at any time on **One.Walmart.com** or **Workday** for Jet associates.

When your company-paid life insurance coverage begins

Company-paid life insurance coverage begins on the date specified in the **Enrollment and effective dates by job classification** charts in the **Eligibility and enrollment** chapter. You must be actively at work for your coverage to become effective. You are considered actively at work on a day that is one of your scheduled work days if you are performing in the usual way all the regular duties of your job. See the **Eligibility and enrollment** chapter for details.

Early payout due to terminal illness

If you are terminally ill, you may elect to receive an "accelerated benefit" while you are still living of up to 50% of the amount your beneficiary(ies) would have received upon your death (measured on the date you provide proof of your terminal illness). Payment may be made in a lump sum or 12 equal monthly installments. Upon your death, your beneficiary(ies) receive the greater of (a) 100% of

your annual earnings, based on the most recent average salary for the last 26 pay-periods, reduced by the amount of any terminal illness proceeds paid under the option to accelerate payment of death benefits, or (b) the amount of insurance in effect prior to payment of any terminal illness proceeds, reduced by the amount of any terminal illness proceeds paid under the option to accelerate payment of death benefits.

If you terminate from the company after you have received (or begun to receive) the accelerated benefit, you will need to convert the policy for your beneficiary(ies) to receive the remaining balance upon your death. If you do not convert the policy upon termination of your employment, no benefit will be payable to your beneficiary(ies). See the **Continuing your company-paid life insurance after you leave Walmart** section in this chapter for details on conversion.

Under the policy, you are considered terminally ill if death is expected within 12 months and a doctor can certify the illness or injury as terminal.

There may be circumstances in which the accelerated benefit is not paid. Contact Prudential at **877-740-2116** for details.

Please consult with a tax professional to assess the impact of this benefit.

Filing a claim

The following information must be provided to Prudential regarding the deceased associate:

- Name
- Social Security number
- Date of death, and
- Cause of death (if known).

An original or certified copy of the death certificate is required as proof of death. The death certificate should be mailed to:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, Pennsylvania 19176

The claim will not be finalized until Prudential receives the death certificate. Acceptance of the death certificate is not a guarantee of payment.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. Your beneficiary(ies) has the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For details, contact Prudential at **877-740-2116**.

If your death occurs outside a 100-mile radius of your home, there is a benefit for expenses incurred to return your body to either a preferred location within the United States, or to your residence at the time of death. The benefit includes expenses for embalming, cremation, a coffin, and transportation of your remains. The benefit is the lesser of the cost to return your remains or $10,000.

When benefits are not paid

Benefits are not paid to any beneficiary(ies) who engaged in an illegal act that resulted in the associate's death. The benefit in this circumstance would go to another eligible designated beneficiary or, if there is no other surviving beneficiary, to a beneficiary in the default list, as specified under **If you do not name a beneficiary** earlier in this chapter.

When coverage ends

Your company-paid life insurance coverage ends:

- At termination of your employment
- On the last day of the pay period when your job status changes to part-time
- On the date of your death
- On the date that you lose eligibility
- On the last day of an approved leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company.

This policy is term life insurance. It has no cash value.

EstateGuidance®

EstateGuidance offers you the convenience of online will preparation from your personal computer at no cost to you. Wills ensure that your assets will be distributed in accordance with your wishes and allow you to name a guardian of your minor children. To complete the online will questionnaire, log on to **willguidance.com**, password: **Walmart**.

NOTE: Your will does not override the beneficiary designation on a life insurance policy or retirement account (such as a 401(k) plan). For this reason, be sure to review your beneficiary designations, particularly after you have created a will, to make sure your designations are consistent and fully in line with your wishes. If the beneficiary(ies) you have listed with Walmart differs from the beneficiary(ies) named in your will, the list that Walmart has prevails.

Continuing your company-paid life insurance after you leave Walmart

In most circumstances, you have two options to continue your company-paid life insurance if your group life coverage ends. The first option, called **portability**, allows you to continue all or a portion of your coverage through a group term policy with Prudential. The second option, called **conversion**, allows you to convert all or a portion of your coverage to a Prudential individual policy.

You must apply for portability or conversion within 31 days of the date your company-paid coverage ends. If you die within 31 days of a qualifying loss of coverage and before electing portability or conversion of your life insurance coverage, Prudential will pay a death benefit to your beneficiary. The benefit will be paid based on the amount of coverage in effect prior to the qualifying loss of coverage, even if you did not apply for portability or conversion of your coverage.

Portability enables you to maintain similar term life insurance with Prudential after your employment ends, if certain conditions are met. Proof of Good Health is required to "port" your coverage. If you do not pass or do not submit Proof of Good Health, you will be eligible to convert your company-paid life insurance to an individual policy, as described in the next column.

You can apply for term life coverage under the portability feature if you meet all of these conditions:

- Your company-paid life coverage ends for any reason other than:
  - you leave the company due to a disability, or
  - Walmart changes group life insurance carriers and you are, or become, eligible within the next 31 days.
- You are actively at work on the day your company-paid insurance ends.
- You are less than age 80.
- Your amount of insurance is at least $20,000 on the day your company-paid insurance ends.

If you meet these conditions, you will have 31 days from your termination date to contact Prudential and enroll.

Conversion is a required Plan provision that allows you to convert your life insurance coverage to an individual policy if coverage would end due to your termination of employment or transfer from an eligible class. Proof of Good Health is not required. Rates are based on your age and amount converted. You have 31 days from the termination date of coverage to request to convert your coverage to an individual policy. If your death occurs during the 31-day conversion period, the death benefit will be payable up to the amount that could have been converted.

If you are a resident of Minnesota, you have a continuation right instead of a conversion right when you lose coverage due to a reduction in your hours or termination of employment (other than for gross misconduct). You may elect to continue coverage at your expense until you obtain coverage under another group life insurance policy; however, the maximum period that coverage may be continued is 18 months. If you continue coverage, at the expiration of the continuation period you may convert your life insurance coverage to an individual policy, as described above.

To request information on portability or conversion, call Prudential at **877-740-2116**.

If you leave the company and are rehired

If you return to work for the company as a full-time hourly or management associate within 13 weeks, you will automatically be reenrolled for coverage.

If you return to work after 13 weeks, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period. See the **Eligibility and enrollment** chapter for details.

Optional associate life insurance

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Optional associate life insurance

Optional associate life insurance takes care of your family by giving them extra financial protection during a difficult time.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Change your beneficiary designation	Go to **One.Walmart.com** or **Workday** for Jet associates	Beneficiary changes cannot be made over the phone
• Get more details • Request an accelerated benefit • Get details about continuing your insurance		Call Prudential at **877-740-2116**
File a claim		Call Prudential at **877-740-2116**

What you need to know about optional associate life insurance

- If you are an hourly or management associate, you can enroll in optional associate life insurance when you are eligible, as described in the **Eligibility and enrollment** chapter.
- Depending on the amount of coverage you choose and when you enroll, you may be required to provide Proof of Good Health.
- You can enroll in, change, or drop optional associate life insurance at any time, but if you enroll at any time other than your initial enrollment period, you will have to provide Proof of Good Health.
- An early payout due to terminal illness is available.
- Coverage is provided through The Prudential Insurance Company of America (Prudential).
- This policy is term life insurance. It has no cash value.

Optional associate life insurance

Optional associate life insurance protects your family if you die while coverage is in effect. If you become terminally ill, a benefit may be payable to you while you are still living.

If you are an hourly or management associate you can enroll in optional associate life insurance when you are eligible, as described in the **Eligibility and enrollment** chapter.

Your coverage choices for optional associate life insurance depend on your job classification, as reflected in the company's payroll system. The coverage amounts you can choose are shown in the chart below.

HOURLY ASSOCIATES AND PART-TIME TRUCK DRIVERS		MANAGEMENT ASSOCIATES	
$25,000	$100,000	$25,000	$200,000
$50,000	$150,000	$50,000	$300,000
$75,000	$200,000	$75,000	$500,000
		$100,000	$750,000
		$150,000	$1,000,000

For details about eligible job classifications, see the **Enrollment and eligibility dates by job classification** section in the **Eligibility and enrollment** chapter

If you die, your beneficiary(ies) may receive a lump sum payment for the coverage amount you select.

The cost of optional associate life insurance is based on the coverage amount you select, your age, and whether you are eligible for tobacco-free rates. Premiums from optional associate life coverage do not subsidize coverage under company-paid life insurance.

If you are an hourly associate, part-time truck driver, or management associate, you can enroll in optional associate life insurance at any time once you are eligible. Proof of Good Health may be required when you enroll, depending on the coverage amount you choose and when you enroll.

You can change or drop coverage at any time. However, you will be required to provide Proof of Good Health if you want to increase your coverage or reenroll for any amount of coverage after dropping coverage.

See the **Company-paid life insurance** chapter for information about other life insurance coverage available to full-time hourly and management associates.

PROOF OF GOOD HEALTH

Proof of Good Health is required for optional associate life insurance if:

- The coverage amount selected is above $25,000 during your initial enrollment period
- You enroll after your initial enrollment period for any amount, or
- You increase your coverage after your initial enrollment period.

Proof of Good Health includes completing a questionnaire regarding your medical history and possibly having a medical exam. The Proof of Good Health questionnaire is made available when you enroll.

Naming a beneficiary

To ensure that your life insurance benefit is paid according to your wishes, you must name a beneficiary(ies) to receive your optional associate life insurance benefit if you die. You may do this by going to **One.Walmart.com** or **Workday** for Jet associates. Any change in beneficiary must be completed and submitted to Walmart before your death and can be submitted only by you, the covered associate. Note that only beneficiary designations made online are accepted.

You can name anyone you wish. If the beneficiary(ies) you list with Walmart differs from the beneficiary(ies) named in your will, the list that Walmart has prevails. If you have not designated a beneficiary(ies) under the optional associate life insurance benefit, payment will be made to your surviving family members as described under **If you do not name a beneficiary** later in this chapter.

The following information is needed for each beneficiary:

- Name
- Current address and phone number
- Relationship to you
- Social Security number
- Date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you, that beneficiary's interest will end and will be shared equally by any remaining beneficiary(ies), unless your beneficiary form states otherwise. If you and a beneficiary die in the same event and it cannot be determined who died first, the beneficiary will be treated as having died before you.

You can name a minor as a beneficiary; however, Prudential may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult an attorney or an estate planner before naming a minor as a beneficiary. If you name a minor as a beneficiary, funeral expenses cannot be paid from the minor's beneficiary proceeds.

CHANGING YOUR BENEFICIARY

You can change your beneficiary(ies) at any time on **One.Walmart.com** or **Workday** for Jet associates. Any change in beneficiary must be completed and submitted to Walmart before your death and can be submitted only by you, the covered associate.

> Be sure to keep your beneficiary information up to date. Proceeds will go to whoever is listed on your beneficiary form with Walmart, regardless of your current relationship with that person, unless state law says otherwise. You can change your beneficiary(ies) at any time on **One.Walmart.com** or **Workday** for Jet associates.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to surviving family members in the following order:

1. Spouse or partner of the deceased; if not surviving, then
2. Children in equal shares; if not surviving, then
3. Parents in equal shares; if not surviving, then
4. Siblings in equal shares; if not surviving, then
5. Your estate.

When your optional associate life insurance coverage begins

When Proof of Good Health is required (as described on the previous page), your coverage becomes effective the day the company receives approval from Prudential or at the end of your eligibility waiting period, whichever is later.

If you should die before Prudential approves coverage, no optional associate life insurance benefit will be paid to your beneficiary(ies).

When Proof of Good Health is not required, your coverage becomes effective on the date you enroll or at the end of your eligibility waiting period, whichever is later.

In either case, you must be actively at work for your coverage to become effective. You are considered actively at work on a day that is one of your scheduled work days if you are performing in the usual way all the regular duties of your job. See the **Eligibility and enrollment** chapter for details.

Early payout due to terminal illness

If you are terminally ill, you may elect to receive an "accelerated benefit" while you are still living of up to 50% of the coverage amount your beneficiary(ies) would have received upon your death, up to a $250,000 maximum. Payment may be made in a lump sum or 12 equal monthly installments. Upon your death, your beneficiary(ies) receive the total amount of coverage in effect at your death minus the amount of early payouts you received before your death).

If you terminate from the company after you have received (or begun to receive) the accelerated benefit, you will need to convert the policy for your beneficiary(ies) to receive the remaining balance upon your death. If you do not convert the policy upon termination of your employment, no benefit will be payable to your beneficiary(ies). See the **Continuing your optional associate life insurance after you leave Walmart** section later in this chapter for details on conversion.

Under the policy, you are considered terminally ill if death is expected within 12 months and a doctor can certify the illness or injury as terminal.

There may be circumstances in which the accelerated benefit is not paid. Contact Prudential at **877-740-2116** for details.

Please consult a tax professional to assess the impact of this benefit.

Filing a claim

The following information must be provided to Prudential regarding the deceased associate:

- Name
- Social Security number
- Date of death, and
- Cause of death (if known).

An original or certified copy of the death certificate is required as proof of death. The death certificate should be mailed to:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, Pennsylvania 19176

The claim will not be finalized until Prudential receives the death certificate. Acceptance of the death certificate is not a guarantee of payment.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. Your beneficiary has the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For more details, contact Prudential at **877-740-2116**.

When benefits are not paid

No benefits are paid to your beneficiary(ies) if you die as a result of suicide while sane or insane during the first two years of coverage. If you increase your coverage and you die as a result of suicide within two years of the date you increase your coverage, your beneficiary(ies) will receive the prior coverage amount.

If your beneficiary(ies) files a claim within the first two years of your approval date, Prudential has the right to re-examine your Proof of Good Health questionnaire. If material facts about you are found to have been stated inaccurately, the true circumstances will be used to determine what amount of coverage should have been in effect, if any, and:

- The claim may be denied, and
- Premiums paid may be refunded.

Break in coverage

There may be occasions in which you must make special arrangements to pay your optional associate life insurance premiums to avoid a break in coverage. These situations occur most commonly if you are on a leave of absence or if your Walmart paycheck is not sufficient to pay your full share of the cost of coverage (such as after a reduction in hours). Depending on your circumstances, failure to make your premium payments by the due date may result in an interruption in the payment of any benefit claims and/or a break in coverage.

For details on the impact a break in coverage may have, and on how to make personal payments to continue your coverage, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

When coverage ends

Your optional associate life insurance coverage ends:

- At termination of your employment
- Upon failure to pay your premiums
- On the date of your death
- On the last day of an approved leave of absence (unless you return to work)
- When the benefit is no longer offered by the company, or
- On the day after you drop coverage.

This policy is term life insurance. It has no cash value.

Continuing your optional associate life insurance after you leave Walmart

In most circumstances, you have two options to continue your optional associate life insurance if your group life coverage ends. The first option, called **portability**, allows you to continue all or a portion of your current coverage through a group term policy with Prudential. The second option, called **conversion**, allows you to convert all or a portion of your coverage to a Prudential individual policy.

You must apply for portability or conversion within 31 days of the date your coverage ends. If you die within 31 days of a qualifying loss of coverage and before electing portability or conversion of your life insurance coverage, Prudential will pay a death benefit to your beneficiary. The benefit will be paid based on the amount of coverage in effect prior to the qualifying loss of coverage, even if you did not apply for portability or conversion of your coverage.

Portability enables you to maintain similar term life insurance with Prudential after your employment ends if certain conditions are met. Proof of Good Health is not required to "port" your coverage. You can, however, receive preferred rates similar to the rates you paid while an active associate if you submit and pass Proof of Good Health. If you do not pass or do not submit Proof of Good Health, your rates will be based on Prudential's standard portability rates.

You can apply for term life coverage under the portability feature if you meet all of these conditions:

- Your optional associate life coverage ends for any reason other than:
  - your failure to pay premiums while an active associate
  - you leave the company due to a disability, or
  - Walmart changes group life insurance carriers and you are, or become, eligible within the next 31 days.
- You meet the active work requirement on the day your insurance ends.

- You are less than age 80.
- Your amount of insurance is at least $20,000 on the day your insurance ends.

If you meet these conditions, you will have 31 days from your termination date to contact Prudential and enroll. Prudential will notify you of the amount of portability coverage offered. The amount of insurance coverage offered will not be more than the amount of coverage you elected under the plan (and not more than five times your annual earnings), and will not be less than $20,000.

Conversion is a required Plan provision that allows you to convert your life insurance coverage to an individual policy if coverage would end due to your termination of employment or transfer from an eligible class. Proof of Good Health is not required. Rates are based on your age and amount converted. You have 31 days from the termination date of coverage to request to convert your coverage to an individual policy. If your death occurs during the 31-day conversion period, the death benefit will be payable up to the amount that could have been converted.

If you are a resident of Minnesota, you have a continuation right instead of a conversion right when you lose coverage due to a reduction in your hours or termination of employment (other than for gross misconduct). You may elect to continue coverage at your expense until you obtain coverage under another group life plan; however, the maximum period that coverage may be continued is 18 months. If you continue coverage, at the expiration of the continuation period you may convert your life insurance coverage to an individual policy, up to the amount of coverage in effect at that time. You have 31 days from the date continuation coverage would end to request to convert your coverage to an individual policy.

To request information on portability or conversion, call Prudential at **877-740-2116**.

If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be reenrolled for the same coverage in effect prior to leaving the company (or the most similar coverage offered under the Plan). You can drop or otherwise change your coverage at any time.

If you return to work after 13 weeks, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period. Proof of Good Health is required for coverage plans above $25,000 (or for any amount if you enroll after your initial enrollment period). See the **Eligibility and enrollment** chapter for details.

If you drop or decrease your coverage and reenroll

If you drop or decrease your coverage and reenroll within 30 days, you may reenroll for the same coverage in effect prior to dropping or decreasing coverage.

If you reenroll more than 30 days after dropping or decreasing your coverage, Proof of Good Health will be required.

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Optional dependent life insurance

Optional dependent life insurance can help ease your financial situation if you lose someone close to you, like a spouse, partner, or child.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get more details	Go to **One.Walmart.com** or **Workday** for Jet associates	Call Prudential at **877-740-2116**
File a claim		Call Prudential at **877-740-2116**

What you need to know about optional dependent life insurance

- If you are an hourly or management associate, you can enroll your eligible dependents in optional dependent life insurance when you are eligible, as described in the **Eligibility and enrollment** chapter. Full-time hourly and management associates can enroll their spouse/partners and/or their children; part-time hourly associates and part-time truck drivers can enroll their children but not their spouse/partners.
- Proof of Good Health for your spouse/partner is required if you enroll for a coverage amount above $5,000 during your initial enrollment period, or for any coverage amount if you enroll at any other time. Proof of Good Health is not required for your children.
- Coverage is provided through the Prudential Insurance Company of America (Prudential).
- This policy is term life insurance. It has no cash value.

Optional dependent life insurance

Optional dependent life insurance pays you a financial benefit if you are an enrolled associate and your dependent dies while coverage is in effect. If you are an hourly or management associate, you can enroll in optional dependent life insurance when you are eligible, as described in the **Eligibility and enrollment** chapter.

All full-time hourly and management associates can enroll their spouses/partners and/or children. All part-time hourly associates, part-time truck drivers, and temporary associates can enroll their children but cannot enroll their spouses/partners.

For details about eligible job classifications, see the **Enrollment and eligibility dates by job classification** charts in that chapter.

When you enroll in optional dependent life insurance, if your covered spouse/partner and/or legal dependent dies, you may receive a lump sum payment for the coverage amount you select. The coverage choices for optional dependent life insurance are as follows:

SPOUSE/PARTNER COVERAGE*		CHILD COVERAGE
$5,000	$75,000	$5,000
$15,000	$100,000	$10,000
$25,000	$150,000	$20,000
$50,000	$200,000	

*Not available for part-time hourly associates, temporary associates, or part-time truck drivers

Depending on the coverage amount you choose and when you enroll, your spouse/partner may be required to provide Proof of Good Health.

You (the associate) are automatically assigned as the primary beneficiary of your dependent's life insurance coverage. If you and your covered dependent or dependents die at the same time, benefits are paid to your dependent's estate or, at Prudential's option, to a surviving relative of the dependent.

The cost of optional dependent life insurance for your spouse/partner is based on the coverage amount you select, your (the associate's) age, and whether your spouse/partner is eligible for the tobacco-free rates. The cost of coverage for your children is based on the coverage amount you select. Premiums from optional dependent life coverage do not subsidize coverage under company-paid life insurance.

You can enroll in optional dependent life insurance at any time. Proof of Good Health is required for your spouse/partner if you enroll after your initial enrollment period. Also, you can change or drop coverage at any time. However, if you want to increase your spouse/partner's coverage or reenroll after dropping coverage, you will be required to provide Proof of Good Health for your spouse/partner.

PROOF OF GOOD HEALTH

Proof of Good Health is required for your spouse/partner's optional dependent life insurance coverage if:

- The coverage amount selected is above $5,000 during your initial enrollment period
- You enroll after your initial enrollment period for any amount, or
- You increase your coverage after your initial enrollment period.

However, within 60 days of marriage, you may elect to cover your spouse or change the amount of insurance for your spouse. In this instance, even though you are outside your initial enrollment period, your spouse is not required to provide Proof of Good Health unless you select a coverage amount greater than $5,000.

Proof of Good Health includes completing a questionnaire regarding your spouse/partner's medical history and possibly requiring your spouse/partner to have a medical exam. The Proof of Good Health questionnaire is made available when you enroll your spouse/partner. Proof of Good Health is not required for children.

When your optional dependent life insurance coverage begins

When Proof of Good Health is required (as described above), coverage for your spouse/partner becomes effective the day the company receives approval from Prudential or at the end of your eligibility waiting period, whichever is later. Proof of Good Health is not required for children.

If your spouse/partner should die before Prudential approves coverage, no optional dependent life insurance will be paid to you.

When Proof of Good Health is not required, coverage for your spouse/partner or child becomes effective on the date you enroll or at the end of your eligibility waiting period, whichever is later.

If your spouse/partner or dependent child is confined for medical treatment (at home or elsewhere), coverage is delayed until the spouse/partner or child has a medical release (does not apply to a newborn child).

You must be actively at work for your dependent coverage to become effective. You are considered actively at work on a day that is one of your scheduled work days if you are performing in the usual way all the regular duties of your job. See the **Eligibility and enrollment** chapter for details.

Additional benefits

Benefits also are payable under the following circumstances:

- If a dependent child is born alive and dies within 60 days of birth and was eligible but not enrolled in optional dependent life insurance prior to the loss — with a live birth certificate and a death certificate — Prudential will pay a $5,000 benefit only.
- If a dependent child is stillborn, Prudential will pay a $5,000 benefit to associates who have met the eligibility waiting period for dependent life insurance. See the **Eligibility and enrollment** chapter for details. A stillborn child is defined as an eligible associate's natural-born child whose death occurs before expulsion, extraction, or delivery and whose fetal weight is 350 grams or more; or, if fetal weight is unknown, whose duration in utero was 20 or more complete weeks of gestation. If both the mother and father of the stillborn child work at Walmart, each associate is eligible to submit a claim for this benefit separately, for a total of $10,000.

Filing a claim

The following information must be provided to Prudential regarding the deceased dependent:

- Name
- Social Security number
- Date of death, and
- Cause of death (if known).

An original or certified copy of the death certificate is required as proof of death. Mail the death certificate to:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, Pennsylvania 19176

The claim will not be finalized until Prudential receives the death certificate. Acceptance of the death certificate is not a guarantee of payment.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For more details, contact Prudential at **877-740-2116**.

When benefits are not paid

No benefits are paid to you if your spouse/partner dies as a result of suicide while sane or insane during the first two years of coverage. If you increase your spouse/partner's coverage and your spouse/partner dies as a result of suicide within two years of the increase in coverage, you will receive the prior coverage amount.

If you file a claim for your spouse/partner within the first two years of your approval date, Prudential has the right to re-examine your spouse/partner's Proof of Good Health questionnaire. If material facts about your spouse/partner are found to have been stated inaccurately, the true circumstances will be used to determine what amount of coverage should have been in effect, if any, and:

- The claim may be denied, and
- Premiums paid may be refunded.

Break in coverage

There may be occasions in which you must make special arrangements to pay your optional dependent life insurance premiums to avoid a break in coverage. These situations occur most commonly if you are on a leave of absence or if your Walmart paycheck is not sufficient to pay your full share of the cost of coverage (such as after a reduction in hours). Depending on your circumstances, failure to make your premium payments by the due date may result in an interruption in the payment of any benefit claims and/or a break in coverage.

For details on the impact a break in coverage may have, and on how to make personal payments to continue your coverage, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

When coverage ends

Your optional dependent life insurance coverage ends:

- At termination of your employment
- Upon failure to pay your premiums
- On the date of your death
- On the date that you or a dependent spouse/partner or child loses eligibility (see the **Eligibility and enrollment** chapter)
- On the last day of an approved leave of absence (unless you return to work)
- When the benefit is no longer offered by the company, or
- The day after you drop your coverage.

In addition, if you have optional dependent life coverage for your spouse/partner and your job status changes to part-time hourly associate, temporary associate, or part-time truck driver, your coverage for your spouse/partner will end on the last day of the pay period when your job status changes.

This policy is term life insurance. It has no cash value.

Continuing spouse/partner coverage after you leave Walmart

If you are a full-time or management associate and carry optional dependent life insurance for your spouse or partner, you have two options to continue your spouse/partner coverage after your group life coverage ends. The first option, called **portability**, allows you and your spouse or partner to continue all or a portion of your current coverage through a group term policy with Prudential. The second option, called **conversion**, allows you to convert all or a portion of your spouse/partner coverage to a Prudential individual policy. These options are not available to part-time hourly associates, temporary associates, or part-time truck drivers.

You must apply for portability or conversion within 31 days of the date your spouse/partner coverage ends. If your spouse or partner dies within 31 days of a qualifying loss of coverage and before electing portability or conversion of the life insurance coverage, Prudential will pay a death benefit. The benefit will be the amount of coverage your spouse or partner could have converted, even if your dependent did not apply for portability or conversion of coverage.

Portability enables you to maintain similar term life insurance for your spouse or partner with Prudential after your associate coverage ends or your spouse or partner loses eligibility due to divorce or separation, if certain conditions are met.

Proof of Good Health is not required to "port" your spouse/partner coverage. You can, however, receive preferred rates for spouse/partner coverage similar to the rates you paid while an active associate if your spouse/partner submits and passes Proof of Good Health. If you do not pass or submit Proof of Good Health for your spouse/partner, your rates will be based on Prudential's standard portability rates.

You can apply for term life coverage under the portability feature if you meet all of these conditions:

- The optional dependent life coverage ends because your optional associate life coverage ends for any reason other than:
  - your failure to pay premiums while an active associate
  - the end of your employment on account of your retirement due to disability, or
  - the end of the optional associate life coverage for all associates when such coverage is replaced by group life insurance from any carrier for which you are or become eligible within the next 31 days.
- You apply and become covered for term life coverage under the portability plan.
- With respect to a dependent spouse or partner, that person is less than age 80.
- The dependent is covered for optional dependent life coverage on the day your optional associate life coverage ends.
- The dependent is not confined for medical care or treatment, at home or elsewhere, on the day your optional associate life coverage ends.

Your spouse or partner may also apply for term life coverage under the portability feature if they meet all of these conditions:

- Your spouse or partner's coverage ends due to divorce or termination of partnership.
- Your spouse or partner is less than age 80.
- Your spouse or partner is not confined for medical care or treatment, at home or elsewhere, on the day your optional dependent life coverage ends.

If you meet these conditions, you will have 31 days from your termination date to contact Prudential and enroll. Prudential will notify you of the amount of portability coverage offered. The amount of insurance coverage offered will not be more than the amount of spouse/partner coverage you elected under the plan. However, if your spouse or partner provides Proof of Good Health, and Prudential accepts such proof, you may increase the amount of your spouse or partner's coverage by $20,000 (or, if less, by your annual earnings amount).

Conversion is a required Plan provision that allows you to convert your life insurance coverage to an individual policy if coverage would end for any reason other than failure to pay premiums or the end of dependent coverage for all associates. Proof of Good Health is not required. Rates are based on your dependent's age and amount converted. You have 31 days from the termination date of coverage to request to convert your coverage to an individual policy. If your dependent's death occurs during the 31-day conversion period, the death benefit will be payable up to the amount that could have been converted.

If you are a resident of Minnesota, you have a continuation right instead of a conversion right when you lose coverage due to a reduction in your hours or termination of employment (other than for gross misconduct). You may elect to continue coverage at your expense until you obtain coverage under another group life insurance policy; however, the maximum period that coverage may be continued is 18 months. If you continue coverage, at the expiration of the continuation period, you may convert your life insurance coverage to an individual policy, up to the amount of coverage in effect at that time. You have 31 days from the date continuation coverage would end to request to convert your coverage to an individual policy. In addition, if you lose coverage for any reason other than a reduction in your hours or termination of employment (other than for gross misconduct), you may convert up to the amount of coverage that was in force under the plan.

To request information on portability or conversion, call Prudential at **877-740-2116**.

If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be reenrolled for the same coverage you had prior to leaving the company (or the most similar coverage offered under the Plan). You can drop or otherwise change this coverage at any time.

If you return to work after 13 weeks, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period. Proof of Good Health is required for spouse/partner coverage plans above $5,000 (or for any amount if you enroll after your initial enrollment period). See the **Eligibility and enrollment** chapter for details.

If you drop or decrease your coverage and reenroll

If you drop or decrease your coverage and reenroll within 30 days, you may reenroll for the same coverage in effect you had prior to dropping or decreasing coverage.

If you reenroll more than 30 days after dropping or decreasing coverage, Proof of Good Health will be required for spouse/partner coverage plans.

IF A DEPENDENT IS DROPPED FROM COVERAGE AND REENROLLED

If your dependent child is dropped from coverage and then determined to be eligible for coverage within 30 days, the dependent will automatically be reenrolled in the same coverage you elect for yourself.

If your dependent regains eligibility and is reenrolled after 30 days, they will be treated as a newly eligible dependent. The associate may enroll them for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

Accidental death and dismemberment (AD&D) insurance

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Prudential regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Accidental death and dismemberment (AD&D) insurance

AD&D benefits can help pay the cost of medical care, childcare, and education expenses if you're seriously injured or die in an accident.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Change your beneficiary designation	Go to **One.Walmart.com** or **Workday** for Jet associates	Beneficiary changes cannot be made over the phone
Get more details		Call Prudential at **877-740-2116**
File a claim		Call Prudential at **877-740-2116**

What you need to know about AD&D insurance

- If you are an hourly or management associate, you can enroll in AD&D insurance when you are eligible, as described in the **Eligibility and enrollment** chapter.
- Proof of Good Health is not required for AD&D insurance, regardless of the coverage amount you choose.
- If you have a covered loss, AD&D insurance pays a lump sum benefit based on the nature of the loss and the coverage amount you select. Additional benefits may be payable, depending on the circumstances of the covered loss.
- Coverage is provided through The Prudential Insurance Company of America (Prudential).

AD&D insurance

AD&D insurance pays a lump sum benefit to you or your beneficiary(ies) if you or a covered dependent experiences a covered loss. The amount of your benefit depends on the type of loss you experience, as described later in this chapter.

If you are an hourly or management associate, you can enroll in AD&D insurance when you are eligible, as described in the **Eligibility and enrollment** chapter. For details about eligible job classifications, see the **Enrollment and eligibility dates by job classification** charts in that chapter.

You have two AD&D coverage decisions. You choose whom you want to cover and your coverage amount.

You can choose to cover:

- Associate only
- Associate + dependents

If you are a part-time hourly associate, temporary associate, or part-time truck driver and you choose associate + dependents coverage, you can cover your dependent children but not your spouse/partner.

The coverage amount for your dependents will be a percentage of the coverage amount you choose for yourself (see **AD&D coverage amount** later in this chapter). The amounts available for you to choose as your associate coverage amount are:

- $25,000
- $50,000
- $75,000
- $100,000
- $150,000
- $200,000

Management associates may also choose the following additional coverage amounts:

- $300,000
- $500,000
- $750,000
- $1,000,000

You can enroll in or make changes to your AD&D insurance during your initial enrollment period, Annual Enrollment, or when you have a status change event. For more information, see the **Eligibility and enrollment** chapter.

The cost of AD&D insurance is based on the coverage amount you select and whether you choose associate-only or associate + dependents coverage.

Naming a beneficiary

To ensure that your AD&D benefit is paid according to your wishes, you must name a beneficiary(ies). You may do this by going to **One.Walmart.com** or **Workday** for Jet associates. Note that only beneficiary designations made online are accepted. You (the associate) will receive any benefits payable for your covered dependents.

You can name anyone you wish. If the beneficiary(ies) you list with Walmart differs from the beneficiary(ies) named in your will, the list that Walmart has prevails. If you have not designated a beneficiary(ies) under the AD&D benefit, payment will be made to your surviving family surviving family members as described under **If you do not name a beneficiary** later in this chapter.

The following information is needed for each beneficiary:

- Name
- Current address and phone number
- Relationship to you
- Social Security number
- Date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you, that beneficiary's interest will end, and it will be shared equally by any remaining beneficiary(ies), unless your beneficiary form states otherwise.

You can name a minor as a beneficiary; however, Prudential may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult an attorney or an estate planner before naming a minor as a beneficiary. If you name a minor as a beneficiary, funeral expenses cannot be paid from the minor's beneficiary proceeds.

CHANGING YOUR BENEFICIARY

You can change your beneficiary(ies) at any time on **One.Walmart.com** or **Workday** for Jet associates. Any change in beneficiary must be completed and submitted to Walmart before your death and can be submitted only by you, the covered associate.

Be sure to keep your beneficiary information up to date. Proceeds go to whoever is listed on your beneficiary form with Walmart, regardless of your current relationship with that person, unless state law says otherwise. You can change your beneficiary(ies) at any time on **One.Walmart.com** or **Workday** for Jet associates.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to surviving family members in the following order:

1. Spouse or partner of the deceased; if not surviving, then
2. Children in equal shares; if not surviving, then
3. Parents in equal shares; if not surviving, then
4. Siblings in equal shares, if not surviving, then
5. Your estate.

When your AD&D coverage begins

If you enroll during Annual Enrollment, your coverage becomes effective on January 1 of the next year.

If you enroll outside of Annual Enrollment, your coverage becomes effective on the date of the status change event or the end of your eligibility waiting period, whichever is later.

Your AD&D coverage begins whether or not you are actively at work, as long as you have reported for your first day of work and enrolled for the benefit. See the **Eligibility and enrollment** chapter for details.

AD&D coverage amount

When you enroll in AD&D insurance, the coverage amount you select is the amount that applies to you, the associate. If you enroll in associate + dependent(s) coverage, the coverage amount for your dependent(s) is a percentage of your associate coverage amount. The coverage amount for your dependent(s) depends on the type of dependents you are covering. See the **Full benefit amount** chart below for information on the coverage amount for your family members.

When AD&D benefits are paid

If you have chosen associate + dependent(s) coverage and you or your dependent sustains an accidental injury that is the direct and sole cause of a covered loss, AD&D benefits are paid when proof of the accidental injury and covered loss have been properly provided to Prudential.

Prudential deems a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements.

"Direct and sole cause" means the covered loss occurs within 12 months of the date of the accidental injury and is a direct result of the accidental injury, independent of other causes.

COVERED LOSSES PAID AT FULL BENEFIT

The following covered losses resulting from an accident are payable at the full benefit:

- Loss of life: It will be presumed that you have suffered a loss of life if your body is not found within one year of disappearance, stranding, sinking, or wrecking of any vehicle in which you were an occupant.
- Loss of both hands above the wrists; both feet above the ankles; total and permanent loss of sight in both eyes; loss of speech and hearing in both ears that lasts for at least six consecutive months following the accident.
- Loss of one hand and one foot: Severance at or above the wrist and ankle joints.
- Loss of one arm or one leg: Severance at or above the elbow or above the knee.
- Loss of one hand or foot and sight in one eye: Severance at or above the wrist or ankle joint, with total and permanent loss of sight in one eye.

FULL BENEFIT AMOUNT

Associate coverage amount	If a spouse/partner is the only dependent covered	If both a spouse/partner and children are covered dependents		If children are the only dependents
Associate — 100%	Spouse/partner — 50%	Spouse/partner — 40%	Children — 10%	Children — 25%
$25,000	$12,500	$10,000	$2,500	$6,250
$50,000	$25,000	$20,000	$5,000	$12,500
$75,000	$37,500	$30,000	$7,500	$18,750
$100,000	$50,000	$40,000	$10,000	$25,000
$150,000	$75,000	$60,000	$15,000	$37,500
$200,000	$100,000	$80,000	$20,000	$50,000
Management associates only:				
$300,000	$150,000	$120,000	$30,000	$75,000
$500,000	$250,000	$200,000	$50,000	$125,000
$750,000	$375,000	$300,000	$75,000	$187,500
$1,000,000	$500,000	$400,000	$100,000	$250,000

- Quadriplegia: Total paralysis of both upper and lower limbs.
- Paraplegia: Total paralysis of both lower limbs.
- Hemiplegia: Total paralysis of upper and lower limbs on one side of the body.

50% OF FULL BENEFIT

The following covered losses resulting from an accident are payable at 50% of full benefit:

- Brain damage: Brain damage means permanent and irreversible physical damage to the brain, causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of more than five consecutive days within 30 days of the accident, and continue for 12 consecutive months.
- Loss of hand or foot: Severance at or above the wrist or ankle.
- Loss of sight in one eye: Total and permanent loss of sight in one eye.
- Loss of speech or hearing in both ears: Total and permanent loss of speech or hearing (i.e., continuing for at least six consecutive months following the accident).

25% OF FULL BENEFIT

The following covered losses resulting from an accident are payable at 25% of full benefit:

- Loss of hearing in one ear: Total and permanent loss of hearing (i.e., continuing for at least six consecutive months following the accident).
- Loss of thumb and index finger of the same hand: Severance at or above the point at which they are attached to the hand.
- Uniplegia: Total paralysis of one limb.

"Paralysis" means loss of use, without severance, of a limb. A doctor must determine that the loss is complete and not reversible. "Severance" means complete separation and dismemberment of the limb from the body.

COMA BENEFIT

If you or a covered dependent is comatose or becomes comatose within 365 days as the result of an accident, a coma benefit equal to 1% of your full benefit amount is paid for 11 consecutive months to you, your spouse/partner, your children, or a legal guardian. The benefit is payable after 31 consecutive days of being comatose. If you or a covered dependent remains comatose beyond 11 months, the full sum of the coverage, less any AD&D benefit already paid, is made to you or your designated beneficiary.

"Coma" means a profound state of unconsciousness from which the comatose person cannot be aroused, even by powerful stimulation, as determined by the person's doctor. Such state must begin within 365 days of the accidental injury and continue for 31 consecutive days and is total, continuous, and permanent at the end of the 31-day period.

The maximum amount that AD&D insurance will pay for all covered losses of an individual resulting from a covered accident is the full benefit amount.

Additional AD&D benefits

Additional benefits may be payable by the Plan:

- Seat belt benefit: If you and/or your covered dependents suffer a loss of life as a result of a covered accident that occurs while wearing a seat belt, an additional benefit may be payable.
- Safe motorcycle rider benefit: If you and/or your covered dependents suffer a loss of life as a result of a covered accident that occurs while wearing a helmet, an additional benefit may be payable.
- Spouse/partner education benefit (full-time hourly and management associates only): If you (the associate) suffer a loss of life, a spouse/partner education benefit may be payable.
- Child education and care benefit: If you (the associate) or your covered spouse/partner suffers a loss of life, a childcare benefit and/or child education benefit may be payable.
- Home alteration and vehicle modification benefit: If you or your covered dependents suffer a covered loss that requires home alteration or vehicle modification, an additional benefit may be payable.
- COBRA monthly medical premium benefit: If you (the associate) suffer a covered accidental bodily injury which results in your death or a termination after a leave of absence, an additional benefit may be payable to assist with the continuation of medical benefits under the Associates' Medical Plan.
- Monthly rehabilitation benefit: If you or your covered dependents suffer a covered accidental bodily injury that requires medically necessary rehabilitation, an additional benefit may be payable.
- Common accident benefit: If you (the associate) or your covered spouse/partner both suffer a loss of life due to the same accident or accidents that occur within 48 hours of each other, a common accident benefit may be payable.

All additional AD&D benefits are subject to eligibility criteria established by Prudential. Contact Prudential for information if any of these benefits might apply to you.

ADDITIONAL BENEFITS		
Benefit	**Benefit amount**	**Limitations**
Seat belt benefit	$10,000	If it cannot be determined that the person was wearing a seat belt at the time of the accident, a benefit of $1,000 will be paid.
Safe motorcycle rider benefit	$10,000	If it cannot be determined that the person was wearing the necessary safety equipment at the time of the accident, a benefit of $1,000 will be paid.
Education benefit for spouse/partner	An amount equal to the least of: • The actual tuition charged for the program; • 10% of your (the associate's) amount of insurance; and • $25,000	Payable for up to 4 years. *Full-time hourly and management associates only.*
Education benefit for child	An amount equal to the least of: • The actual annual tuition, exclusive of room and board, charged by the school; • 10% of the amount of insurance on the person incurring the loss; and • $25,000	Payable annually for up to 4 consecutive years, but not beyond the date the child reaches age 26.
Childcare benefit	An amount equal to the least of: • The actual cost charged by a childcare center per year; • 10% of the amount of insurance on the person incurring the loss; and • $12,500	Payable annually for up to 5 consecutive years, but not beyond the date the child reaches age 13.
Home alteration and vehicle modification benefit	An amount equal to the least of: • The actual cost charged for the alteration or modification; • 10% of the amount of insurance on the person incurring the loss; and • $10,000	Payable for an amount no greater than $10,000.
COBRA premium benefit for associate	An amount equal to the least of: • The amount of the medical premium; • 5% of your (the associate's) amount of insurance; and • $500	Payable monthly until the first of these occurs: • Your continued enrollment in the AMP ends • You become covered under any other group medical plan • The benefit has been paid for 36 consecutive months
COBRA premium benefit for dependent	An amount equal to the lesser of: • The actual amount of the medical premium; and • $10,000	Payable yearly until the first of these occurs: • Your dependent's continued enrollment in the AMP ends • Your dependent becomes covered under any other group medical plan • The benefit has been paid for 3 consecutive years. *A benefit for spouse/partner premiums is only available to full-time hourly and management associates only.*
Monthly rehabilitation benefit	An amount equal to the lesser of: • 10% of the amount of insurance on the person incurring the loss; and • $250	Payable monthly until the first of these occurs: • A doctor determines the person no longer needs rehabilitation • The person fails to furnish any required proof of a continuing need for rehabilitation • The person fails to submit to a required medical exam • The benefit has been paid for 36 consecutive months
Common accident benefit	An amount equal to the difference between: • The amount of insurance payable under the coverage for your loss of life; and • The amount of insurance payable under the coverage for your spouse or domestic partner's loss of life	

Filing a claim

The following information must be provided to Prudential regarding the claimant:

- Name
- Social Security number
- Date of death or injury, and
- Cause of death or injury (if known).

Prudential will send a claim packet to your address on file. The required information must be completed and returned with the claim forms and an original or certified copy of the death certificate, when applicable, to:

The Prudential Insurance Company of America
Group Claim Life Division
P.O. Box 8517
Philadelphia, Pennsylvania 19176

Benefits are paid in a lump sum. If you or a covered dependent sustains more than one covered loss due to an accidental injury, the amount paid, on behalf of any such injured person, will not exceed the full amount of the benefit.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You or your beneficiary has the right to appeal a claim denial.

When benefits are not paid

AD&D benefits are not paid for any loss that occurs prior to your enrollment in the Plan, nor any loss caused or contributed to by the following:

- Suicide or attempted suicide, while sane or insane
- Intentionally self-inflicted injuries, or any attempt to inflict such injuries
- Sickness, whether the loss results directly or indirectly from the sickness
- Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment
- Bacterial or viral infection, but not including:
  - Pyogenic infection resulting from an accidental cut or wound, or
  - Bacterial infection resulting from accidental ingestion of a contaminated substance.
- Taking part in any insurrection
- War, declared or undeclared, or any act of war
- An accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces (not including Reserve or National Guard active duty for training)
- Travel or flight in any vehicle used for aerial navigation if you are riding as a passenger in any aircraft not intended or licensed for the transportation of passengers (including getting in, out, on, or off such vehicle)
- Commission or attempted commission of an assault or felony
- Operating a land, water, or air vehicle while being legally intoxicated, or
- Being under the influence of or taking any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, and all amendments, unless prescribed by and administered in accordance with the advice of the insured's doctor.

Break in coverage

There may be occasions in which you must make special arrangements to pay your AD&D insurance premiums to avoid a break in coverage. These situations occur most commonly if you are on a leave of absence or if your Walmart paycheck is not sufficient to pay your full share of the cost of coverage (such as after a reduction in hours). Depending on your circumstances, failure to make your premium payments by the due date may result in an interruption in the payment of any benefit claims and/or a break in coverage.

For details on the impact a break in coverage may have, and on how to make personal payments to continue your coverage, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

IF YOU GO ON A LEAVE OF ABSENCE

You may continue your coverage up to the last day of an approved leave of absence, provided that you pay your premiums before or during the leave. For information about making payments while on a leave of absence, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

When coverage ends

Your AD&D coverage ends:

- At termination of your employment
- Upon failure to pay your premiums
- On the date of your death
- On the date you or a dependent spouse/partner or child loses eligibility
- On the last day of an approved leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company. AD&D coverage cannot be converted to individual coverage after coverage ends.

In addition, if you have chosen associate + dependent(s) coverage and your job status changes to part-time hourly associate, temporary associate, or part-time truck driver, your coverage for your spouse/partner will end on the last day of the pay period when your job status changes.

If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be reenrolled for the same coverage in effect prior to leaving the company (or the most similar coverage offered under the Plan). If your break is greater than 30 days but less than 13 weeks, you will have 60 days after resuming employment to drop or otherwise change the coverage in which you were automatically reenrolled.

If you return to work after 13 weeks, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period.

See the **Eligibility and enrollment** chapter for details.

If you drop or decrease your coverage and reenroll

If you drop or decrease your coverage and reenroll within 30 days, you may reenroll for the same coverage in effect prior to dropping or decreasing coverage.

If you reenroll more than 30 days after dropping or decreasing coverage, you may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

IF A DEPENDENT IS DROPPED FROM COVERAGE AND REENROLLED

If your dependent child is dropped from coverage and then determined to be eligible for coverage within 30 days, the dependent will automatically be reenrolled in the same coverage you elect for yourself.

If your dependent regains eligibility and is reenrolled after 30 days, they will be treated as a newly eligible dependent. The associate may enroll them for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policies issued by the applicable insurers under this chapter regarding the calculation of benefits and limitations under the policies, the terms of the policies will govern. You may obtain a copy of these policies by contacting the Plan.

Business travel accident insurance

When you're traveling on authorized company business, this insurance protects you and your loved ones financially if you have an accident resulting in certain types of injury or death.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Change your beneficiary designation	Go to **One.Walmart.com** or **Workday** for Jet associates	Beneficiary changes cannot be made over the phone
Get more details		Call Prudential at **877-740-2116**
File a business travel accident insurance claim		Call Prudential at **877-740-2116**
Get more details about international business travel medical insurance through GeoBlue	Go to **geo-blue.com**	Call GeoBlue at **888-412-6403** Outside the U.S. call **610-254-5830**

What you need to know about business travel accident insurance

- Walmart provides all associates with business travel accident insurance. There is no cost to you and no enrollment is necessary.
- Business travel accident insurance pays a benefit for loss of life, limb, sight, speech, or hearing, or paralysis, due to an accident you are involved in while traveling on authorized company business.
- Your coverage amount for accidents while traveling is three times your base annual earnings to a maximum of $1 million.
- This company-paid insurance is provided through The Prudential Insurance Company of America (Prudential).
- International business travel medical insurance is available for eligible business travelers through GeoBlue.

Business travel accident insurance

To protect you while you travel on company business, Walmart provides all associates with business travel accident insurance. There is no cost to you and no enrollment is necessary. Coverage is effective on your first day of active work, as described in the **Eligibility and enrollment** chapter.

If you experience a covered injury resulting in loss or death while traveling on authorized company business, a lump-sum benefit is payable to you or your beneficiary(ies) of up to three times your base annual earnings, with a maximum of $1 million and minimum of $200,000 (unless otherwise specified).

Base annual earnings is defined as follows:

- **For hourly associates:** Annualized hourly rate as shown in the Walmart payroll system as of date of loss or death.
- **For management associates and officers:** Base salary as shown in the Walmart payroll system as of date of loss or death.
- **For truck drivers:** Annualized average day's pay as of date of loss or death, as determined by Logistics Finance.

Note that any bonus you may receive is not included in base annual earnings.

Naming a beneficiary

To ensure that your business travel accident insurance benefit is paid according to your wishes, you must name a beneficiary(ies). You may do this by going to **One.Walmart.com** or **Workday** for Jet associates. Note that only beneficiary designations made online are accepted. You (the associate) will receive any benefits payable for the injuries listed in **When business travel accident insurance benefits are paid** later in this chapter.

You can name anyone you wish. If the beneficiary(ies) you list with Walmart differs from the beneficiary(ies) named in your will, the list that Walmart has prevails. If you have not designated a beneficiary(ies) under the business travel accident benefit, payment will be made to your surviving family members as described under **If you do not name a beneficiary** later in this chapter.

The following information is needed for each beneficiary:

- Name
- Current address and phone number
- Relationship to you
- Social Security number
- Date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance benefit equally. If a named beneficiary dies before you, that beneficiary's interest will end, and it will be shared equally by any remaining beneficiary(ies), unless your beneficiary form states otherwise. If you and a beneficiary die in the same event and it cannot be determined who died first, the beneficiary will be treated as having died before you.

You can name a minor as a beneficiary; however, Prudential may not be legally permitted to pay the minor until the minor reaches legal age. You may want to consult an attorney or an estate planner before naming a minor as a beneficiary. If you name a minor as a beneficiary, funeral expenses cannot be paid from the minor's beneficiary proceeds.

CHANGING YOUR BENEFICIARY

You can change your beneficiary(ies) at any time on **One.Walmart.com** or **Workday** for Jet associates. Any change in beneficiary must be completed and submitted to Walmart before your death and can be submitted only by you, the covered associate.

IF YOU DO NOT NAME A BENEFICIARY

If no beneficiary is named or there is no surviving beneficiary at the time of your death, payment will be made to your surviving family members in the following order:

1. Spouse or partner of the deceased; if not surviving, then
2. Children in equal shares; if not surviving, then
3. Parents in equal shares; if not surviving, then
4. Siblings in equal shares; if not surviving, then
5. Your estate.

Be sure to keep your beneficiary information up to date. Proceeds will go to whoever is listed on your beneficiary form with Walmart, regardless of your current relationship with that person, unless state law says otherwise. You can change your beneficiary(ies) at any time on **One.Walmart.com** or **Workday** for Jet associates.

Filing a claim

Within 12 months of the covered associate's injury or death or within 90 days after any periodic payment is due (such as periodic payments for coma), the following information must be provided regarding the associate:

- Name
- Social Security number
- Occurrence, character, and extent of the injury
- Date of injury or death, and
- Cause of injury or death (if known).

An original or certified copy of the death certificate is required as proof of death. The death certificate should be mailed to:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, Pennsylvania 19176

The claim will not be finalized until Prudential receives the death certificate, where applicable. Acceptance of the death certificate is not a guarantee of payment.

Benefits can be paid in a lump sum or, upon written request, in monthly installments. Only one benefit, the highest, will be paid if you suffer more than one loss resulting from a single accident.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. Your beneficiary(ies) has the right to appeal a claim denial.

Benefits are paid according to the terms of the insurance policy. For details, contact Prudential at **877-740-2116**.

When benefits are paid

Benefits are paid if you sustain an accidental injury while traveling on authorized company business or due to a felonious assault while you are working; your injuries are the direct and sole cause of a covered loss; and you properly provide proof of the accidental loss and covered loss to Prudential.

Traveling for business includes travel using a common carrier or any means of transportation owned and operated by the company. An accidental injury includes exposure to the elements. "Direct and sole cause" means the covered loss occurs within 12 months of the date of the accidental injury and is a direct result of the accidental injury, independent of other causes.

BENEFIT AMOUNT

COVERED INJURY OCCURS…	BENEFIT AMOUNT
While traveling on authorized company business	Three times your base annual earnings to a maximum of $1,000,000 Minimum benefit: $200,000
Due to a felonious assault while you are working	Up to $10,000

COVERED LOSSES PAID AT FULL BENEFIT

- Quadriplegia: Total paralysis of both upper and lower limbs.
- Paraplegia: Total paralysis of both lower limbs.
- Hemiplegia: Total paralysis of upper and lower limbs on one side of the body.
- Loss of both hands, both feet, or sight in both eyes: Severance through or above both wrists or both ankle joints, or total and irrecoverable loss of sight.
- Loss of one hand and one foot: Severance through or above the wrist or ankle joint.
- Loss of speech and hearing in both ears: Total loss of speech and hearing that lasts for at least six consecutive months following the accident.
- Loss of hand or foot and sight in one eye: Severance through or above the wrist or ankle joint, with total and irrecoverable loss of sight in one eye.

50% OF FULL BENEFIT

- Loss of hand or foot: Permanent severance through or above the wrist but below the elbow, or permanent severance at or above the ankle but below the knee.
- Brain damage: Brain damage means permanent and irreversible physical damage to the brain, causing the complete inability to perform all of the substantial and material functions and activities of everyday life. Such damage must manifest itself within 30 days of the accidental injury, require hospitalization of at least five days and persist for 12 consecutive months.
- Loss of sight in one eye: Total and permanent loss of sight in one eye.
- Loss of speech or hearing in both ears: Total loss of speech or hearing that lasts for at least six consecutive months following the accident.

25% OF FULL BENEFIT

- Loss of thumb and index finger of the same hand: Severance of each through or above the joint closest to the wrist.
- Uniplegia: Total paralysis of one limb.

"Paralysis" means loss of use, without severance, of a limb. A doctor must determine that the loss is complete and not reversible. ("Severance" means complete separation and dismemberment of the limb from the body.)

COMA BENEFIT

If you are comatose or become comatose within 365 days as the result of a covered accident, a monthly coma benefit equal to the greater of 2% of your full benefit amount or $100 is paid for up to 50 months. The benefit is payable after 31 consecutive days of being comatose.

"Coma" means a profound state of unconsciousness from which the comatose person cannot be aroused, even by powerful stimulation, as determined by the person's doctor. Such state must begin within 365 days of the accidental injury and continue for 31 consecutive days and is total, continuous, and permanent at the end of the 31-day period.

The maximum amount the business travel accident insurance will pay you for all covered losses resulting from a covered accident is the full benefit amount. If more than one associate suffers a loss as a result of the same accident, the maximum the business travel accident insurance policy will pay for all losses is $10 million per accident and, if necessary, benefits will be prorated among the affected associates suffering a loss in the accident. The maximum total payment is increased to $20 million if the covered accident occurs while you are traveling to or from, or while you are attending, Walmart's Annual Shareholders Meeting, annual holiday meeting, or annual year beginning meeting.

Additional benefits

Business travel accident insurance provides these additional benefits:

- Seat belt benefit: If you suffer a loss of life as a result of a covered accident that occurs while wearing a seat belt, an additional benefit of up to $10,000 may be payable.
- Airbag benefit: If you suffer a loss of life as a result of a covered accident that occurs while you are wearing a seat belt and a properly functioning airbag deploys in the seat you were occupying, an additional benefit of up to $10,000 may be payable.
- Funeral expenses benefit: If you suffer a loss of life within 365 days of and as a result of a covered accident, an additional benefit of up to $5,000 may be payable.
- Medical evacuation benefit: If, as a result of a covered accident, you require medical evacuation and are at least 100 miles from your home, an additional benefit of up to $15,000 may be payable.
- Family relocation and accompaniment: If your spouse or partner or dependent child suffers a covered loss while traveling with you on business (or while on their way to meet you), an additional benefit of up to $100,000 may be payable for losses sustained by your spouse or partner, and $10,000 for losses sustained by each dependent child.

All of these additional benefits are subject to additional eligibility criteria established by Prudential. Please contact Prudential if any of these benefits might apply for additional information.

When benefits are not paid

Business travel accident insurance benefits will not be paid for for any loss that results from any of the following:

- Suicide or attempted suicide, while sane or insane
- Intentionally self-inflicted injuries, or any attempt to inflict such injuries
- Sickness, whether the loss results directly or indirectly from the sickness
- Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment
- Any bacterial or viral infection, except a pyogenic infection resulting from an accidental cut or wound or a bacterial infection resulting from accidental ingestion of a contaminated substance
- War or act of war (declared or undeclared), including resistance to armed aggression or an accident while on full-time active duty with the armed services for more than 30 days (this does not include Reserve or National Guard active duty for training)
- Riding in an unlicensed aircraft
- Flying as a crew member of an airplane, except one owned and operated by the company
- Commission or attempted commission of an assault or felony
- Operating a land, water, or air vehicle while being legally intoxicated, or
- Being under the influence of or taking any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, and all amendments, unless prescribed by and administered in accordance with the advice of the insured's doctor.

When coverage ends

Your business travel accident insurance coverage ends on your last day of employment.

If you leave the company and are rehired

Your business travel accident insurance coverage (or the most similar coverage offered under the Plan) will be reinstated.

International business travel medical insurance

International business travel medical insurance is available through a policy with GeoBlue for associates who travel internationally for business.

GeoBlue provides travel assistance services to you and your eligible dependents if you require emergency medical treatment while traveling on company-authorized business. Walmart pays for this coverage in full — there is no cost to you and no enrollment is necessary. Coverage is valid for a trip lasting up to 180 days. Coverage is not available for personal travel even when you add personal travel to a business trip.

You are not eligible to make health savings account contributions for any month in which you are traveling on Walmart business outside the U.S. and are covered under the GeoBlue policy. If you have medical coverage under the Saver Plan, you are encouraged to consult with your tax advisor if you have questions about the amount to reduce your HSA contributions based on your individual circumstances.

GEOBLUE SERVICES

Business travel medical insurance through GeoBlue provides coverage for emergency medical treatment including hospitalization, doctor visits, and prescription drug coverage (not including over-the-counter medication).

GeoBlue has a network of doctors, physicians, and medical facilities in over 180 countries and can also make appointments on your behalf and arrange for direct billing. Associates are advised to contact GeoBlue Customer Service at **888-412-6403** before obtaining medical treatment to ensure that the treatment is covered.

GeoBlue provides the following services:

- Reimbursement for eligible medical expenses
- Assistance in location of physician, medical facilities, and making medical appointments
- Direct billing and payment guarantees
- Coordination for emergency medical evacuation to the nearest appropriate medical facility for the associate and an accompanying family member(s), and
- Repatriation of remains.

If you incur eligible medical expenses, submit them to GeoBlue for reimbursement. They should not be charged to the corporate credit card or submitted for reimbursement through the travel and expense system.

Associates are advised to register on **geo-blue.com** before their business travel, using group access code **QHG99999WALM**. By registering, you gain access to services and benefits including:

- Ability to print out your insurance ID card in case yours is lost
- Doctor/facility locator
- Symptom checker
- Translate medical terms and medications, and
- Information about health and security risks.

Downloading the GeoBlue app: Once you've registered, download the GeoBlue app and log in with the email address and password you create when you register on the website. The app provides you with convenient access to your ID card and GeoBlue's self-service tools including mapping to your nearest approved medical facility/provider, making appointments, etc.

GeoBlue member ID cards: Cards carry the Blue Cross Blue Shield logo and are available in your travel department. Additional or replacement cards can be downloaded via **geo-blue.com**.

Claims: Claim forms are generally not required for GeoBlue services. However, if you have a question about your benefits or disagree with the benefits provided, you may contact GeoBlue or file a claim. To submit a claim via email or fax, download a claim form and view detailed instructions in the Member Hub at **geo-blue.com**. Submit your claim by email to **claims@geo-blue.com** or by fax to **610-482-9623**.

You may also submit claims by post. Download a claim form from the Member Hub at **geo-blue.com** and send your completed form to:

GeoBlue
Claims Department
P.O. Box 1748
Southeastern, Pennsylvania 19399-1748

Claims and appeals are determined under the time frames and requirements set out in the GeoBlue policy. Contact GeoBlue at any time by calling **888-412-6403**. Outside the U.S. call collect: **610-254-5830**.

Short-term disability for full-time hourly associates

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Short-term disability for full-time hourly associates

If pregnancy, a scheduled surgery, or an unexpected illness or injury keeps you off the job for an extended period, this plan for full-time hourly associates can protect part of your paycheck. When you can't work, the Walmart short-term disability plan works for you.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
To request a leave	Go to **One.Walmart.com**	Call Sedgwick at **800-492-5678**
To file a claim or get more information (all states except California and Rhode Island)	Go to **One.Walmart.com**	Call Sedgwick/Lincoln at **800-492-5678**
If you work in California	Go to **edd.ca.gov**	Call the state of California at **800-480-3287**
If you work in Rhode Island	Go to **dlt.ri.gov/tdi**	Call the state disability carrier at **401-462-8420**
If you work in Washington (to file a state benefit claim)	Go to **paidleave.wa.gov**	Call the state of Washington at **833-717-2273**

What you need to know about short-term disability for full-time hourly associates

- Walmart offers its short-term disability basic plan to eligible full-time hourly associates at no cost to you. Eligible associates are enrolled in the plan automatically after your 12-month waiting period. During your initial enrollment period, you can also enroll in the short-term disability enhanced plan. For details about your enrollment period, see the **Eligibility and enrollment** chapter.
- If you are an hourly full-time associate who works in California, Hawaii, New Jersey, or Rhode Island, which have legally mandated plans, you are not eligible for Walmart's short-term disability coverage.
- In addition to the states named above, certain other states and local governments (currently New York and Washington) also have legally mandated plans, but Walmart extends its short-term disability coverage options to full-time hourly associates in these other states and localities in order to supplement their state and local government disability benefits.
- Walmart's short-term disability basic plan replaces 50% of your income as an eligible associate up to a maximum of $200 per week. The short-term disability enhanced plan replaces 60% of your income with no weekly maximum (the New York short-term disability enhanced plan has a maximum of $6,000 per week).
- If you are eligible to participate and enroll in the short-term disability enhanced plan during your initial enrollment period, your coverage begins on your effective date, as described in the **Eligibility and enrollment** chapter. If you enroll in the short-term disability enhanced plan at any time other than during your initial enrollment period, your short-term disability enhanced plan coverage will not begin until you complete a 12-month waiting period.

Short-term disability for full-time hourly associates

If you are a full-time hourly associate (except for associates in certain states and local governments with legally mandated plans, as noted below), you are automatically enrolled for coverage in the short-term disability basic plan after your 12-month eligibility waiting period. During your initial enrollment period, you also have the opportunity to enroll in the short-term disability enhanced plan. For details about your enrollment period, see the **Eligibility and enrollment** chapter.

The short-term disability basic plan is provided by the company at no cost to you. Your cost for the short-term disability enhanced plan is based on your biweekly earnings and your age.

See **Legally mandated plans** later in this chapter for details about coverage options available to associates in states and localities with legally mandated plans.

Except in certain states and localities (as noted in **Legally mandated plans** below), Walmart's short-term disability coverage is self-insured. This means no insurance company collects premiums and pays benefits. The company funds benefits under the short-term disability basic plan by using the company's general assets, assets of the Plan or Trust, or through a combination of these sources. No associate contributions are required for the short-term disability basic plan. If you participate in the short-term disability enhanced plan, your contributions are intended to cover the costs of benefits.

How short-term disability is administered

Walmart's short-term disability coverage is administered by Sedgwick Claims Management Services, Inc. (Sedgwick) in all states and localities except those with legally mandated plans. Details follow regarding disability coverage available for associates in states and localities with legally mandated plans.

LEGALLY MANDATED PLANS

For associates who work in states and localities with legally mandated plans, differences in state and local laws and administrative procedures will affect your eligibility to participate in Walmart's short-term disability plans and the amount of your disability benefit. General information can be found in the chart below. Call the appropriate number listed in the **Resources** chart at the beginning of this chapter for details about benefits in these states.

Legally mandated and administered plans	**California** **Rhode Island** Associates in these states are not eligible to participate in Walmart's short-term disability plans for hourly associates. Their benefit is administered by the state.
Legally mandated plans, administered by Lincoln Financial Group ("Lincoln")	**Hawaii** **New Jersey** Associates in these states are not eligible to participate in Walmart's short-term disability plans for hourly associates. Their benefit is provided in accordance with the state program and administered by Lincoln.
	New York Associates in New York are eligible to participate in Walmart's short-term disability basic plan and New York short-term disability enhanced plan to supplement their state benefit, which is insured and administered by Lincoln.
Legally mandated plans, administered by Sedgwick **See page 331**	**All other states** Associates in other states and localities with legally mandated benefits are eligible to participate in Walmart's short-term disability plans to supplement their state or local benefits, which are administered by Sedgwick. Associates who work in Washington will have the opportunity to enroll in the short-term disability enhanced plan to supplement their state benefits. To be eligible to receive benefits under the Walmart short-term disability plans, you must apply through the state or local government for your legally mandated benefits, as permitted by law. The amount of the benefit under Walmart's short-term disability plans will be reduced by the amount of the legally mandated benefit. The total benefits payable under the Walmart short-term disability plans will not exceed the level of benefits otherwise payable under the plans.

Your short-term disability benefit

If you become disabled as defined by the Plan, Walmart's short-term disability basic plan provides up to 50% of your average weekly wage for up to 25 weeks of an approved disability, after a waiting period of seven calendar days. The maximum weekly benefit under the short-term disability basic plan is $200. For more information about your average weekly wage, see **Calculating your short-term disability benefit** later in this chapter.

If you become disabled as defined by the Plan, the short-term disability enhanced plan provides up to 60% of your average weekly wage for up to 25 weeks after a waiting period of seven calendar days, with no maximum weekly benefit. For participants who work in New York, the New York short-term disability enhanced plan provides up to 60% of your average weekly wage for up to 25 weeks after a waiting period of seven calendar days if you become disabled as defined by the Plan, and has a $6,000 maximum weekly benefit.

ENROLLMENT FOR SHORT-TERM DISABILITY BENEFITS

You are automatically enrolled in the short-term disability basic plan after your 12-month eligibility waiting period. You must be actively at work for your coverage to become effective. You are considered actively at work on a day that is one of your scheduled work days if you are performing in the usual way all the duties of your job. See the **Eligibility and enrollment** chapter for details.

The date your short-term disability enhanced plan coverage begins depends on when you enroll for coverage:

- If you enroll during your initial enrollment period, your coverage begins on your effective date. See the **Eligibility and enrollment** chapter for information on your initial enrollment period and your effective date.
- If you enroll after transferring from one job classification to another, your coverage begins on your effective date. See the **Eligibility and enrollment** chapter for details about your transition enrollment period and your effective date.
- If you enroll at any time after your initial enrollment period as a late enrollee, you are required to finish a 12-month waiting period before your coverage is effective. You are not required to pay short-term disability enhanced plan premiums during your 12-month waiting period.
  - If your late enrollment is due to a status change event, your 12-month waiting period begins as of the date of the event.
  - If your late enrollment is during an Annual Enrollment, your 12-month waiting period begins as of the date you enroll.

You may drop your short-term disability enhanced plan coverage at any time; the change is effective the day after you drop coverage. If you drop your short-term disability enhanced plan coverage and later decide to reenroll, you will be treated as a late enrollee with a 12-month waiting period.
See page 298

When you qualify for benefits

To qualify for short-term disability benefits through the Plan, you must meet the following requirements:

- You must be actively at work at the time of your disability (except in certain cases of leave of absence or layoff, as described later in this chapter under **Coverage during a leave of absence or temporary layoff**).
- You must submit medical evidence provided by a qualified doctor that you are disabled as defined by the Plan (qualified doctors are legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors [M.D.], osteopaths [D.O.], nurse practitioners, physician's assistants, psychologists, or other medical practitioners whose services are eligible for reimbursement by the Associates' Health and Welfare Plan).
- You must receive approval by Sedgwick or Lincoln of your claim.

These conditions apply whether you are covered under the short-term disability basic plan, enhanced plan, or New York short-term disability enhanced plan. Sedgwick or Lincoln may require written proof of your disability or additional information before making a decision on your claim. A statement by your physician that you are unable to work does not by itself qualify you for short-term disability benefits. Approval of a medical leave of absence does not constitute approval for short-term disability benefits.

As defined by the Plan, "disabled" or "disability" means that you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy. Benefits are payable during a loss of license only while you are disabled and pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. The determination of whether you are disabled is made by Sedgwick (or Lincoln, as applicable) on the basis of objective medical evidence, which consists of facts and findings, including X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from your physician. In addition, you must be under

the continuous care of a qualified doctor and following the course of treatment prescribed. Loss of license by itself is not sufficient for meeting the definition of disability.

If Sedgwick or Lincoln requests that you be examined by an independent physician or other medical professional, you must attend the exam to be considered for benefits.

If your disability is the result of more than one cause, you will be paid as if they were one. The maximum benefit for any one period of disability is limited to 25 weeks, after the initial waiting period of seven calendar days.

If your disability is due to pregnancy, you will be deemed to meet the definition of disability, and Sedgwick (or Lincoln, as applicable) will not require objective medical evidence as a condition for approving your disability claim for the short-term disability maternity benefit, except in the following situations:

- You begin your leave of absence more than two weeks before your estimated delivery date, or
- You do not begin your leave of absence immediately after your delivery date.

The maternity benefit generally begins on the earlier of two weeks before your estimated delivery date (as determined by a qualified doctor) or no later than your actual delivery date.

If your disability is caused by a mental illness or substance abuse, you are encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, or clinical social worker who holds a Master of Social Work (M.S.W.), specializes in mental health and substance abuse, and is licensed pursuant to state law.

Filing a claim

Claims for short-term disability benefits in Hawaii, New Jersey, and New York must be submitted to Sedgwick within 30 days of the date your disability begins. Sedgwick will notify Lincoln of your disability claim.

For all other states, you must submit your short-term disability claim to Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

If you experience a disabling illness or injury, or are scheduled to begin maternity leave, follow these steps:

STEP 1: Notify Sedgwick to apply for a leave of absence and file a short-term disability claim as soon as you know you will be absent from work due to an illness, injury or pregnancy. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated. Report your disability online by going to **One.Walmart.com** > **mySedgwick**, or call **800-492-5678**. Your claim cannot be processed until you have stopped working.

STEP 2: Tell your doctor's office that it will be contacted and asked to complete an attending physician's statement and provide medical information, including:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, and
- Doctor visit notes.

You must sign a form authorizing your doctor to release this information. (If filing your claim online, an electronic signature is accepted.)

STEP 3: Follow up with your doctor to ensure that information was forwarded to the disability administrator.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

You may be required to provide written proof of your disability or additional medical information before your benefit payments begin.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that is:

- Not under the care of and being treated by a qualified doctor
- Caused by taking part in an insurrection, rebellion or a riot, or civil disorder
- Resulting from your commission of or attempt to commit a crime (e.g., assault, battery, felony, or any illegal occupation or activity)
- One for which workers' compensation benefits are paid, or may be paid, if properly claimed, or
- Sustained as a result of doing any work for pay or profit.

When benefits begin

If you are approved for short-term disability benefits, the benefit will begin, after a waiting period of seven calendar days, on the eighth calendar day after your disability begins.

You may use up to 40 hours of available paid time off (PTO) during the benefit waiting period. You must repay the company for PTO taken beyond the benefit waiting period of seven calendar days.

If you are receiving short-term disability at the end of the PTO plan year, please refer to your location's PTO policy for payout and/or carryover information. You do not accrue additional PTO while receiving short-term disability benefits.

Calculating your benefit

The amount of your short-term disability benefit is based on:

- Your average weekly wage, and
- Whether or not you have enrolled in the short-term disability enhanced plan.

AVERAGE WEEKLY WAGE	
Length of employment	**How average weekly wage is determined**
Employed 12 months or more	Total gross pay ÷ 52 weeks For example, the average weekly wage for an associate with a total gross pay of $36,400 is $700 ($36,400 ÷ 52)
Employed less than 12 months	Total gross pay ÷ number of weeks worked For example, the average weekly wage for an associate with a total gross pay of $8,400 for 12 weeks of work is $700 ($8,400 ÷ 12)

If a weekly benefit is payable for less than a week, your pay will be 1/7 of the weekly benefit for each day you were disabled.

Total gross pay includes:

- Overtime
- Bonuses
- PTO and other illness protection benefits (not including any previously paid disability benefits), and
- Personal pay for the 26 pay periods prior to your last day worked (or for the number of pay periods worked if less than 26). Note that if you have any pay periods in which you had no earnings, those pay periods are excluded and the number of pay periods used for the calculation will be decreased.

The maximum weekly benefit under the short-term disability basic plan is $200. There is no maximum weekly benefit under the short-term disability enhanced plan, except in New York, where the maximum is $6,000 per week. A hypothetical benefit calculation is shown below, using an average weekly wage of $700.

YOUR SHORT-TERM DISABILITY BENEFIT: AN EXAMPLE	
If you have	**Your benefit is**
Short-term disability basic plan coverage	50% of your average weekly wage to a maximum of $200/week
	Average weekly wage: $700 50% of $700: $350 Reduced to the maximum weekly benefit: $200
Short-term disability enhanced plan coverage	60% of your average weekly wage
	Average weekly wage: $700 60% of $700: $420 There is no maximum weekly benefit under the short-term disability enhanced plan, so this figure would not be reduced (in New York, there is a maximum weekly benefit of $6,000).
NOTE: For associates who are eligible for legally mandated benefits as well as benefits under Walmart's short-term disability plans, the amount of the benefit under Walmart's short-term disability plans will be reduced by the amount of the legally mandated benefit.	

MATERNITY BENEFIT

For full-time hourly associates, except for those who work in California, Hawaii, New Jersey, and Rhode Island, if your disability is due to pregnancy, and you begin your short-term disability leave on your delivery date or up to two weeks before your expected delivery date, you will be deemed to meet the plan's definition of disability and eligible for maternity disability benefits. The short-term disability plan for hourly associates pays a maternity benefit of 100% of your average weekly wage for up to the first nine weeks, after an initial waiting period of seven calendar days. However, if you begin your leave later than your actual delivery date, you must meet the plan's definition of disability and will be eligible for the non-maternity disability benefits only.

If you are eligible for benefits and continue to meet the definition of disability after the first nine weeks of disability payments, the short-term disability basic plan will pay up to 50% of your average weekly wage to a maximum of $200 per week and the enhanced plan will pay up to 60% of your average weekly wage, from week 11 up to 25 weeks.

Full-time hourly associates who work in California, Hawaii, New Jersey, and Rhode Island generally are not eligible for the Walmart short-term disability plan because these states have legally mandated disability plans with their own eligibility terms. If you work in one of these states and your disability is due to pregnancy, you will be eligible for maternity benefits under the short-term disability plan for hourly associates, subject to the following:

- If you are eligible for legally mandated short-term disability benefits, the short-term disability plan for hourly associates supplements the legally mandated short-term disability benefits, as shown in the chart below.
- If you are not eligible for legally mandated short-term disability benefits, the short-term disability plan pays a maternity benefit of 100% of your average weekly wage up to the first nine weeks, after an initial waiting period of seven calendar days. The short-term disability maternity benefits will end after nine weeks.

If you begin your leave later than your actual delivery date, you will not be eligible for maternity benefits under the short-term disability plan for hourly associates.

Maternity benefits under the short-term disability plan for full-time hourly associates are as described here:

MATERNITY BENEFIT		
Associate's work location (state or locality)	**Up to 9 weeks***	**Beyond 9 weeks***
If you work in a state or locality with no legally mandated benefit	100% of your average weekly wage after an initial waiting period of 7 calendar days.	If you experience medical complications during pregnancy or post-partum, benefits may be payable under the short-term disability plan for hourly associates. Benefits would be equal to 50% or 60% of your average weekly wage, depending on your coverage election, from week 11 up to 25 weeks.
If you work in a state or locality with legally mandated benefits and you *are eligible* to receive the state or local government benefit	Legally mandated benefits are payable at the applicable state or local government rate; the Walmart short-term disability maternity benefit will make up the difference between the legally mandated benefit and 100% of your average weekly wage after an initial waiting period of 7 calendar days.	Applicable state or local government benefits
If you work in a state or locality with legally mandated benefits and you *are not eligible* to receive the state or local government benefit	100% of your average weekly wage after an initial waiting period of 7 calendar days.	Walmart's short-term disability benefits are not available; maternity benefits end after the first 9 weeks.
If you work in Washington state	Legally mandated benefits are payable at the applicable state rate; the Walmart short-term disability maternity benefit will make up the difference between the state benefit and 100% of your average weekly wage after an initial waiting period of 7 calendar days.	If you experience medical complications during pregnancy or post-partum, benefits may be payable under both Walmart's short-term disability plan for hourly associates and the state benefits. Benefits under Walmart's plans would be equal to 50% or 60% of your average weekly wage, depending on your coverage election, from week 11 up to 25 weeks. The amount of the benefit under Walmart's plans will be reduced by the amount of the legally mandated benefit.

*You may also be eligible for additional parental pay equal to 100% of your average weekly wage under Walmart's Parental Pay policy. For more information, refer to the parental pay policy on **One.Walmart.com**.

TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT

The taxation of benefits payable to you depends on whether you are enrolled only in the short-term disability basic benefit or in the enhanced benefit. If you are enrolled in short-term disability basic, benefits payable to you are subject to taxes. This is because you do not make contributions to the short-term disability basic plan or pay any tax on the coverage that Walmart provides. If you are enrolled in short-term disability enhanced, only a portion of your benefits will be taxed, because both Walmart and you pay for the cost of the coverage through a combination of Walmart pretax and associate after-tax contributions. Walmart generally withholds federal, state, local, and Social Security taxes from the portion of the benefit that is taxable.

In Hawaii, New Jersey, and New York, benefits are partially taxed. Please contact Lincoln for more information. Associates in other states or localities with legally mandated benefits should contact the state or locality for information about the tax status of state or local government benefits.

The Plan has the right to recover from you, and you must repay, any amount overpaid to you for short-term disability benefits under this Plan. See **The Plan's right to recover overpayment** and **Right to salary/wage deduction** in the **Claims and appeals** chapter. If you do not repay overpaid amounts in a timely manner, the company may treat the portion of such amounts that were not taxed when paid as taxable wages to you (reportable on your Form W-2) or, alternatively, deduct such amounts from your paycheck or future disability benefit payments, to the extent permitted by law.

When short-term disability benefit payments end

If you are receiving short-term disability benefits from the Plan due to an approved disability, your benefit payments from the Plan will end on the earliest of:

- The date you no longer meet the plan's definition of disabled
- The date you fail to furnish required proof of disability when requested to do so by Sedgwick or Lincoln
- The date you are no longer under the continuous care and treatment of a qualified doctor
- The date you refuse to be examined, if Sedgwick or Lincoln requires an examination
- The last day of the maximum period for which benefits are payable (25 weeks or nine weeks for maternity disability benefits)
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart, or
- The date of your death.

When your short-term disability benefits end, and for any reason you do not return to work, you must request an extension of your leave. Failure to do so may result in your employment being terminated.

If you return to work within 30 days of the end of your approved disability period, you will be reinstated to the disability coverage you had prior to your disability. If you do not return to work within 30 days of the end of your approved disability period, your coverage will lapse until you return to work and meet the active work requirement.

State and local government short-term disability programs may have different end dates from Walmart's coverage.

Returning to work

Sedgwick will contact you before your expected return-to-work date and advise you of steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return-to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

Notify Sedgwick when you physically return to work. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options, which include requesting an extension of your leave or voluntarily terminating employment. Failure to request an extension may result in your employment being terminated.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less of active full-time work (with or without medical restrictions) and become disabled again from the same or a related condition that caused the first period of disability, as determined by Sedgwick or Lincoln, known as a "relapse/recurrent claim," your short-term disability benefits will pick up where they left off before you came back to work. There will be no additional waiting period of seven calendar days. The combined benefit duration for both periods of disability will not exceed 25 weeks.

If you have returned to active full-time work for more than 30 calendar days and then become disabled from the same or a related cause, it will be considered a new disability, and you may be able to receive up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

If you return to active full-time work for any number of calendar days and then become disabled from a new and unrelated cause, it will be considered a new disability, and you may qualify for up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

Coverage during a leave of absence or temporary layoff

Once your short-term disability coverage is effective and you are eligible to file a claim for benefits, if you are not actively at work due to an approved non-disability leave of absence or temporary layoff, you will continue to be eligible for short-term disability benefits for 90 days from your last day of work. Your eligibility for short-term disability benefits ends on the 91st day after the beginning of your approved non-disability leave or temporary layoff, but is reinstated if you return to active work status within one year.

When coverage ends

Your short-term disability basic plan and enhanced plan coverage ends:

- At termination of your employment
- On the last day of the pay period when your job status changes from an eligible job status
- On the date you lose eligibility
- On the date of your death
- On the 91st day of an approved leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company.

In addition, coverage under the short-term disability enhanced plan would end the day after you drop your coverage.

If you leave the company and are rehired

If you leave the company and return to full-time work for the company within 13 weeks, you will automatically be reenrolled for the same coverage plan you had prior to leaving the company (or the most similar coverage offered under the Plan). If you are automatically reenrolled in short-term disability enhanced plan coverage and choose to drop it after you return, you may do so at any time.
See page 298

If you return to full-time work after 13 weeks, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you lose and then regain eligibility

If you lose eligibility and then regain eligibility within 30 days, you will automatically be reenrolled for the same coverage you had prior to leaving the company (or the most similar coverage offered under the Plan).

If you lose eligibility and then regain eligibility after 30 days, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

Salaried short-term disability plan

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This information does not create an express or implied contract of employment or any other contractual commitment. Walmart may modify this information at its sole discretion without notice, at any time, consistent with applicable law.

Salaried short-term disability plan

If pregnancy, a scheduled surgery, or an unexpected illness or injury keeps you off the job for an extended period, this plan for salaried associates can protect part of your paycheck. When you can't work, the Walmart salaried short-term disability plan works for you.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get more details or file a claim (provided to salaried associates in all 50 states)	Go to **One.Walmart.com**	Call Sedgwick at **800-492-5678**
If you work in Washington (to file a state benefit claim)	Go to **paidleave.wa.gov**	Call state of Washington at **833-717-2273**
Request an appeal of a denied short-term disability claim	Go to **One.Walmart.com/LOA** > **mySedgwick**	Call Sedgwick at **800-492-5678**

What you need to know about salaried short-term disability

- If you are a salaried (management) associate, you are automatically enrolled in the salaried short-term disability plan. Coverage is effective as of your date of hire and there is no cost to you.
- If you become disabled and are eligible to receive short-term disability benefits, the salaried short-term disability plan replaces 100% of your base pay for up to six weeks and 75% of your base pay for up to 19 additional weeks, after an initial waiting period of seven calendar days. (Different rules may apply to work-related disabilities that qualify for workers' compensation through Walmart. See the chart titled **Your salaried short-term disability plan benefit** for more information.)
- If your disability is due to pregnancy, the salaried short-term disability plan replaces 100% of your base pay for nine weeks, after an initial waiting period of seven calendar days. Generally no medical evidence is required for this short-term disability maternity benefit.
- The salaried short-term disability plan is not a benefit covered by ERISA and is not part of the Associates' Health and Welfare Plan.
- The claims and appeals procedures described in this chapter apply to the salaried short-term disability benefit rather than the procedures in the **Claims and appeals** chapter.

Salaried short-term disability

You are automatically enrolled for coverage in the salaried short-term disability plan as of your date of hire if you are a salaried/management associate (exempt). For details about eligible job classifications, see the **Enrollment and eligibility dates by job classification** section in the **Eligibility and enrollment** chapter.

How salaried short-term disability is administered

Salaried short-term disability coverage is administered by Sedgwick Claims Management Services, Inc. (Sedgwick) and is provided by the company at no cost to you.

If you become disabled and eligible to receive short-term disability benefits, the salaried short-term disability plan generally pays 100% of your base pay for up to six weeks of an approved disability, after an initial waiting period of seven calendar days of continuous disability. (Disabilities that qualify for workers' compensation through Walmart are treated differently, as described in the chart titled **Your salaried short-term disability plan benefit**.) If you remain disabled and eligible for benefits after the first six weeks of disability payments, the salaried short-term disability plan will pay 75% of your base pay for up to 19 additional weeks.

If your disability is due to pregnancy, you will be deemed to meet the definition of disability, and the salaried short-term disability plan pays a maternity benefit of 100% of your base pay for the first nine weeks, after an initial waiting period of seven calendar days.

For your pay to continue during the initial waiting period of seven calendar days, you may use paid time off (PTO). Salaried short-term disability benefits begin on the eighth calendar day after your eligible disability begins.

LEGALLY MANDATED PLANS

Short-term disability benefits provided by individual states and local governments generally have no impact on your eligibility for the salaried short-term disability benefit through Walmart, or the amount of the benefit you receive under Walmart's plan.

Exceptions to this policy apply to all eCommerce salaried associates who work in California and all associates who work in Washington. General information can be found in the chart at the bottom of the page.

When you qualify for benefits

To qualify for short-term disability benefits through the salaried short-term disability plan, you must meet the following requirements:

- You must submit medical evidence provided by a qualified doctor that you are disabled as defined by the salaried short-term disability plan (qualified doctors are legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors [M.D.], osteopaths [D.O.], nurse practitioners, physician's assistants, psychologists, or other medical practitioners recognized by the Associates' Health and Welfare Plan).
- You must receive approval by Sedgwick of your claim.

If your disability is caused by a mental illness or substance abuse, you are encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, or clinical social worker who holds a Master of Social Work (M.S.W.), specializes in mental health and substance abuse, and is licensed pursuant to state law.

LEGALLY MANDATED PLANS	
eCommerce salaried associates who work in California	Associates are eligible to participate in Walmart's salaried short-term disability plan to supplement their state benefits. The amount of the benefit under Walmart's salaried short-term disability plan will be reduced by the amount of the legally mandated benefit.
Associates who work in Washington	Associates are eligible to participate in Walmart's salaried short-term disability plan to supplement their state benefits. To be eligible to receive benefits under the Walmart salaried short-term disability plan, you must apply through the state or local government for your legally mandated benefits, as permitted by law. The amount of the benefit under Walmart's salaried short-term disability plan will be reduced by the amount of the legally mandated benefit. The total benefits payable under the Walmart short-term disability plan will not exceed the level of benefits otherwise payable under the plan.

See page 331 *for updated terms replacing the chart above.*

Sedgwick may require written proof of your disability or additional information before making a decision on your claim. A statement by your physician that you are unable to work does not by itself qualify you for short-term disability benefits. Approval of a medical leave of absence does not constitute approval for short-term disability benefits.

As defined by the salaried short-term disability plan, "disabled" or "disability" means that you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy. Benefits are payable during a loss of license only while you are disabled or pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. The determination of whether you are disabled is made by Sedgwick on the basis of objective medical evidence, which consists of facts and findings, including X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from your physician. In addition, you must be under the continuous care of a qualified doctor and following the course of treatment prescribed. Loss of license by itself is not sufficient for meeting the definition of disability.

If Sedgwick requests that you be examined by an independent physician or other medical professional, you must attend the exam to be considered for benefits.

If your disability is the result of more than one cause, you will be paid as if they were one. The maximum benefit for any one period of disability is limited to 25 weeks, after the initial waiting period of seven calendar days.

If your disability is due to pregnancy, you will be deemed to meet the definition of disability, and Sedgwick will not require objective medical evidence as a condition for approving your disability claim for the short-term disability maternity benefit, except in the following situations:

- You begin your leave of absence more than two weeks before your estimated date of delivery, or
- You do not begin your leave of absence immediately after the date of delivery.

The maternity benefit generally begins on the earlier of two weeks before the estimated date of delivery (as determined by a qualified doctor) or no later than the actual date of delivery.

Filing a claim

If you experience a disabling illness or injury, or are planning to begin maternity leave, follow these steps:

STEP 1: Notify Sedgwick to apply for a leave of absence and file a short-term disability claim as soon as you know you will be absent from work due to an illness, injury or pregnancy. Sedgwick will send you an initial packet providing the information you will need and describing any actions you will need to take. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated. Report your disability online by going to **One.Walmart.com/LOA** > **mySedgwick**, or call **800-492-5678**.

Processing of your claim cannot begin until you have stopped working. All claims for benefits under Walmart's salaried short-term disability plan must be submitted to Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

STEP 2: Tell your doctor's office that it will be contacted and asked to complete an attending physician's statement and provide medical information, including:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, and
- Doctor visit notes.

You must sign a form authorizing your doctor to release this information. (If filing your claim online, an electronic signature is accepted.)

STEP 3: Follow up with your doctor to ensure that information was forwarded to the disability administrator.

If you become disabled, file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption to your wages, or the denial of your claim.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that is:

- Not under the care of and being treated by a qualified doctor
- Caused by taking part in an insurrection, rebellion or a riot, or civil disorder
- Resulting from your commission of or attempt to commit a crime (e.g., assault, battery, felony, or any illegal occupation or activity), or
- Sustained as a result of doing any work for pay or profit.

Your pay after filing a claim

Sedgwick will send you an initial packet when you file your claim. You will have until the Medical Due Date, which is stated in your initial packet, to provide the required medical documentation. Your pay will continue until your Medical Due Date; this pay is known as "provisional pay." Your pay will be suspended after your Medical Due Date if the required medical documentation has not been approved.

Be sure to provide the required medical documentation at your earliest opportunity. If you do not meet the Medical Due Date deadline, your pay will be suspended effective the first day of the pay period in which it falls. (In cases of pregnancy, verification of your due date is the only medical verification required for the short-term disability maternity benefit, unless you begin your leave of absence more than two weeks before your estimated date of delivery.) If your claim is approved, the approval will be effective as of the date of your disability, and the period of provisional pay will count toward the duration of your disability benefit.

If your claim is denied before the Medical Due Date due to your medical circumstances not meeting the salaried short-term disability plan's definition of disability, your pay will be suspended and Walmart will commence efforts to recover the amount paid to you for the period following your illness or injury.

Provisional pay does not apply to relapse/recurrent claims.

Benefits determination

Sedgwick makes a decision within 45 days of receiving your properly filed claim. The time for a decision may be extended for up to two additional 30-day periods. You will be notified in writing before any extension period that an extension is necessary due to matters beyond Sedgwick's control. Those matters must be identified and you must be given the date by which Sedgwick will make a decision. If your claim is extended due to your failure to submit information Sedgwick deems necessary to decide your claim, the time for decision will be suspended as of the date on which the notification of the extension is sent to you until the date Sedgwick receives your response. If Sedgwick approves your claim, the decision will contain information sufficient to inform you of that decision.

If Sedgwick denies your claim, you will be sent a written notification of the denial, which will include:

- Specific reasons for the decision
- Specific reference to the policy provisions on which the decision is based
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
- A description of the appeal procedures and time limits applicable to such procedures, and
- If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the denial, either
  - The specific rule, guideline, protocol, or other similar criteria, or
  - A statement that such a rule, guideline, protocol, or other similar criteria was relied upon in making the denial and that a copy will be provided free of charge to you upon request.

APPEALING A DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for benefits is denied and you would like to appeal, you must submit a written or oral appeal to Sedgwick within 180 days of the denial. Your appeal should include any comments, documents, records, or any other information you would like considered.

You have the right to request copies, free of charge, of all documents, records, or other information relevant to your claim. Your appeal will be reviewed, without regard to your initial determination, by someone other than the party who decided your initial claim.

Sedgwick will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if it is determined that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification of the denial that will include:

- The specific reason(s) for the adverse determination
- Reference to the specific plan provisions on which the determination was based
- A statement describing your right to request copies, free of charge, of all documents, records, or other information relevant to your claim
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- A statement describing any appeal procedures offered by the Plan.

VOLUNTARY SECOND APPEAL OF A SALARIED SHORT-TERM DISABILITY CLAIM

If your appeal is denied, you may make a voluntary second appeal of your denial orally or in writing to Sedgwick. You must submit your second appeal within 180 days of the receipt of the written notice of denial. You may submit any written comments, documents, records, and any other information relating to your claim. The same criteria and response times that applied to your first appeal, as described earlier, are generally applied to this voluntary second appeal.

All salaried short-term disability appeals should be sent to:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14028
Lexington, Kentucky 40512

When benefits begin

If you are approved for short-term disability benefits, the benefit will begin after a waiting period of seven calendar days, on the eighth calendar day after your disability begins. (There is no waiting period for work-related disabilities that qualify for workers' compensation through Walmart.)

In order for your pay to continue during the initial waiting period of seven calendar days, you may use paid time off (PTO). Salaried short-term disability benefits begin on the eighth calendar day after your eligible disability begins. PTO may not be used while receiving short-term disability benefits.

If you are receiving short-term disability at the end of the PTO plan year, please refer to your location's PTO policy for payout and/or carryover information.

Calculating your benefit

The amount of your short-term disability benefit is based on:

- Your base pay as of your last day worked, and
- The duration of your disability.

Base pay, for purposes of the salaried short-term disability benefit, is defined as follows:

ASSOCIATE TYPE	BASE PAY
Exempt associates	Gross biweekly salary
Non-exempt associates	Hourly rate multiplied by hours scheduled that pay period

If you become disabled and eligible to receive short-term disability benefits, the salaried short-term disability plan pays benefits as described below:

YOUR SALARIED SHORT-TERM DISABILITY PLAN BENEFIT		
Duration of your disability	**Your benefit is:**	
	If your disability does not qualify for workers' compensation through Walmart	**If you have a work-related disability that qualifies for workers' compensation through Walmart**
Up to 7 weeks	After an initial waiting period of 7 calendar days, 100% of your base pay. Benefits begin on the 8th calendar day. You may use PTO during your first 7 calendar days of continuous disability.	100% of your base pay, with no initial waiting period. Benefits are payable as of the date of your disability.
More than 7 weeks, up to 26 weeks	75% of your base pay. For example, if your base pay is $1,000, 75% of $1,000 is a $750 benefit.	Workers' compensation benefits are payable at the applicable state rate; short-term disability benefits make up the difference up to 75% of your base pay. For example, if your base pay is $1,000 and workers' compensation pays 66% for your disability, or $660, short-term disability will pay an additional $90, for a total benefit of $750. (If the legally mandated workers' compensation rate exceeds 75% of your base pay, you will not receive any short-term disability benefit.)
NOTE: For associates who are eligible for legally mandated benefits (as noted in **Legally mandated plans** earlier in this chapter) as well as benefits under Walmart's salaried short-term disability plan, the amount of the benefit under Walmart's salaried short-term disability plan will be reduced by the amount of the legally mandated benefit.		

If a benefit is payable for less than a week, your pay will be based on your base pay divided by your regular work schedule for each day you are disabled.

NOTE: Workers' compensation and short-term disability benefits are made as separate payments.

MATERNITY BENEFIT

Maternity benefits under the salaried short-term disability plan are as described here:

MATERNITY BENEFIT		
Duration of benefit	**Your benefit is:**	**If you are eligible for legally mandated benefits in WA:**
Up to 9 weeks*	100% of your base pay after an initial waiting period of 7 calendar days.	Legally mandated benefits are payable at the applicable state or local government rate; the Walmart salaried short-term disability maternity benefit will make up the difference between the state or local government benefit and 100% of your base pay after an initial waiting period of 7 calendar days.
	Maternity benefits under the salaried short-term disability plan begin on the 8th calendar day after your eligible disability begins. You may use PTO during your first 7 calendar days of continuous disability.	
* You may also be eligible for additional parental and family care pay equal to 100% of your base pay. For more information, refer to the Parental and Family Care Pay policy on **One.Walmart.com**.		
NOTE: For associates who are eligible for legally mandated benefits (as noted in **Legally mandated plans** earlier in this chapter) as well as benefits under Walmart's salaried short-term disability plan, the amount of the benefit under Walmart's salaried short-term disability plan will be reduced by the amount of the legally mandated benefit.		

If you begin your short-term disability leave on your delivery date or up to two weeks before your expected delivery date, you will be deemed to meet the plan's definition of disability and eligible for maternity disability benefits.

If you begin your leave later than your actual delivery date, you must meet the plan's definition of disability and will be eligible for the non-maternity disability benefits only.

If you experience medical complications during pregnancy or post-partum, benefits may be payable under the salaried short-term disability plan after the end of the nine-week duration of maternity benefits if you continue to meet the definition of disability. Benefits would be equal to 75% of your base pay from week 11, up to 25 weeks.

TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT

Benefits payable to you under Walmart's salaried short-term disability plan are company-provided, at no cost to you. Because you do not make any contributions to the salaried short-term disability plan, any benefits payable to you are subject to taxes. Walmart generally withholds federal, state, local, and Social Security taxes from the amount of your benefits.

The salaried short-term disability plan has the right to recover from you, and you must repay, any amount overpaid to you for short-term disability benefits under this plan. See **The Plan's right to recover overpayment** and **Right to salary/wage deduction** in the **Claims and appeals** chapter. If you do not repay overpaid amounts in a timely manner, the company may deduct such amounts from your paycheck or future disability benefit payments, to the extent permitted by law.

When short-term disability benefit payments end

If you are receiving short-term disability benefit payments from the salaried short-term disability plan due to an approved disability, your benefit payments from the plan will end on the earliest of:

- The date you no longer meet the plan's definition of disabled
- The date you fail to furnish the required proof of disability when requested to do so by Sedgwick
- The date you are no longer under the continuous care and treatment of a qualified doctor
- The date you refuse to be examined, if Sedgwick requires an examination
- The last day of the maximum period for which benefits are payable (25 weeks, or nine weeks for maternity disability benefits)
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart
- The date your employment terminates, or
- The date of your death.

When your short-term disability benefits end and for any reason you do not return to work, you must request an extension of your leave; failure to do so may result in your employment being terminated.

Returning to work

Sedgwick will contact you before your expected return-to-work date and advise you of steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return-to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

Notify Sedgwick when you physically return to work. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options, which include requesting an extension of your leave or voluntarily terminating employment. Failure to request an extension may result in your employment being terminated.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less of active full-time work (with or without medical restrictions) and become disabled again from the same or a related condition that caused the first period of disability, as determined by Sedgwick, known as a "relapse/recurrent claim," your short-term disability benefits will pick up where they left off before you came back to work. There will be no additional waiting period. The combined benefit duration will not exceed 25 weeks.

If you return to active full-time work for more than 30 calendar days and then become disabled from the same or a related cause, it will be considered a new disability, and you may be able to receive up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

If you have returned to active full-time work for any number of calendar days and then become disabled from a new and unrelated cause, it will be considered a new disability, and you may qualify for up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

Intermittent leave. If you are able to return to work after a period of short-term disability and need to miss work periodically for reasons related to your disability, notify Sedgwick and your facility of your situation. Your treatment may be covered under your prior short-term disability claim for up to 12 months from the date you return to work from your short-term disability claim. Salaried short-term disability generally pays 100% of your base pay for the duration of your approved intermittent leave. You will not need to use PTO for the absences.

Coverage during a leave of absence or temporary layoff

If you are not working due to an approved non-disability leave of absence or temporary layoff, you will continue to be eligible for short-term disability benefits for 90 days from your last day of work. Your eligibility for short-term disability benefits ends on the 91st day after the beginning of your approved non-disability leave or temporary layoff, but is reinstated if you return to work. See **Benefits continuation if you go on a leave of absence** in the **Eligibility and enrollment** chapter for more information, including details on paying for benefits while on leave.

When coverage ends

Your short-term disability coverage ends:

- At termination of your employment
- On the last day of the pay period when your job status changes from an eligible job status
- On the date you lose eligibility
- On the date of your death
- On the 91st day of an approved non-disability leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company.

If you leave the company and are rehired

If you leave the company and return to work for the company as a salaried associate, you will automatically be reenrolled in the salaried short-term disability plan.

Truck driver short-term disability plan

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This information does not create an express or implied contract of employment or any other contractual commitment. Walmart may modify this information at its sole discretion without notice, at any time, consistent with applicable law.

Truck driver short-term disability plan

If pregnancy, a scheduled surgery, or an unexpected illness or injury keeps you off the job for an extended period, this plan for truck drivers can protect part of your paycheck. When you can't work, the Walmart truck driver short-term disability plan works for you.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get more details or file a claim	Go to **One.Walmart.com**	Call Sedgwick at **800-492-5678**
If you work in Washington (to file a state benefit claim)	Go to **paidleave.wa.gov**	Call state of Washington at **833-717-2273**
Request an appeal of a denied short-term disability claim	Go to **One.Walmart.com/LOA** > **mySedgwick**	Call Sedgwick at **800-492-5678**

What you need to know about truck driver short-term disability

- If you are a full-time truck driver, you are automatically enrolled in the truck driver short-term disability plan. Coverage is effective as of your date of hire and there is no cost to you.
- If you become disabled and are eligible to receive short-term disability benefits, the truck driver short-term disability plan replaces 75% of your average day's pay for up to 25 weeks, after an initial waiting period of seven calendar days. (Different rules may apply to work-related disabilities that qualify for workers' compensation through Walmart. See the chart titled **Your truck driver short-term disability plan benefit** for more information.)
- If your disability is due to pregnancy, the truck driver short-term disability plan replaces 100% of your average day's pay for up to nine weeks, after an initial waiting period of seven calendar days. Generally, no medical evidence is required for this short-term disability maternity benefit.
- The truck driver short-term disability plan is not a benefit covered by ERISA and is not part of the Associates' Health and Welfare Plan.
- The claims and appeals procedures described in this chapter apply to the truck driver short-term disability benefit rather than the procedures in the **Claims and appeals** chapter.

Truck driver short-term disability

You are automatically enrolled in the truck driver short-term disability plan as of your date of hire if you are a full-time truck driver. For details about eligible job classifications, see the **Enrollment and eligibility dates by job classification** section in the **Eligibility and enrollment** chapter.

How truck driver short-term disability is administered

Truck driver short-term disability coverage is administered by Sedgwick Claims Management Services, Inc. (Sedgwick) and is provided by the company at no cost to you.

If you become disabled and eligible to receive short-term disability benefits, the truck driver short-term disability plan generally pays 75% of your average day's pay for up to 25 weeks of an approved disability, after an initial waiting period of seven calendar days of continuous disability. The waiting period begins on your next scheduled work day after your total disability begins. (Disabilities that qualify for workers' compensation through Walmart are treated differently, as described in the chart titled **Your truck driver short-term disability plan benefit**.)

If your disability is due to pregnancy, you will be deemed to meet the definition of disability, and the truck driver short-term disability plan pays a maternity benefit of 100% of your average day's pay for the first nine weeks of an approved disability, after an initial waiting period of seven calendar days.

For your pay to continue during the initial waiting period of seven calendar days, you may use paid time off (PTO). Truck driver short-term disability benefits begin the day after the initial waiting period ends.

LEGALLY MANDATED PLANS

Short-term disability benefits provided by individual states and local governments generally have no impact on your eligibility for the truck driver short-term disability benefit plan through Walmart, or the amount of the benefit you receive under Walmart's plan.

An exception to this policy applies to associates who work in the state of Washington. These associates are eligible to participate in Walmart's truck driver short-term disability plan to supplement their state benefits. To be eligible to receive benefits under the Walmart truck driver short-term disability plan, you must apply through the state or local government for your legally mandated benefits, as permitted by law. The amount of the benefit under Walmart's plan will be reduced by the amount of the legally mandated benefit. The total benefits payable under the Walmart short-term disability plan will not exceed the level of benefits otherwise payable under the plan.

When you qualify for benefits

To qualify for short-term disability benefits through the truck driver short-term disability plan, you must meet the following requirements:

- You must submit medical evidence provided by a qualified doctor that you are disabled as defined by the truck driver short-term disability plan (qualified doctors are legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors [M.D.], osteopaths [D.O.], nurse practitioners, physician's assistants, psychologists, or other medical practitioners recognized by the Associates' Health and Welfare Plan).
- You must receive approval by Sedgwick of your claim.

If your disability is caused by a mental illness or substance abuse, you are encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, or clinical social worker who holds a Master of Social Work (M.S.W.), specializes in mental health and substance abuse, and is licensed pursuant to state law.

Sedgwick may require written proof of your disability or additional information before making a decision on your claim. A statement by your physician that you are unable to work does not by itself qualify you for short-term disability benefits. Approval of a medical leave of absence does not constitute approval for short-term disability benefits.

As defined by the truck driver short-term disability plan, "disabled" or "disability" means that you are unable to perform the essential duties of your job for your normal work schedule, or a license required for your job duties has been suspended due to a mental or physical illness or injury, or pregnancy. Benefits will be payable during a loss of license only while you are disabled or pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. The determination of whether you are disabled is made by Sedgwick on the basis of objective medical evidence, which consists of facts and findings, including but not limited to X-rays, laboratory reports, tests, consulting physician reports as well as reports and chart notes from your physician. In addition, you must be under the continuous care of a qualified doctor and following the course of treatment prescribed. Loss of license by itself is not sufficient for meeting the definition of disability.

If Sedgwick requests that you be examined by an independent physician or other medical professional, you must attend the exam to be considered for benefits.

If your disability is the result of more than one cause, you will be paid as if they were one. The maximum benefit for any one period of disability is limited to 25 weeks, after the initial waiting period.

If your disability is due to pregnancy, you will be deemed to meet the definition of disability, and Sedgwick will not require objective medical evidence as a condition for approving your disability claim for the short-term disability maternity benefit, except in the following situations:

- You begin your leave of absence more than two weeks before your estimated date of delivery, or
- You do not begin your leave of absence immediately after the date of delivery.

The maternity benefit generally begins on the earlier of two weeks before the estimated date of delivery (as determined by a qualified doctor) or no later than the actual date of delivery.

Filing a claim

If you experience a disabling illness or injury, or are planning to begin maternity leave, follow these steps:

STEP 1: Notify Sedgwick to apply for a leave of absence and file a short-term disability claim as soon as you know you will be absent from work due to an illness, injury, or pregnancy. Sedgwick will send you an initial packet providing the information you will need and describing any actions you will need to take. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated. Report your disability online by going to **One.Walmart.com/LOA** > **mySedgwick**, or call **800-492-5678**.

Processing of your claim cannot begin until you have stopped working. All claims for benefits under Walmart's truck driver short-term disability plan must be submitted to Sedgwick within 90 days of the date your disability begins. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

STEP 2: Tell your doctor's office that it will be contacted and asked to complete an attending physician's statement and provide medical information, including the following:

- Diagnosis
- Disability date and expected duration of disability
- Restrictions and limitations
- Physical and/or cognitive exam findings and test results
- Treatment plan, and
- Doctor visit notes.

You must sign a form authorizing your doctor to release this information. (If filing your claim online, an electronic signature is accepted.)

STEP 3: Follow up with your doctor to ensure that information was forwarded to the disability administrator.

If you become disabled, file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption to your wages, or the denial of your claim.

When benefits are not paid

Short-term disability benefits are not paid for an illness or injury that is:

- Not under the care of and being treated by a qualified doctor
- Caused by taking part in an insurrection, rebellion or a riot, or civil disorder
- Resulting from your commission of or attempt to commit a crime (e.g., assault, battery, felony, or any illegal occupation or activity), or
- Sustained as a result of doing any work for pay or profit.

Your pay after filing a claim

Sedgwick will send you an initial packet when you file your claim. You will have until the Medical Due Date, which is stated in your initial packet, to provide the required medical documentation. Your pay will continue until your Medical Due Date; this pay is known as "provisional pay." Your pay will be suspended after your Medical Due Date if the required medical documentation has not been approved.

Be sure to provide the required medical documentation at your earliest opportunity. If you do not meet this Medical Due Date deadline, your pay will be suspended effective the first day of the pay period in which it falls. (In cases of pregnancy, verification of your due date is the only medical verification required for the short-term disability maternity benefit, unless you begin your leave of absence more than two weeks before your estimated date of delivery.) If your claim is approved, the approval will be effective as of the date of your disability, and the period of provisional pay will count toward the duration of your disability benefit.

If your claim is denied before the Medical Due Date due to your medical circumstances not meeting the truck driver short-term disability plan's definition of disability, your pay will be suspended and Walmart will commence efforts to recover the amount paid to you for the period following your illness or injury.

Provisional pay does not apply to relapse/recurrent claims.

Benefits determination

Sedgwick makes a decision within 45 days of receiving your properly filed claim. The time for a decision may be extended for up to two additional 30-day periods. You will be notified in writing before any extension period that an extension is necessary due to matters beyond Sedgwick's control. Those matters must be identified and you must be given the date by which Sedgwick will make a decision. If your claim is extended due to your failure to submit information Sedgwick deems necessary to decide your claim, the time for decision will be suspended as of the date on which the notification of the extension is sent to you until the date Sedgwick receives your response. If Sedgwick approves your claim, the decision will contain information sufficient to inform you of that decision.

If Sedgwick denies your claim, you will be sent a written notification of the denial, which will include:

- Specific reasons for the decision
- Specific reference to the policy provisions on which the decision is based
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
- A description of the appeal procedures and time limits applicable to such procedures, and
- If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the denial, either
  - The specific rule, guideline, protocol, or other similar criteria, or
  - A statement that such a rule, guideline, protocol, or other similar criteria was relied upon in making the denial and that a copy will be provided free of charge to you upon request.

APPEALING A DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for benefits is denied and you would like to appeal, you must submit a written or oral appeal to Sedgwick within 180 days of the denial. Your appeal should include any comments, documents, records or any other information you would like considered.

You have the right to request copies, free of charge, of all documents, records, or other information relevant to your claim. Your appeal will be reviewed, without regard to your initial determination, by someone other than the party who decided your initial claim.

Sedgwick will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if it is determined that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification of the denial that will include:

- The specific reason(s) for the adverse determination
- Reference to the specific plan provisions on which the determination was based
- A statement describing your right to request copies, free of charge, of all documents, records, or other information relevant to your claim
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- A statement describing any appeal procedures offered by the Plan.

VOLUNTARY SECOND APPEAL OF A TRUCK DRIVER SHORT-TERM DISABILITY CLAIM

If your appeal is denied, you may make a voluntary second appeal of your denial orally or in writing to Sedgwick. You must submit your second appeal within 180 days of the receipt of the written notice of denial. You may submit any written comments, documents, records, and any other information relating to your claim. The same criteria and response times that applied to your first appeal, as described earlier, are generally applied to this voluntary second appeal.

All truck driver short-term disability appeals should be sent to:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14028
Lexington, Kentucky 40512

When benefits begin

If you are approved for short-term disability benefits, the benefit will begin after a waiting period of seven calendar days. The waiting period begins on your next scheduled work day after your disability begins. (Work-related disabilities that qualify for workers' compensation through Walmart may have different waiting periods under state law.)

In order for your pay to continue during the initial waiting period of seven calendar days, you may use paid time off (PTO). Truck driver short-term disability benefits begin after the initial waiting period. PTO may not be used while receiving short-term disability benefits.

If you are receiving short-term disability at the end of the PTO plan year, please refer to your location's PTO policy for payout and/or carryover information.

You do not accrue additional PTO while you are receiving short-term disability benefits.

Calculating your benefit

The amount of your short-term disability benefit is based on your average day's pay as of your last day worked. If you become disabled and eligible to receive short-term disability benefits, the truck driver short-term disability plan replaces 75% of your average day's pay as of your last day before your disability for up to 25 weeks, after an initial waiting period of seven calendar days. There is no maximum weekly benefit under the truck driver short-term disability plan.

YOUR TRUCK DRIVER SHORT-TERM DISABILITY PLAN BENEFIT		
Duration of your disability	**Your benefit is:**	
	If your disability does not qualify for workers' compensation through Walmart	**If you have a work-related disability that qualifies for workers' compensation through Walmart**
Up to 26 weeks	After an initial waiting period of 7 calendar days, 75% of your average day's pay. The waiting period begins on your next scheduled workday after your total disability begins. You may use PTO during your first 7 calendar days of continuous disability. For example, if your average day's pay over the week totals $1,000, 75% of $1,000 is a $750 weekly benefit.	75% of your average day's pay. Sedgwick will pay 75% during the state workers' compensation waiting period, then workers' compensation will pay according to the state's compensation rate. Sedgwick will "top off" this pay to 75%. If the state compensation rate is greater than 75%, you will not receive additional benefits from Sedgwick. For example, if your workers' compensation benefit or anticipated benefit is 66%, the short-term disability benefit will provide 9% of your wages. Workers' compensation is not taxed, while short-term disability benefits are taxed. Short-term disability benefits are paid through your payroll check, while workers' compensation is paid through a separate check.
NOTE: For associates who work in Washington and are eligible for legally mandated benefits as well as benefits under Walmart's truck driver short-term disability plan, the amount of the benefit under Walmart's truck driver short-term disability plan will be reduced by the amount of the legally mandated benefit.		

If a benefit is payable for less than a week, your pay will be based on 75% of your average day's pay multiplied by your program for each day you were disabled.

NOTE: Workers' compensation and short-term disability benefits are made as separate payments except in the states of Texas and Wyoming, where the entire benefit is included in the payment you receive from Walmart.

MATERNITY BENEFIT

Maternity benefits under the truck driver short-term disability plan are as described here:

MATERNITY BENEFIT		
Duration of benefit	**Your benefit is:**	**If you are eligible for legally mandated benefits in WA:**
Up to 9 weeks*	100% of your average day's pay after an initial waiting period of 7 calendar days	Legally mandated benefits are payable at the applicable state or local government rate; the Walmart truck driver short-term disability maternity benefit will make up the difference between the state or local government benefit and 100% of your average day's pay after an initial waiting period of 7 calendar days.
	Maternity benefits under the truck driver short-term disability plan begin on the 8th calendar day after your eligible disability begins. You may use PTO during your first 7 calendar days of continuous disability.	
* You may also be eligible for additional parental and family care pay equal to 100% of your average day's pay. For more information, refer to the Parental and Family Care Pay policy on **One.Walmart.com**.		

If you begin your short-term disability leave on your delivery date or up to two weeks before your expected delivery date, you will be deemed to meet the plan's definition of disability and eligible for maternity disability benefits.

If you begin your leave later than your actual delivery date, you will be eligible for the non-maternity disability benefits only.

If you experience medical complications during pregnancy or post-partum, benefits may be payable under the truck driver short-term disability plan after the end of the nine-week duration of maternity benefits if you continue to meet the definition of disability. Benefits would be equal to 75% of your average day's pay from week 11, up to 25 weeks.

TAXES AND YOUR SHORT-TERM DISABILITY BENEFIT

Benefits payable to you under the truck driver short-term disability plan are company-provided, at no cost to you. Because you do not make any contributions to the truck driver short-term disability plan, any benefits payable to you are subject to taxes. Walmart generally withholds federal, state, local and Social Security taxes from the amount of your benefit payments.

The truck driver short-term disability plan has the right to recover from you, and you must repay, any amount overpaid to you for short-term disability benefits under this plan. See **The Plan's right to recover overpayment** and **Right to salary/wage deduction** in the **Claims and appeals** chapter. If you do not repay overpaid amounts in a timely manner, the company may deduct such amounts from your paycheck or future disability benefit payments, to the extent permitted by law.

When short-term disability benefit payments end

If you are receiving short-term disability benefit payments from the truck driver short-term disability plan due to an approved disability, your benefit payments from the plan will end on the earliest of:

- The date you no longer meet the plan's definition of disabled
- The date you fail to furnish the required proof of disability when requested to do so by Sedgwick
- The date you are no longer under the continuous care and treatment of a qualified doctor
- The date you refuse to be examined, if Sedgwick requires an examination
- The last day of the maximum period for which benefits are payable (end of 25 weeks, or nine weeks for maternity benefits)
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart
- The date your employment terminates, or
- The date of your death.

When your short-term disability benefits end and for any reason you do not return to work, you must request an extension of your leave; failure to do so may result in your employment being terminated.

Returning to work

Sedgwick will contact you before your expected return-to-work date and advise you of steps you may need to take, including getting a return-to-work certification completed by your doctor. In some cases, your doctor may release you to work with certain medical restrictions; any such restrictions should be explicitly stated on your return-to-work certification or written release. If you receive a return-to-work certification containing medical restrictions, you may be subject to a review to determine whether a job adjustment or accommodation will help you return to work.

Notify Sedgwick when you physically return to work. If your short-term disability benefits have ended and you have not returned to work or communicated your intentions, Sedgwick will notify you of your options, which include requesting an extension of your leave or voluntarily terminating employment. Failure to request an extension may result in your employment being terminated.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 30 calendar days or less of active full-time work (with or without medical restrictions) and become disabled again from the same or a related condition that caused the first period of disability, as determined by Sedgwick, known as a "relapse/recurrent claim," your short-term disability benefits will pick up where they left off before you came back to work. There will be no additional waiting period. The combined benefit duration will not exceed 25 weeks.

If you have returned to active full-time work for more than 30 calendar days and then become disabled from the same or a related cause, it will be considered a new disability, and you may be able to receive up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

If you have returned to active full-time work for any number of calendar days and then become disabled from a new and unrelated cause, it will be considered a new disability, and you may qualify for up to 25 weeks of benefits. A new benefit waiting period of seven calendar days will apply.

Intermittent leave. If you are able to return to work after a period of short-term disability and need to miss work periodically for reasons related to your disability, notify Sedgwick and your facility of your situation. Your treatment may be covered under your prior short-term disability claim for up to 12 months from the date you return to work from your short-term disability claim. Truck driver short-term disability generally pays 100% of your average day's pay for the duration of your approved intermittent leave. You will not need to use PTO for the absences.

Coverage during a leave of absence or temporary layoff

If you are not working due to an approved non-disability leave of absence or temporary layoff, you will continue to be eligible for short-term disability benefits for 90 days from your last day of work. Your eligibility for short-term disability benefits ends on the 91st day after the beginning of your approved non-disability leave or temporary layoff, but is reinstated if you return to work. See **Benefits continuation if you go on a leave of absence** in the **Eligibility and enrollment** chapter for more information, including details on paying for benefits while on leave.

When coverage ends

Your short-term disability coverage ends:

- At termination of your employment
- On the last day of the pay period when your job status changes from an eligible job status
- On the date you lose eligibility
- On the date of your death
- On the 91st day of an approved non-disability leave of absence (unless you return to work), or
- When the benefit is no longer offered by the company.

If you leave the company and are rehired

If you leave the company and return to work for the company as a full-time truck driver, you will automatically be reenrolled in the truck driver short-term disability plan.

Long-term disability

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Lincoln Financial Group (Lincoln) regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting Lincoln.

Long-term disability

If you become disabled and can't work, the company's long-term disability plan can help. When you enroll, the plan works with other benefits you get during a disability to replace part of your paycheck.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get more details or file a claim	Go to **One.Walmart.com**	Call Lincoln at **800-492-5678**

What you need to know about long-term disability

- Walmart offers a long-term disability (LTD) plan and also an LTD enhanced plan. If you are a full-time hourly or management associate, you are eligible to enroll in either plan.
- The LTD plans work with certain other benefits you receive while disabled to replace 50% of your average monthly wage under the LTD plan or 60% of your average monthly wage under the LTD enhanced plan.
- If you enroll in either plan after your initial eligibility period, your long-term disability coverage will not begin until you complete a 12-month waiting period.

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The LTD plans

You are eligible to enroll in LTD coverage if you are a full-time hourly or management associate. For details about eligible job classifications, see the **Enrollment and eligibility dates by job classification** section in the **Eligibility and enrollment** chapter.

You can choose one of two available plans:

- **The LTD plan.** Provides up to 50% of your average monthly wage up to a maximum monthly benefit of $15,000 after your benefit waiting period if you become disabled as defined by the plan.
- **The LTD enhanced plan.** Provides up to 60% of your average monthly wage up to a maximum monthly benefit of $18,000 after your benefit waiting period if you become disabled as defined by the plan.

Both plans are insured by Lincoln. For information about your waiting period, see **When LTD benefits begin** later in this chapter. For information about your average monthly wage, see **Calculating your benefit** later in this chapter.

The date your coverage begins depends on when you enroll for coverage:

- If you enroll during your initial enrollment period, your coverage begins on your effective date, as detailed in the **Eligibility and enrollment** chapter.
- If you enroll upon transferring from one eligible job classification to another, your coverage begins on your effective date. See the **Eligibility and enrollment** chapter for information on your transition enrollment period and your effective date.
- If you enroll at any time after your initial enrollment period, you will be considered a late enrollee and required to finish a 12-month waiting period before your coverage is effective, as described below. You are not required to pay LTD plan or LTD enhanced plan premiums during your 12-month waiting period.
  - If your late enrollment is due to a status change event, your 12-month waiting period begins on the date of the event.
  - If your late enrollment is during an Annual Enrollment, your 12-month waiting period begin on the date you enroll.

You may drop your LTD plan or LTD enhanced plan coverage at any time; the change is effective the day after you drop coverage. If you drop LTD coverage and later reenroll, you will be treated as a late enrollee with a 12-month waiting period, as described above.
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To receive benefits under the LTD plan or the LTD enhanced plan, you must be actively at work at the time of your disability.

THE COST OF LTD COVERAGE

Your cost for LTD coverage is based on your biweekly earnings, your age, and whether you select the LTD plan or the LTD enhanced plan. Premiums are deducted from all wages, including bonuses. You are not required to pay LTD premiums from any LTD benefit payments you receive. If, however, you receive any other earnings, including bonuses, through the Walmart payroll systems while you are receiving LTD benefits, your premiums will be withheld from those payments.

When you qualify for LTD benefits

Under the terms of the LTD plan and LTD enhanced plans, "disability" or "disabled" means that, due to a covered injury or sickness during the benefit waiting period and for the next 24 months of disability, you are unable to perform the material and substantial duties of your own occupation, and after 24 months of benefit payments, you are unable to perform the material and substantial duties of any occupation.

In determining whether you are disabled, Lincoln does not consider employment factors, including interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing, or loss of professional or occupational license or certification.

To qualify for LTD benefits:

- You must be unable to return to work after the initial benefit waiting period of disability.
- You must continue to be under the appropriate care of a qualified doctor (qualified doctors include legally licensed physicians and practitioners who are not related to you and are performing services within the scope of their licenses).
- Lincoln must receive and approve certification with accompanying medical documentation of a disability from your qualified doctor before benefits are considered for payment.

With respect to covered persons employed as pilots and copilots of an aircraft: "disability" or "disabled" also means that, as a result of an injury or sickness, you are unable to perform the material and substantial duties of your own occupation under the applicable Federal Aviation Administration fitness standards.

PRE-EXISTING CONDITION EXCLUSION

You will not receive LTD benefits for any condition, diagnosed or undiagnosed, for which you received treatment during the 90-day period prior to your effective date, unless you have not been treated for the same or related pre-existing condition for more than 365 days while

insured. Under the terms of the pre-existing condition exclusion, you are receiving "treatment" when you are consulting, receiving care or services provided by or under the direction of a physician, including diagnostic measures; being prescribed drugs or medicines, whether you choose to take them or not; and taking drugs or medicines.

If you change from the LTD plan (50% benefit) to the LTD enhanced plan (60% benefit), the pre-existing condition exclusion will apply to the additional coverage amount. If you had satisfied the pre-existing condition requirement of the LTD plan (50% benefit) and then suffer a disability before you satisfy the pre-existing condition exclusion of the LTD enhanced plan (60% benefit), you will only receive benefits under the LTD plan (50% benefit).

Filing an LTD claim

If you are on an approved short-term disability claim and are eligible for LTD benefits, your claim will be automatically transitioned from Sedgwick to Lincoln. You may also call Lincoln at **800-492-5678** as soon as you know you will need to use your LTD benefit. Lincoln will provide you with additional information on how to complete your claim.

Associates receiving workers' compensation benefits and enrolled in the LTD plan or LTD enhanced plan may be eligible for disability benefits after their benefit waiting period has expired. Call Lincoln at **800-492-5678** to report your LTD claim.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

When benefits are not paid

Benefits are not paid for any LTD claim due to:

- War, declared or undeclared, or any act of war
- Active participation in a riot
- The committing of or attempting to commit a felony or misdemeanor, or
- Cosmetic surgery, unless such surgery is in connection with an injury or sickness sustained while you are a covered person.

No benefit is payable during any period of incarceration.

When LTD benefits begin

If you are approved by Lincoln for LTD benefits, they will begin after your waiting period: 26 weeks or the end of your short-term disability benefits, whichever is longer.

Paid time off (PTO) may not be used while receiving LTD benefits. If you are receiving LTD benefits at the end of the PTO plan year, refer to your location's PTO policy for payout and/or carryover information. You do not accrue additional PTO while receiving LTD benefits.

IF YOU RETURN TO WORK DURING YOUR WAITING PERIOD AND BECOME DISABLED AGAIN

If you cease to be disabled and return to work full-time for a total of 60 calendar days or less during a waiting period, the waiting period will be suspended and you must meet the balance of the waiting period if you become disabled again. If you return to work for a total of more than 60 calendar days while satisfying your benefit waiting period, you must satisfy an entirely new benefit waiting period if you again become disabled before you are eligible to receive LTD benefits.

Calculating your benefit

The amount of your LTD benefit is based on:

- Your average monthly wage, and
- If you are enrolled in the LTD plan or the LTD enhanced plan.

AVERAGE MONTHLY WAGE	
Length of employment	**How average monthly wage is determined**
Employed 12 months or more	Prior annual pre-disability earnings ÷ 12 months For example, the average monthly wage for an associate with prior annual pre-disability earnings of $36,000 is $3,000 ($36,000 ÷ 12).
Employed less than 12 months	Prior annual pre-disability earnings ÷ number of months worked For example, the average monthly wage for an associate with prior annual pre-disability earnings of $21,000 for seven months of work is $3,000 ($21,000 ÷ 7).

Annual pre-disability earnings include:

- Overtime
- Bonuses
- Paid time off (not including any previous disability benefits), and
- Personal pay for the 26 pay periods (52 if paid weekly) prior to your last day worked. Any pay periods in which you have no earnings are excluded, decreasing the number of pay periods used for the calculation.

Commissions or any other extra compensation or fringe benefits are not included.

If you have been employed less than 12 months, an annualized average of earnings will be used.

Your LTD benefit is shown below:

YOUR LTD BENEFIT	
If you are enrolled	**Your coverage is**
In the LTD plan	50% of your average monthly wage minus the amount of other benefits or income you or your family are eligible to receive (for example, Social Security disability benefits*), up to a maximum monthly benefit of $15,000
In the LTD enhanced plan	60% of your average monthly wage minus the amount of other benefits or income you or your family are eligible to receive (for example, Social Security disability benefits*), up to a maximum monthly benefit of $18,000
* See **Other benefits or income that reduces LTD benefits** for more information.	

Your benefit will be no less than $100 or 10% of your gross benefit, whichever is greater, for any month that you are eligible to receive LTD benefits. The total of your monthly disability payment, plus all earnings, cannot exceed 100% of your average monthly wage prior to your disability.

LTD benefits are paid biweekly, as long as you continue to be disabled as defined by the LTD plans.

Lincoln has the right to recover, and you must repay, any amount overpaid to you for LTD benefits under the LTD plan or LTD enhanced plan.

TAXES AND YOUR LTD BENEFIT

You pay 100% of the costs of your LTD coverage with after-tax contributions. As such, benefits payable to you under the LTD plans are not subject to income taxes.

OTHER BENEFITS OR INCOME THAT REDUCES LTD BENEFITS

Your LTD benefit amount is reduced, or offset, by other benefits or income you or your family receives or are eligible to receive. Examples include income from the following:

- Social Security disability insurance
- Social Security retirement benefits granted after the date of disability
- Workers' compensation
- Employer-related individual policies
- No-fault automobile insurance
- Any ongoing short-term disability benefits payable under Walmart short-term disability coverage (i.e., relapse-related benefits)
- An employer retirement plan that begins after the date of the disability, or
- Settlement or judgment, less associated costs of a lawsuit that represents or compensates for your loss of earnings.

If any of the benefits that reduce your LTD benefits are subsequently adjusted by cost-of-living increases, your LTD benefit will not be further reduced. Refer to the policy for a complete list of offsets. You may obtain a copy of the LTD policy by calling Lincoln at **800-492-5678**.

EXAMPLE: REDUCTION OF LTD BENEFIT		
Annual salary: $36,000	**LTD Plan (50%)**	**LTD Enhanced Plan (60%)**
Average monthly wage	$3,000	$3,000
Benefit amount (percentage of average monthly wage, subject to the monthly maximum)	$1,500	$1,800
Less estimated Social Security disability benefit	- $750	-$750
Less dependent's estimated Social Security benefit	- $375	- $375
LTD payment (monthly)	$375	$675

APPLYING FOR SOCIAL SECURITY DISABILITY BENEFITS

You may be eligible to receive Social Security disability benefits after you have been disabled for five months. If your disability has lasted 12 consecutive months, or is expected to, the LTD policy terms may require you to apply for Social Security disability benefits. If the Social Security Administration denies your application for benefits, you will be required to follow the Social Security Administration's appeal process.

Failure to file for Social Security disability benefits could result in your Social Security retirement benefits being reduced when you reach the age of retirement. If you qualify for Social Security disability or retirement benefits while you are receiving benefits under the LTD plan and your Social Security disability claim is approved retroactively, you must reimburse Lincoln for any LTD benefits overpaid during the period covered by the retroactive Social Security approval.

Lincoln may assist you in filing for Social Security disability benefits. To be eligible for assistance, you must be receiving a benefit from Lincoln.

If you are disabled and working

You may be eligible to receive disability benefits if you are partially disabled. Under the Plan, "partial disability" and "partially disabled" mean that, as a result of sickness or injury, you are able to:

- Perform one or more, but not all, of the material and substantial duties of your own or any occupation on a full-time or part-time basis, or
- Perform all of the material and substantial duties of your own occupation on a part-time basis, and
- Earn between 20% and 80% of your indexed pre-disability earnings.

"Pre-disability monthly earnings" means your regular monthly rate of pay in effect for the 26 regular pay periods (52 if paid weekly) immediately prior to your last day worked, divided by 12. Pre-disability earnings include overtime, bonuses, paid time off, vacation, illness protection, and personal pay, but not commissions or other fringe benefits or extra compensation. If you have worked for less than 12 months with the company, your regular monthly rate of pay will be based on the total earnings you actually received while working for the company immediately prior to the date you became disabled, annualized and divided by 12.

"Indexed pre-disability monthly earnings" means your pre-disability earnings increased annually by 7% or the percentage change in the Consumer Price Index, whichever is less.

Lincoln offers a work incentive benefit for the first three months that you are partially disabled and working. You will continue to receive the full amount of your monthly benefit for the first three months if you are partially disabled, unless your benefit and current monthly earnings exceed your pre-disability monthly earnings. Your monthly benefit will be reduced by the excess amount so that the monthly benefit plus your earnings do not exceed 100% of your pre-disability monthly earnings.

After the first three months that you are partially disabled and working, the following calculation is used to determine your monthly benefit for a partial disability.

DISABLED AND WORKING BENEFIT CALCULATION	
$\frac{(A - B) \times C}{A} = D$	
A	Your indexed pre-disability monthly earnings
B	Your current monthly earnings
C	The monthly benefit payable if you were qualified as disabled
D	The disabled and working benefit payable

IF YOU PASS AWAY WHILE RECEIVING LTD BENEFITS

Coverage under the LTD plans ends upon your death. However, if you pass away while receiving LTD benefits, a lump-sum payment of $5,000 or three times your gross monthly LTD benefit, whichever is greater, will be paid to your surviving spouse/partner. If you are not survived by a spouse/partner, the payment will be made to your surviving children, including stepchildren and legally adopted children, in equal shares. However, if any of these children are minors or incapacitated, payment will be made on their behalf to the court-appointed guardian of the children's property. If you are not survived by a spouse/partner or children, the payment will be made to your estate.

When LTD benefit payments end

LTD benefit payments end on the earliest of:

- The date you fail to furnish proof of continued disability and regular attendance of a doctor
- The date you fail to cooperate in the administration of your claim. For example: providing information or documents needed to determine whether benefits are payable and/or determining the benefit amount
- The date you refuse to be examined or evaluated at reasonable intervals
- The date you refuse to receive appropriate available treatment
- The date you refuse a similar job with Walmart, paying comparable wages, where workplace modifications or accommodations are made to allow you to perform the material and substantial duties of your job
- The date you are able to work in your own occupation on a part-time basis but choose not to
- The date your partial disability monthly earnings exceed 80% of your indexed pre-disability earnings
- The date you no longer meet the plan's definition of disabled
- The last day of the maximum period for which benefits are payable (see charts on the next page), or
- The date of your death.

MAXIMUM DURATION OF LTD BENEFITS	
Age when you become disabled	**Benefits duration (months of LTD benefits)**
Prior to age 62	Until normal retirement age (as listed below)
62	48 months
63	42 months
64	36 months
65	30 months
66	27 months
67	24 months
68	21 months
69 or older	18 months

SOCIAL SECURITY NORMAL RETIREMENT AGE	
Year of birth	**Normal retirement age**
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 through 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

IF THE DISABILITY IS DUE TO MENTAL ILLNESS, ALCOHOLISM, OR DRUG ADDICTION

To receive LTD benefits for more than 24 months for the following disabilities, you must be confined in a hospital or other facility licensed to provide medical care:

- Mental illness (excluding demonstrable, structural brain damage)
- Any condition that results from mental illness
- Alcoholism, and
- Non-medical use of narcotics, sedatives, stimulants, hallucinogens, or similar substances.

When you are not confined to a hospital or other licensed facility, there is a 24-month lifetime benefit for these disabilities unless you are fully participating in an extended treatment plan for the condition that caused the disability, in which case the benefit is payable for up to 36 months.

If you return to work and become disabled again

If you return to work for less than six months of active full-time work and become disabled again from the same or a related condition that caused the first period of disability, as determined by Lincoln, known as a "relapse/recurrent claim," the recurrent disability will be part of the same disability.

Your LTD benefits will pick up where they left off before you came back to work. There will be no additional waiting period. The combined benefit duration for both periods of disability will not exceed the maximum duration listed in the chart to the left.

If you return to work as an active full-time associate for six months or more, any recurrence of a disability will be treated as a new disability. A new benefit waiting period must be completed.

Coverage during a leave of absence or temporary layoff

Once your LTD coverage is effective and you are eligible to file a claim for benefits, if you are not actively at work due to an approved non-disability leave of absence or temporary layoff, you will continue to be eligible for LTD benefits for 90 days from your last day of work. Your eligibility for LTD benefits ends on the 91st day after your approved non-disability leave or temporary layoff begins, but is reinstated if you return to active work status within one year. See **Benefits continuation if you go on a leave of absence** in the **Eligibility and enrollment** chapter for more information, including details on paying for benefits while on leave.

When coverage ends

Your LTD coverage ends:

- At termination of your employment, unless you have been absent due to disability during the 26-week benefit waiting period and any period during which premium payments are waived
- On the last day of the pay period when your job status changes from an eligible job status
- Upon failure to pay your premiums
- On the date you lose eligibility
- If you do not return to work after the last day of an approved leave of absence
- When the benefit is no longer offered by the company
- The day after you drop coverage, or
- On the date of your death.

If you leave the company and are rehired

If you leave the company and return to full-time work for the company within 13 weeks, you will automatically be reenrolled for the same coverage plan you had prior to leaving the company (or the most similar coverage offered under the Plan). If you are automatically reenrolled in LTD plan or LTD enhanced plan coverage and choose to drop it after you return, you may do so at any time.

See page 298

If you return to full-time work after 13 weeks, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you lose and then regain eligibility

If you lose eligibility and then regain eligibility within 30 days, you will automatically be reenrolled for the same coverage you had prior to losing eligibility (or the most similar coverage offered under the Plan).

If you lose eligibility and then regain eligibility after 30 days, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

Truck driver long-term disability

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This information is intended to be a summary of your benefits and may not include all policy provisions. If there is a discrepancy between this document and the policy issued by Lincoln Financial Group (Lincoln) regarding the calculation of benefits and limitations under the policy, the terms of the policy will govern. You may obtain a copy of this policy by contacting the Plan.

Truck driver long-term disability

If a disability keeps you off the road and unable to work, this plan works with other benefits you get to replace part of your paycheck. There are two long-term disability plans for truck drivers that pay benefits for different lengths of time.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get more details or file a claim	Go to **One.Walmart.com**	Call Lincoln at **800-492-5678**

What you need to know about truck driver long-term disability

- Walmart offers truck drivers a long-term disability (LTD) plan and also an LTD enhanced plan. If you are a full-time truck driver, you are eligible to enroll in either plan. Each plan offers a choice of full-duration coverage or five-year coverage.
- The truck driver LTD plans works with certain other benefits you receive while disabled to replace 50% of your average monthly wage if you select the truck driver LTD plan or 60% of your average monthly wage if you select the truck driver LTD enhanced plan.
- If you enroll in either plan after your initial eligibility period, you will have to submit Evidence of Insurability, and you may be required to undergo a medical exam at your own expense before you can be approved for coverage.

The truck driver LTD plans

You are eligible to enroll in truck driver LTD coverage if you are a full-time truck driver. You can choose between two coverage plans, each of which is available in two options:

- **LTD plan**
  - Five-year coverage
  - Full-duration coverage
- **LTD enhanced plan**
  - Five-year coverage
  - Full-duration coverage

The truck driver LTD plan options pay benefits as described in the following chart.

Both plans are insured by Lincoln.

TRUCK DRIVER LTD		
	LTD PLAN	**LTD ENHANCED PLAN**
Five-year coverage	Pays 50% of average monthly wage up to a maximum monthly benefit of $15,000	Pays 60% of average monthly wage up to a maximum monthly benefit of $18,000
	Both plans pay benefits for 60 months, unless the longer of the following time periods is less than 60 months, in which case the monthly benefit will be payable for the longer period: • The amount of time shown in the **Maximum duration of truck driver LTD** chart (later in this chapter), or • The amount of time between the date you become disabled and your normal retirement age under the Social Security Act, as shown in the **Social Security normal retirement age** chart (later in this chapter).	
	LTD PLAN	**LTD ENHANCED PLAN**
Full-duration coverage	Pays 50% of average monthly wage up to a maximum monthly benefit of $15,000	Pays 60% of average monthly wage up to a maximum monthly benefit of $18,000
	Both plan options pay benefits for the longer of: • The amount of time shown in the **Maximum duration of LTD benefits** chart (later in this chapter), or • The amount of time between the date you become disabled and your normal retirement age under the Social Security Act, as shown in the **Social Security normal retirement** age chart (later in this chapter).	

The date your coverage is effective depends on when you enroll for coverage:

- If you enroll during your initial enrollment period, your coverage will be effective on your date of hire.
- If you enroll at any time after your initial enrollment period, you will be considered a late enrollee. Your coverage will be effective the first day of the pay period after People Services receives approval from Lincoln. You will be required to provide Evidence of Insurability (you must complete a medical history questionnaire and may be required to undergo a medical exam at your own expense) and may be denied coverage.
- If you enroll in the five-year coverage plan and subsequently decide to enroll in the full-duration coverage plan, you will be considered a late enrollee and required to provide Evidence of Insurability before you can be approved for coverage. Your coverage will be effective the first day of the pay period after People Services receives approval from Lincoln.

You may drop your truck driver LTD plan or truck driver LTD enhanced plan coverage at any time; the change will be effective the day after you drop coverage. If you drop LTD coverage and later decide to reenroll in either plan, you will be treated as a late enrollee, as described above.
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THE COST OF TRUCK DRIVER LTD COVERAGE

Your cost for truck driver long-term disability coverage is based on your biweekly earnings and the type of truck driver LTD coverage you select. Premiums are deducted from all wages, including bonuses. You are not required to pay truck driver LTD premiums from any truck driver LTD benefit payments you receive. If, however, you receive any other earnings, including bonuses, through the Walmart payroll systems while you are receiving truck driver LTD benefits, your premiums will be withheld from those payments.

When you qualify for truck driver LTD benefits

Under the terms of the truck driver LTD plans, "disability" or "disabled" means that, due to an injury or sickness during the benefit waiting period and for the next 24 months of disability, you are unable to perform the material and substantial duties of your own occupation, or you lose medical certification in accordance with the Federal Motor Carrier Safety Regulations. After 24 months of benefit payments, "disability" or "disabled" means that you are unable to perform the material and substantial duties of any occupation.

In determining whether you are disabled, Lincoln does not consider employment factors, including interpersonal conflict in the workplace, recession, job obsolescence, pay cuts, job sharing, or loss of professional or occupational license or certification for reasons other than a covered injury or sickness.

To qualify for truck driver LTD benefits:

- You must be unable to return to work after the initial benefit waiting period of disability.
- You must continue to be under the appropriate care of a qualified doctor (qualified doctors include legally licensed physicians and practitioners who are not related to you and are performing services within the scope of their licenses).
- Lincoln must receive and approve certification with accompanying medical documentation of a disability from your qualified doctor before benefits are considered for payment.

If you file a claim within the first two years of your approval date, Lincoln has the right to re-examine your Evidence of Insurability questionnaire. If material facts about you are found to have been stated inaccurately, the true circumstances will be used to determine if your coverage should be in effect and for what amount, and your premium may be adjusted.

PRE-EXISTING CONDITION EXCLUSION

You will not receive truck driver LTD benefits for any condition, diagnosed or undiagnosed, for which you received treatment during the 90-day period prior to your effective date unless you have not been treated for the same or related pre-existing condition for more than 365 continuous days while insured. Under the terms of the pre-existing condition exclusion, you are receiving "treatment" when you are consulting, receiving care or services provided by or under the direction of a physician, including diagnostic measures; being prescribed drugs or medicines, whether you choose to take them or not; and taking drugs or medicines.

If you change from the five-year duration coverage to the full-duration coverage under either of the truck driver LTD plans, the pre-existing condition exclusion will apply to the additional duration. If you had satisfied the pre-existing condition requirement of the five-year duration coverage plan and then suffer a disability before you satisfy the pre-existing condition exclusion of the full-duration coverage plan, you will only receive benefits under the five-year duration coverage plan.

Filing a truck driver LTD claim

If you are on an approved short-term disability claim and are eligible for LTD benefits, your claim will be automatically transitioned from Sedgwick to Lincoln. You may also call Lincoln at **800-492-5678** as soon as you know you will need to use your truck driver LTD benefit. Lincoln will provide you with additional information on how to complete your claim.

Claims are determined under the time frames and requirements set out in the **Claims and appeals** chapter. You have the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

When benefits are not paid

Benefits are not paid for any truck driver LTD claim due to:

- War, declared or undeclared, or any act of war
- Active participation in a riot
- The committing of or attempting to commit a felony or misdemeanor, or
- Cosmetic surgery, unless such surgery is in connection with an injury or sickness sustained while the individual is a covered person.

No benefit is payable during any period of incarceration.

When truck driver LTD benefits begin

If you are approved by Lincoln for truck driver LTD benefits, they will begin after your benefit waiting period: 26 weeks or the end of your short-term disability benefits — whichever is longer.

Paid time off (PTO) may not be used while receiving LTD benefits. If you are receiving LTD benefits at the end of the PTO plan year, refer to your location's PTO policy for payout and/or carryover information. You do not accrue additional PTO while receiving LTD benefits.

IF YOU RETURN TO WORK DURING YOUR WAITING PERIOD AND BECOME DISABLED AGAIN

If you cease to be disabled and return to work for a total of 60 calendar days or less during a waiting period, the waiting period will be suspended and you must meet the balance of the waiting period if you become disabled again. If you return to work for a total of more than 60 calendar days while satisfying your benefit waiting period, you must satisfy an entirely new benefit waiting period if you again become disabled before you are eligible to receive LTD benefits.

Calculating your benefit

The amount of your truck driver LTD is based on:

- Your average monthly wage, and
- Which truck driver LTD plan you're enrolled in.

AVERAGE MONTHLY WAGE	
Length of employment	**How average monthly wage is determined**
Employed 12 months or more	Your activity pay, mileage rate, and bonuses, paid in the 26 pay periods prior to your last day worked÷ 12 months
Employed less than 12 months	Your activity pay, mileage rate, and bonuses ÷ the number of months worked

Note that any pay periods in which you have no earnings are excluded, decreasing the number of pay periods used for the calculation.

Your truck driver long-term disability benefit is shown below:

YOUR TRUCK DRIVER LONG-TERM DISABILITY BENEFIT	
If you are enrolled	**Your coverage is**
In the truck driver five-year coverage LTD plan or the truck driver full-duration coverage LTD plan	50% of your average monthly wage minus the amount of other benefits or income you or your family are eligible to receive (for example, Social Security disability benefits*), up to a maximum monthly benefit of $15,000
In the truck driver five-year coverage LTD enhanced plan or the truck driver full-duration coverage LTD enhanced plan	60% of your average monthly wage minus the amount of other benefits or income you or your family are eligible to receive (for example, Social Security disability benefits*), up to a maximum monthly benefit of $18,000
* See **Other benefits or income that reduces truck driver long-term disability benefits** for more information	

Your benefit will be no less than $100 or 10% of your gross benefit, whichever is greater, for any month that you are eligible to receive truck driver LTD benefits. The total of your monthly disability payment, plus all earnings, cannot exceed your average monthly wage prior to your disability.

Truck driver LTD benefits are paid biweekly, as long as you continue to be disabled as defined by the truck driver LTD plans.

Lincoln has the right to recover from you any amount that is overpaid to you for truck driver LTD benefits under the truck driver LTD plan or the truck driver LTD enhanced plan.

TAXES AND YOUR LTD BENEFIT

You pay 100% of the costs of your LTD coverage with after-tax contributions. As such, benefits payable to you under the truck driver LTD plans are not subject to income taxes.

OTHER BENEFITS OR INCOME THAT REDUCES TRUCK DRIVER LTD BENEFITS

Your truck driver LTD benefit amount is reduced, or offset, by other benefits or income you or your family receive or are eligible to receive. Examples include income from the following:

- Social Security disability insurance
- Social Security retirement benefits that are granted after the date of disability
- Workers' compensation
- Employer-related individual policies
- No-fault automobile insurance
- Any ongoing short-term disability benefits payable under Walmart short-term disability coverage (i.e., relapse-related benefits)
- An employer retirement plan that begins after the date of the disability, or
- Settlement or judgment, less associated costs of a lawsuit, that represents or compensates for your loss of earnings.

If any of the benefits that reduce your LTD benefits are subsequently adjusted by cost-of-living increases, your LTD benefit will not be further reduced. Refer to the policy for a complete list of offsets. You may obtain a copy of the truck driver LTD policy by calling Lincoln at **800-492-5678**.

EXAMPLE: REDUCTION OF TRUCK DRIVER LTD BENEFIT		
	LTD Plan (50%)	**LTD Enhanced Plan (60%)**
Average monthly wage	$3,000	$3,000
Benefit amount (percentage of average monthly wage, subject to the monthly maximum)	$1,500	$1,800
Less estimated Social Security disability benefit	- $750	- $750
Less dependent's estimated Social Security benefits	- $375	- $375
LTD payment (monthly)	$375	$675

APPLYING FOR SOCIAL SECURITY DISABILITY BENEFITS

You may be eligible to receive Social Security disability benefits after you have been disabled for five months. If your disability has lasted 12 consecutive months, or is expected to, the truck driver LTD policy terms may require you to apply for Social Security disability benefits. If the Social Security Administration denies you benefits, you will be required to follow the Social Security Administration's appeal process.

Failure to file for Social Security disability benefits could result in your Social Security retirement benefits being reduced when you reach the age of retirement. If you qualify for Social Security disability or retirement benefits while you are receiving benefits under any of the truck driver LTD plan options and your Social Security disability claim is approved retroactively, you must reimburse Lincoln for any LTD benefits overpaid during the period covered by the retroactive Social Security approval.

Lincoln may assist you in filing for Social Security disability benefits. To be eligible for assistance, you must be receiving a benefit from Lincoln.

If you are disabled and working

You may be eligible to receive disability benefits if you are partially disabled. Under the truck driver LTD plans, "partial disability" and "partially disabled" mean that, as a result of sickness or injury, you are able to:

- Perform one or more, but not all, of the material and substantial duties of your own or any occupation on a full- time or part-time basis, or
- Perform all of the material and substantial duties of your own occupation on a part-time basis, and
- Earn between 20% and 80% of your indexed pre-disability earnings.

"Pre-disability monthly earnings" means your activity pay, mileage rate, and bonus in effect for the 52 weeks immediately prior to your last day worked, divided by 12.

"Indexed pre-disability monthly earnings" means your pre-disability monthly earnings increased annually by 7% or the percentage change in the Consumer Price Index, whichever is less.

Lincoln offers a work incentive benefit for the first three months that you are partially disabled and working. You will continue to receive the full amount of your monthly benefit for the first three months if you are partially disabled, unless your benefit and current monthly earnings exceed your pre-disability monthly earnings. Your monthly benefit will be reduced by the excess amount so that the monthly benefit plus your earnings do not exceed 100% of your pre-disability monthly earnings.

After the first three months that you are partially disabled and working, the following calculation is used to determine your monthly benefit for a partial disability.

DISABLED AND WORKING BENEFIT CALCULATION	
$\frac{(A - B) \times C}{A} = D$	
A	Your indexed pre-disability monthly earnings
B	Your current monthly earnings
C	The monthly benefit payable if you were qualified as disabled
D	The disabled and working benefit payable

IF YOU PASS AWAY WHILE RECEIVING TRUCK DRIVER LTD BENEFITS

Coverage under the truck driver LTD plans ends upon your death. However, if you pass away while receiving truck driver LTD benefits, a lump sum payment of $5,000 or three times your gross monthly LTD benefit, whichever is greater, will be paid to your surviving spouse/partner. If you are not survived by a spouse/partner, the payment will be made to your surviving children, including stepchildren and legally adopted children, in equal shares. However, if any of these children are minors or incapacitated, payment will be made on their behalf to the court-appointed guardian of the children's property. If you are not survived by a spouse/partner or children, the payment will be made to your estate.

When truck driver LTD benefit payments end

Truck driver LTD benefit payments end on the earliest of:

- The date you fail to furnish proof of continued disability and regular attendance of a doctor
- The date you fail to cooperate in the administration of your claim. For example: providing information or documents needed to determine whether benefits are payable and/or determining the benefit amount
- The date you refuse to be examined or evaluated at reasonable intervals
- The date you refuse to receive appropriate available treatment
- The date you refuse a similar job with Walmart, paying comparable wages, where workplace modifications or accommodations are made to allow you to perform the material and substantial duties of your job
- The date you are able to work in your own occupation on a part-time basis but choose not to
- The date your partial disability monthly earnings exceed 80% of your indexed pre-disability earnings
- The date you no longer meet the plan's definition of disabled
- The last day of the maximum period for which benefits are payable (see charts on the right), or
- The date of your death.

FIVE-YEAR COVERAGE

Five-year coverage pays benefits for 60 months unless the longer of the following time periods is less than 60 months, in which case the monthly benefit will be payable for the longer period:

- The amount of time shown in the **Maximum duration of truck driver LTD** chart on the right; or
- The amount of time between the date you become disabled and your normal retirement age under the Social Security Act, as shown in the **Social Security normal retirement age** chart on the right.

FULL-DURATION COVERAGE

Full-duration coverage pays benefits for the longer of:

- The amount of time shown in the **Maximum duration of truck driver LTD** chart on the right; or
- The amount of time between the date you become disabled and your normal retirement age under the Social Security Act, as shown in the **Social Security normal retirement age** chart on the right.

MAXIMUM DURATION OF LTD BENEFITS

Age when you become disabled	Benefits duration
Prior to age 62	Until normal retirement age (as listed below)
62	48 months
63	42 months
64	36 months
65	30 months
66	27 months
67	24 months
68	21 months
69 or older	18 months

SOCIAL SECURITY NORMAL RETIREMENT AGE

Year of birth	Normal retirement age
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 through 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

IF THE DISABILITY IS DUE TO MENTAL ILLNESS, ALCOHOLISM, OR DRUG ADDICTION

To receive truck driver LTD benefits for more than 24 months for the following disabilities, you must be confined in a hospital or other place licensed to provide medical care:

- Mental illness (excluding demonstrable, structural brain damage)
- Any condition that results from mental illness
- Alcoholism, and
- Non-medical use of narcotics, sedatives, stimulants, hallucinogens, or similar substances.

When you are not confined to a hospital or other licensed facility, there is a 24-month lifetime benefit for these disabilities unless you are fully participating in an extended treatment plan for the condition that caused the disability, in which case the benefit is payable for up to 36 months.

If you return to work and become disabled again

If you return to work for less than six months of active full-time work and become disabled again from the same or a related condition that caused the first period of disability, as determined by Lincoln, known as a "relapse/recurrent claim," the recurrent disability will be part of the same disability. Your LTD benefits will pick up where they left off before you came back to work. No additional waiting period will be required. The combined benefit duration for both periods of disability will not exceed the maximum duration listed in the chart on the previous page.

If you return to work as an active full-time associate for six months or more, any recurrence of a disability will be treated as a new disability. A new benefit waiting period must be completed.

Coverage during a leave of absence or temporary layoff

Once your truck driver LTD coverage is effective and you are eligible to file a claim for benefits, if you are not actively at work due to an approved non-disability leave of absence or temporary layoff, you will continue to be eligible for truck driver LTD benefits for 90 days from your last day of work. Your eligibility for truck driver LTD benefits ends on the 91st day after your approved non-disability leave or temporary layoff begins, but is reinstated if you return to active work status within one year. See **Benefits continuation if you go on a leave of absence** in the **Eligibility and enrollment** chapter for more information, including details on paying for benefits while on leave.

When coverage ends

Your truck driver LTD coverage ends:

- At termination of your employment, unless you have been absent due to disability during the 26-week benefit waiting period and any period during which premium payments are waived
- On the last day of the pay period when your job status changes from an eligible job status
- Upon failure to pay your premiums
- On the date you lose eligibility
- If you do not return to work after the last day of an approved leave of absence
- When the benefit is no longer offered by the company
- On the day after you drop coverage, or
- On the date of your death.

If you leave the company and are rehired

If you leave the company and return to full-time work for the company within 13 weeks, you will automatically be reenrolled for the same coverage you had prior to leaving the company (or the most similar coverage offered under the Plan). If you are automatically reenrolled in truck driver LTD plan or LTD enhanced plan coverage and choose to drop it after you return, you may do so at any time.
See page 298

If you return to full-time work after 13 weeks, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you lose and then regain eligibility

If you lose eligibility and then regain eligibility within 30 days, you will automatically be reenrolled for the same coverage you had prior to losing eligibility (or the most similar plans offered under the Plan).

If you lose eligibility and then regain eligibility after 30 days, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

The Associate Stock Purchase Plan (ASPP)

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The Associate Stock Purchase Plan (ASPP)

The Associate Stock Purchase Plan (ASPP or Plan) allows you to buy Walmart stock conveniently through payroll deductions and through direct payments to the Plan Administrator. You can have any amount from $2 to $1,000 withheld from your biweekly paycheck ($1 to $500 if you are paid weekly) to buy stock. Walmart matches $0.15 for every dollar that you contribute through payroll deduction to purchase stock, up to the first $1,800 you contribute to the Plan in each Plan year (April through March).

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Enroll in the Plan or change your deduction amount	Complete an online enrollment session on **One.Walmart.com/ASPP** or **Workday** for Jet associates	
• Access your account information • Get your account statement • Get a Form 1099	Go to the Computershare website at **computershare.com/walmart**	Call Computershare at **800-438-6278** (hearing impaired: **800-952-9245**) or get the Associate Stock app (available for Apple or Android devices)
Send money directly to Computershare		Send check to: **Computershare** **Attn: Walmart ASPP** **P.O. Box 505042** **Louisville, Kentucky 40233** (Company matching contributions will not be made on money sent directly to Computershare)

What you need to know about the Associate Stock Purchase Plan

- All eligible associates can purchase Walmart stock through convenient payroll deductions and direct payments to Computershare.
- Walmart matches $0.15 for every $1 you put into the Plan through payroll deductions, up to the first $1,800 that you contribute in each plan year.
- There are no fees to purchase shares of Walmart stock through the Plan. You only pay a fee when you sell shares of stock.
- Your shares will be credited to an account that is maintained in your name at Computershare. You can access your account online, by telephone, or app (see **Resources** chart above) to get your balance or sell stock held in your account.

Associate Stock Purchase Plan eligibility

You are eligible to enroll in the Associate Stock Purchase Plan if you are:

- Not a member of a collective bargaining unit whose benefits were the subject of good faith collective bargaining.
- At least 18 years of age or the legal age of majority in your payroll state to participate (19 is the legal age of majority in Alabama and Nebraska). If you live in Puerto Rico, you must be 21 years of age to participate. If you have questions about the age requirement, review your state laws on legal age of majority.

Enrolling in the Associate Stock Purchase Plan

You can enroll in the Plan by completing an online benefits enrollment session on **One.Walmart.com/ASPP** or **Workday** for Jet associates. Before you enroll in this plan, you should carefully review this Associate Stock Purchase Plan brochure and the Plan Prospectus (a copy of which appears on the following pages), as well as the reports and other documents that the company has incorporated by reference into the Plan Prospectus.

The decision to participate in the Plan and to purchase company stock is an individual decision to be made solely by you. The company is not recommending, endorsing, or soliciting your participation in the Plan or purchase of company stock. In making your decision, you should be aware that the past performance of the company stock is not an indication or prediction of future performance. The value of company stock may be affected by many factors, including those outside the company itself, such as economic conditions. The company urges you to consult with your financial and tax advisors regarding your participation in the Plan and investment in company stock.

Walmart's contribution to your company stock ownership

The Associate Stock Purchase Plan allows all eligible associates to buy Walmart stock conveniently through payroll deductions. You can have any whole dollar amount from $2 to $1,000 withheld from your paycheck to buy stock ($1 to $500 for associates with a weekly paycheck).

Walmart contributes to your stock purchase account by matching $0.15 for every $1 you contribute to the Plan through payroll deductions, up to your first $1,800 you contribute in each Plan year. The Plan year runs from April through March. The company match is reflected as income on your check stub and on your Form W-2.

In addition to your payroll deductions, you can also contribute to the Associate Stock Purchase Plan by sending money directly to Computershare, the Plan's administrator, at:

Computershare
Attn: Walmart ASPP
P.O. Box 505042
Louisville, Kentucky 40233

Money sent directly to Computershare will not receive the Walmart matching contribution. The total of your payroll deductions and money sent directly to Computershare cannot exceed $125,000 per Plan year. Dividends paid on the stock you hold as of each dividend record date are automatically reinvested to buy additional shares of stock for you, but do not count against the $125,000 maximum.

The value of the stock you purchase can fluctuate and may decline. There is no way to guarantee that your stock will have the same value in the future that it had when you made the purchase or that the value of the stock will increase.

When making a decision about purchasing Walmart stock, consider all your investments, including other Walmart stock you may own. For investment questions, consult a financial advisor. Investment in the stock is subject to certain risks as described in the Plan Prospectus and Walmart's most recent Annual Report on Form 10-K that is incorporated by reference in the Plan Prospectus.

WALMART'S CONTRIBUTION TO YOUR COMPANY STOCK OWNERSHIP

If you contribute	Your Plan year payroll deduction contribution is	Walmart's matching contribution* is	Total amount used to purchase Walmart stock
$10 biweekly	$260	$39	$299
$20 biweekly	$520	$78	$598
$70 biweekly	$1,820	$270 (Walmart matches $0.15 for every $1 up to $1,800)	$2,090

* Company contributions will be made only on stock purchased through payroll deductions. Company contributions will not be made on money sent directly to Computershare.

Selling stock through the Plan

No fees are charged to you for buying stock; however, when you sell stock you will be charged a fee. The fees charged by Computershare as described in this section are subject to change from time to time.

If you choose to sell your stock, your stock will be sold pursuant to a market order. Your stock will be sold as soon as your request can reasonably be processed. Generally, market orders are executed immediately after they are placed. The price at which your order will be executed is not guaranteed, and the Walmart stock price prior to the execution of your order is not necessarily the price at which your order will be executed.

Generally, any sales of your stock will be executed over the New York Stock Exchange (NYSE). If the NYSE is closed when your order is ready to be processed, your order will be processed as early as possible on the next NYSE trading day. The fee is $25.50 per sale plus $0.05 (five cents) per share sold for each sell you execute.

You can sell stock from **computershare.com/walmart**, from the Associate Stock app (available for Apple and Android devices), or by calling Computershare at **800-438-6278**. You can choose to have your proceeds deposited to a bank account on file or have a check mailed to the address on file at Computershare. If you choose to deposit your proceeds in a bank account, your funds are sent to the bank on the share settlement date, which is two business days from the date of sale. If you select to receive your proceeds via check, you should receive your check within seven to 10 business days after you place an order to sell stock in your Plan account.

The sell fee is automatically deducted from the amount deposited or reported on your check for the net proceeds of the sale. Each time you sell stock, you will receive a transaction summary form. For tax reporting purposes, you'll receive appropriate tax documents (1099B and/or 1099DIV) enclosed with your annual statement in the first quarter of the following year (January through March). These documents will be mailed to your address on file with Computershare and should be used when filing your taxes.

It's important to understand the tax consequences of a stock sale. If you have tax-related questions, please consult a financial advisor or tax consultant.

Keeping track of your Computershare account

You will receive a statement from Computershare at least annually (first quarter) that shows the activity in your account. However, if you opted to receive your statements electronically, you will receive an email informing you that your statement is ready and can be found on **computershare.com/walmart**.

The annual statement you receive will contain important tax information. It is very important that you keep your statement so that you will know the difference between your purchase price and sale price of any shares of stock you sell. You will need this information for your income taxes.

You can access your account information online at **computershare.com/walmart**, by the Associate Stock app (available for Apple and Android devices), or by phone at **800-438-6278** (hearing impaired: **800-952-9245**).

If you request replacement statements from Computershare, there is a $5 charge per statement for previous years' statements. Or, you can obtain copies free of charge through the website at **computershare.com/walmart**.

Ending your participation and closing your account

To cancel your payroll deductions to the Associate Stock Purchase Plan, complete an online benefit enrollment session on **One.Walmart.com/ASPP** or **Workday** for Jet associates.

After you cancel your payroll deductions, you can close your account by selling or transferring the remaining stock in your account. To avoid paying a sales transaction fee twice, cancel your payroll deductions before closing your account. You also have the option to stop payroll deductions and to continue to hold your shares through the Plan at Computershare.

If you leave the company

If you leave the company, you will have several options concerning the status of your account:

- You can keep your account open without the weekly or biweekly payroll deduction and the company match. You can make voluntary cash purchases and benefit from having no broker's fee. There is an annual maintenance fee of $35 per year, which will be automatically deducted from your account through the sale of an appropriate number of shares or portion of a share of stock to cover the fee during the first quarter of the year.
- You can close your account and transfer your shares to another brokerage.
- You can close your account and sell some or all of the shares in your account.

In order to prevent any residual balances and to avoid paying a sales transaction fee twice, wait until you receive your final paycheck before closing your account.

It is very important that you update Computershare if you have an address change after you have left the company.

Prospectus

This document below constitutes a prospectus covering securities that have been registered under the Securities Act of 1933.

50,000,000 Shares

WALMART INC.

Common Stock
($.10 par value per share)

WALMART INC.
2016 Associate Stock Purchase Plan
(formerly, the Wal-Mart Stores, Inc. 2016 Associate Stock Purchase Plan,
the Wal-Mart Stores, Inc. 2004 Associate Stock Purchase Plan,
and the Walmart Stores, Inc. Associate Stock Purchase Plan of 1996)

This prospectus relates to the purchase of the number of shares of the common stock, $0.10 par value per share, of Walmart Inc. ("Walmart," the "Company" or "we") shown above under the Walmart Inc. 2016 Associate Stock Purchase Plan (the "Plan") by eligible Walmart associates who elect to participate in the Plan.

These securities have not been approved or disapproved by the Securities and Exchange Commission or any state securities commission nor has the Securities and Exchange Commission or any state securities commission passed upon the accuracy or adequacy of this prospectus. Any representation to the contrary is a criminal offense.

No one is authorized to give any information or to make any representations other than those contained in this Prospectus and, if given or made, you should not rely on them. This Prospectus is not an offer to sell or a solicitation of an offer to buy any of the securities referred to in this Prospectus in any state or other jurisdiction where such an offer or solicitation would be unlawful. Neither the delivery of this Prospectus nor acquisition of securities described in this Prospectus implies that no change in the affairs of the company has occurred since the date of this Prospectus.

Investment in shares of the Common Stock offered hereby involves certain risks. See "Part I, Item 1A. **Risk Factors**" in Walmart's Annual Report on Form 10-K most recently filed with the Securities and Exchange Commission for a discussion of certain risks that may affect our business, operations, financial condition, results of operations and cash flows. See "**Stock Ownership, fees and risks**" below.

The date of this Prospectus is September 1, 2019

Introduction and overview

The Plan is an amendment and restatement of the Wal-Mart Stores, Inc. 2004 Associate Stock Purchase Plan which had previously amended and restated the Wal-Mart Stores, Inc. Associate Stock Purchase Plan of 1996. The Plan was most recently approved by the stockholders of Walmart at our Annual Stockholders' Meeting held on June 3, 2016. As of June 30, 2019, up to 59,423,969 shares of the company's common stock, par value $.10 per share (the "Stock"), were available for purchase from the company or on the open market under the Plan; 20,000,000 shares of Stock were available for purchase from the company under the Plan; and 30,000,000 shares of Stock were available for purchase on the open market under the Plan. On November 30, 2018, 50,000,000 shares were registered with the United States Securities and Exchange Commission for offer and sale on Registration Statements on Form S-8. Shares of the Stock are listed for trading on the New York Stock Exchange. Participating associates may be referred to as "you" in this Prospectus.

The Plan has two parts — the Stock Purchase Program and the Outstanding Performance Award Program. The Stock Purchase Program gives eligible associates an opportunity to share in company ownership by allowing them to purchase

shares of Stock by payroll deduction. In addition, if they make or have made purchases through such payroll deductions under the Plan, they may also purchase shares of Stock by making voluntary contributions to the Plan out of their other funds. Under the Outstanding Performance Award Program, the company may reward associates for exceptional job performance by awarding shares of Stock to them.

We believe that the Plan is not subject to any provisions of the Employee Retirement Income Security Act of 1974, as amended. The Plan is not qualified under Section 401(a) or 423 of the Internal Revenue Code of 1986, as amended.

Plan administration; account management

The Plan provides that the Compensation and Management Development Committee of our Board of Directors (the "Committee") has the overall authority for administering the Plan. The Committee may delegate (and revoke the delegation of) some or all aspects of Plan administration to the officers or managers of the company or of a wholly-owned or majority-owned subsidiary of the company (which subsidiaries are referred to in this Prospectus as "affiliates"), subject to terms as it deems appropriate. The members of the Committee are selected by Walmart's Board of Directors. The Board of Directors may remove a member from the Committee at its discretion, and a member will cease to be a Committee member if he or she ceases to be a director of Walmart for any reason. At the date of this Prospectus, the members of the Committee were Mr. Steve Reinemund, Mr. Steve Easterbrook, Ms. Carla Harris, and Ms. Marissa Mayer.

The Committee has selected a third-party administrator, currently Computershare Trust Company, N.A. ("Computershare"), to establish and maintain accounts under the Plan. Computershare also serves as the company's stock transfer agent and provides other stock-related services to the company and its shareholders.

The Committee, as administrator of the Plan, or its delegate, must follow the terms of the Plan, but otherwise has full power and discretion to administer the Plan, including, but not limited to, the power to: (i) determine when, to whom and in what types and amounts contributions should be made; (ii) authorize the company to make contributions to eligible associates in any number and to determine the terms and conditions applicable to each such contribution; (iii) set a minimum and maximum dollar, share or other limitation on the various contributions permitted under the Plan; (iv) determine whether an entity of which we own more than 50% or otherwise control, directly or indirectly (an "affiliate") should become (or cease to be) a Participating Employer (as defined below); (v) determine whether (and which) associates of non-U.S. Participating Employers should be eligible to participate in the Plan; (vi) make all determinations deemed necessary or advisable for the administration of the Plan; (vii) make, amend, waive and rescind rules and regulations for the administration of the Plan; and (viii) exercise any powers, perform any acts and make any determinations it deems necessary or advisable to administer the Plan. All decisions made by the Committee under the Plan are final and binding on all persons, including the company and its affiliates, any associate, any person claiming any rights under the Plan from or through any participant, and shareholders of the company. The members of the Committee do not act as the trustees of the participants or hold the Stock credited to the participants' Plan accounts, any funds contributed to the Plan by any associate or the proceeds of any sale of shares of stock in trust for the benefit of the participants.

Plan participation and eligibility

If you are eligible to participate in the Plan, you can become a participant in the Plan by enrolling online at **One.Walmart.com** to authorize payroll deductions to be taken from your regular compensation and contributed to the Plan for the purchase of Stock to be held in your Plan account. You can also become a participant in the Plan if the Committee grants you an award of Stock under the Outstanding Performance Award Program.

All associates of the company and approved affiliates of the company ("Participating Employers") are eligible to participate in the Plan, except:

- If you are restricted or prohibited from participating in the Plan under the law of your state or country of residence, you may not participate in the Plan or your participation in the Plan may be limited. It is your responsibility to ensure there are no such restrictions or prohibitions on your participation in the Plan.
- You must have attained the age of majority in your state of residence or employment to participate. It is your responsibility to ensure you are of sufficient age to participate. The company may terminate your participation if it discovers you are not of legally sufficient age to participate in the Plan.
- If you are a member of a collective bargaining unit whose benefits were the subject of good faith collective bargaining, you are excluded from participation in the Plan.
- If your employer is a non-U.S. Participating Employer, you may participate only if you are an approved associate (listed by group, category or by individual).
- If you are an officer of Walmart subject to subsection 16(a) of the Securities Exchange Act of 1934, or otherwise subject to our Insider Trading Policy, your ability to acquire or sell shares of Stock may be restricted.

If you are on a bona fide leave of absence from the company or a Participating Employer, you will continue to be eligible to make contributions to the Plan during your leave of absence, but you will not be eligible for company matching contributions during that time. If you are on a military leave of absence from the company or a Participating Employer, please contact the Benefits Department to see whether you are eligible to receive company matching contributions during your leave. Please note that you must make contributions from your own funds if you are not receiving a paycheck while you are on a leave of absence, as payroll deduction would not be available as an option. Any other circumstances which would permit you to continue to participate in the Plan while on a leave must be approved by the Committee.

Plan contributions — Stock Purchase Program

To make payroll deduction contributions, you need to complete an online benefits enrollment session at **One.Walmart.com**. Once you have properly enrolled in the Plan, your payroll deduction contributions will continue in accordance with your most recent payroll deduction authorization (subject to any restrictions imposed by the Plan) as long as you are employed by the company or a Participating Employer, unless you change or terminate your payroll deduction authorization or the Plan itself is terminated.

Please note that no deduction will be drawn from any paycheck in which your payroll deduction contribution exceeds your net pay after taxes are withheld. You can change or terminate your payroll deduction authorization by completing an online benefits enrollment session at **One.Walmart.com**. Your request will be processed as soon as practicable. Your enrollment or request may be delayed or rejected if your enrollment or requested change is prohibited at the time of the attempted enrollment or the request by any company policy, including the company's Insider Trading Policy.

Note that payroll deduction contributions are generally taken from your last paycheck as an associate. If you do not want to have payroll deduction contributions taken from your last paycheck, it is important that you timely terminate your payroll deduction authorization. If you work in a state that requires your last paycheck to be paid outside of the normal payroll cycle, payroll deduction contributions will not be taken out of your last paycheck.

Payroll deductions can be as little as $2 or as much as $1,000 per biweekly payroll period. Payroll deductions for associates paid on a weekly basis can be as little as $1 or as much as $500 per weekly payroll period. The amount of any biweekly or weekly deduction in excess of the minimum must be in $1 increments. The Company or your Participating Employer will make a matching cash contribution on your behalf to your Plan account when you make contributions to the Plan by payroll deduction. The matching contribution is currently 15 percent of the first $1,800 you contribute to the Plan by payroll deduction, or up to $270 per Plan year. The company's matching contribution will be used to buy Stock for your Plan account.

If you participate or have participated in payroll deductions under the Plan and your Plan account has not been closed as described below, you can also voluntarily contribute cash (in U.S. dollars) from your other resources to fund the purchase of Stock under the Plan to be held in your Plan account, including after your employment with the Company or any Participating Employer has been terminated. Any voluntary contributions must be made directly to Computershare. Instructions for making such voluntary contributions are available from Computershare. Neither the Company nor your Participating Employer will make matching contributions on amounts you contribute directly to Computershare. In addition, you may also deposit shares of Stock that you hold outside of the Plan (whether you originally acquired those shares through the Plan or otherwise) to your Plan account by making arrangements directly with Computershare.

The total of your payroll deductions and voluntary cash contributions to the Plan cannot exceed $125,000 per Plan year (April 1 through March 31). Dividends credited to your Plan account will not count against the maximum.

The Committee establishes and may change the maximum and minimum contributions, may change the conditions for voluntary cash or Stock contributions, and may change the amount of the matching contributions of an employer at any time.

OUTSTANDING PERFORMANCE AWARD PROGRAM

Under the Outstanding Performance Award component, you can be granted an award of Stock for demonstrating consistently outstanding performance in your job over the period of a month, a quarter or a year. The Committee approves all Outstanding Performance Awards and sets maximum dollar limitations on these awards from time to time.

Your Stock under the Outstanding Performance Award component will be given to you through an account maintained for your benefit by Computershare.

STOCK PURCHASES

Your employer will send all of your payroll deductions along with any matching contributions to Computershare as soon as practicable following each pay period. Computershare will purchase Stock for your Plan account no later than five business days after it receives the funds. If you make a voluntary cash contribution outside of payroll deductions, Computershare will purchase your Stock with that voluntary cash contribution no later than five business days after it receives the funds.

Computershare may purchase Stock for the Plan accounts on a national stock exchange, from the company, or from a combination of these places. However, the Committee reserves the right to direct Computershare to purchase from a particular source, consistent with applicable securities rules and the applicable rules of any national stock exchange.

Typically, when Computershare purchases Stock for the Plan on a national stock exchange, the shares are purchased as part of a bundled group rather than individually for each participant. In some instances, the shares of Stock for a bundled group must be purchased for the Plan over more than one day. When shares of Stock are purchased for you as part of a bundled group, your purchase price for each share of Stock will be equal to the average price of all shares of Stock purchased for that group as determined by Computershare. A participant is not permitted to direct an order for Computershare to purchase shares of Stock solely for himself or herself that are part of the bundled group.

If Computershare buys shares of Stock from the company, whether authorized but unissued shares or treasury shares, the per-share price paid to the company for those shares of Stock will be equal to the Volume Weighted Average Price (VWAP) as reported on the New York Stock Exchange – Composite Transactions on the date of purchase. The VWAP is the weighted average of the prices at which all trades of the company's Stock are made on the NYSE on the date of the Stock is purchased from the company. While the Plan permits the Committee to designate another methodology for valuing Stock purchased from the company, as of the date of this Prospectus no other methodology has been designated.

The number of shares allocated to your Plan account in connection with any purchase of Stock will equal the total amount of the contributions and dividends available for your Plan account and used to fund such purchases, divided by the purchase price for each share of Stock attributable to those purchases as discussed above.

Non-U.S. Participants Please Note: All amounts contributed to the Plan by payroll deduction, all matching contributions, and any contributions made pursuant to the Outstanding Performance Award component will be converted from your local currency to U.S. dollars prior to the time the shares of Stock are purchased. Generally, the exchange rate used is the one for the business day immediately prior to the day the funds are sent to Computershare, but that may not be practicable in all circumstances. All voluntary cash contributions must be converted to U.S. dollars before being sent to Computershare to purchase shares of Stock.

Stock ownership, fees, and risks

STOCK OWNERSHIP

From the time that shares of Stock are credited to your Plan account, you will have full ownership of those shares (including any fractional shares) of Stock. The shares of Stock held in your Plan account will be registered in Computershare's name until you request to have your Stock certificates delivered to you from the Plan account or you sell the shares credited to your Plan account. You may not assign or transfer any interest in the Plan before shares are credited to your account. However, you may sell, transfer, assign or otherwise deal with your shares of Stock credited to your Plan account once they are credited to your Plan account, just like any other stockholder of the company. You may not transfer or assign your Plan account to another person who is not an eligible participant in the Plan. There is no automatic lien or security interest on the shares of Stock held in your Plan account, and the terms of the Plan do not provide for anyone to have or to have the ability to create a lien on any funds or shares of Stock credited to your Plan account. However, you may pledge, hypothecate or deal with the shares of Stock credited to your Plan accounts in the same manner as you may do with other shares of Stock you may own, subject to compliance with our Insider Trading Policy.

For example, you may pledge the shares of Stock credited to your Plan account as collateral in connection with a loan. If you pledge shares of Stock credited to your Plan account to secure a loan under the Stock Secured Line of Credit Program maintained by USBancorp (prior to September 30, 2018) or any other loan made available to you, the lender will have a security interest in the shares of Stock held in your Plan account. Neither Walmart nor any Participating Employer is a sponsor of or will be responsible for any amounts owed by a participant under the Stock Secured Line of Credit Program or any loan. If you fail to repay the amounts you owe to the lender for your loan, including the accrued interest and any fees thereon, the lender may foreclose its lien on, and sell, the number of shares pledged to secure the loan that will yield net sales proceeds in an amount necessary to pay the amounts you owe the lender. If the net proceeds from such a sale of shares are less than the amount you owe the lender, you, and not Walmart or a Participating Employer, will be responsible for paying the deficiency from your other resources.

DIVIDENDS AND VOTING

Dividends on shares in your account will be automatically reinvested in additional shares of Stock. You will be able to direct the vote on each full share of Stock held in your Plan account, but not fractional shares. You will receive at no cost and as promptly as practicable (by mail or otherwise) all notices of meetings, proxy statements, notices of internet availability of proxy materials and other materials distributed by the company to its stockholders. To vote the shares of Stock held in your Plan account, you must deliver signed voting instructions, also known as proxy instructions, in a timely manner described in the company's proxy materials. If you do not provide properly completed and executed voting instructions as described in the company's proxy materials, your shares will not be voted with respect to any election of directors, any advisory vote on executive compensation, or many other matters that may be subject to a shareholder vote. However, in those circumstances, your shares of Stock may be voted in the manner recommended by the company in its proxy statement or as directed by the Committee on matters defined by the New York Stock Exchange as "routine," such as the ratification of the appointment of the company's independent auditors, provided that doing so would comply with applicable law and any applicable listing standard of a national stock exchange.

FEES AND ACCOUNT STATEMENTS

The company pays all fees associated with the purchase of Stock. Generally, no maintenance fees or other charges will be assessed to your Plan account as long as you are employed by the company or one of its affiliates (even if that affiliate is not a Participating Employer). However, you must pay any commissions or charges resulting from other Computershare services you request, for example, brokerage commissions and other fees applicable to the sale of Stock. Computershare can tell you if a particular request would cause you to incur a charge. The fees charged by Computershare described in this Prospectus are subject to change from time to time.

At least annually, you will receive a statement of your account under the Plan, reflecting all activity with respect to your Plan account for the period of time covered by the statement. You may elect to receive your statements online. If you elect to do so, you will receive an email informing you that your statement is ready and can be found on **computershare.com/walmart**. Your annual statement will also contain important tax information. It is very important that you keep your statement so that you will know the difference between your purchase price and sales price of any shares of Stock you sell. You will need this information for your income taxes.

You may also access information regarding your account at any time by logging on to **computershare.com/walmart**. You can access your account information by phone at **800-438-6278** (hearing impaired **800-952-9245**).

If you request replacement statements from Computershare, there is currently a $5 charge per statement for statements for years preceding the most recently completed plan year. Or, you can obtain copies free of charge through the website at **computershare.com/walmart**.

RISKS

Many of your risks of Plan participation are the same as those of any other stockholder of the company, in that you assume the risk that the value of the Stock may increase or decrease. There are no guarantees as to the value of a share of Stock. This means that you assume the risk of fluctuations in the value or market price of the Stock. Our latest Annual Report on Form 10-K filed with the SEC and, as noted below, incorporated by reference in this Prospectus, discusses, and other of our reports filed with the SEC may discuss, certain risks relating to the company, its operations and financial performance that can affect the value, market price and liquidity of the Stock. The company urges you to review those discussions in connection with any determination to participate in the Plan, to change the terms of your participation in the Plan, to terminate your participation in the Plan or to make any voluntary contributions under the Plan.

If you are a non-U.S. participant, you also assume the risk of fluctuation in currency exchange rates. Also, your payroll deductions (as well as the corresponding matching contributions) are applied by Computershare to purchase shares of Stock, such funds are considered general assets of the company or the Participating Employer and, as such, are subject to the claims of the company's or Participating Employer's creditors. No interest will be paid on any contributions to the Plan.

Stock certificate delivery and Stock sales

Computershare will send you, on request, a stock certificate representing any or all full shares of Stock credited to your Plan account at no cost to you. Your shares that are represented by a stock certificate will no longer be credited or otherwise related to any Plan account that you continue to have in effect and the dividends those shares will not be reinvested under the Plan.

You may also have Computershare transfer any or all of the shares of Stock credited to your Plan account into your name in the Direct Registration System. Such a transfer

means that you would hold your shares as "book-entry" securities and your ownership would be shown on our stock transfer records and represented by a statement which shows your holdings of shares of Stock.

You may request that Computershare sell all or a portion of the shares of Stock (including any fractional interests) credited to your Plan account at any time, whether or not you want to close your Plan account.

You will be charged a brokerage commission, as well as any other applicable fees, if for any reason you have Computershare sell shares of Stock held in your Plan account. Any brokerage commission or fees will be at the rates posted by Computershare from time to time. These rates are available upon request from Computershare. A current schedule of Computershare's fees applicable to the Plan can be found at **computershare.com/walmart**. The company negotiated the amount of such fees with Computershare.

If you choose to sell your Stock, your Stock will be sold pursuant to a market order. Although the Plan permits sales of shares of Stock held in Plan accounts to be made through batch orders and such sales have been made through batch orders in the past, sales of shares of Stock under the Plan are now made solely pursuant to market orders. As a result, if you direct Computershare to sell any shares of Stock credited to your Plan account, Computershare will sell those shares in the open market at the then current best available price. However, the price at which your order will be executed is not guaranteed, and the last-traded price for the Stock prior to the execution of your order to sell your shares of Stock is not necessarily the price at which your order will be executed. From time to time, we repurchase shares of Stock in the open market under a stock repurchase program adopted by our Board of Directors. As a result, if Computershare sells shares credited to your Plan account in the open market, we could be the purchaser of such shares. However, we will typically not know if any of the shares of Stock we purchase in the open market are purchased from you. Your shares of Stock will be sold as soon as your request can reasonably be processed. Generally, market orders are executed immediately after they are placed. We expect that any sales of your shares of Stock will be executed over the New York Stock Exchange (the "NYSE"), but orders for those sales need not be executed over the NYSE. If the NYSE is closed when your order is ready to be processed, your sale transaction will be processed as early as practicable on the next NYSE trading day. Orders for the sale of shares of Stock under the Plan may be executed by or through an affiliate of Computershare that is registered with the SEC as a broker-dealer under the Securities Exchange Act of 1934. Sales of the Stock will be made in U.S. dollars. If you are employed outside the U.S. by a Participating Employer and if provided by Computershare for your country, the proceeds from the sale may be converted for a fee to another currency if you request it when you request your Stock to be sold. If the proceeds are converted to another currency, the exchange rate that will be used is the exchange rate published in *The Wall Street Journal* (or other similar source) on the date your sale transaction is executed. You will assume the risk of any fluctuations in currency exchange rates.

Termination of participation; account closure

Once you become a participant in the Plan, you will remain a participant until you elect to close your Plan account and all Stock and sale proceeds credited to it have been distributed out of your Plan account, or until all Stock and sale proceeds have been distributed from your Plan account after your employment with the company or one of its affiliates has terminated.

If you terminate your payroll deduction authorization, or your employment with the company and all its affiliates has terminated, you may choose to continue your Plan account; or you may close your Plan account if you specify this to Computershare. Specifically:

- You may keep your Plan account open (without the weekly or biweekly payroll deduction and your employer's matching contributions). If you keep your account open, you may continue to make voluntary cash contributions and no brokerage commissions will be charged on the purchase of Stock. If you cease to be employed by the company or one of its affiliates, an annual maintenance fee will be charged to your account. Computershare has the option to collect such maintenance fee either in the form of quarterly installments, or in an annual lump sum payment, which is due in the first quarter of each calendar year and will be paid by means of the sale of an appropriate number of shares or portion of a share of Stock by Computershare. (If you are transferred to a company affiliate that is not a Participating Employer, the company may continue to pay the maintenance fee for you.)
- If you own at least one full share of Stock, you may close your Plan account by moving your Stock into a "General Shareholder" account maintained on your behalf by Computershare. You may accomplish this move either by receiving all full shares in certificate form with a check for any fractional share ownership or by re-depositing the shares in the General Shareholder account, or Computershare can move the shares electronically at your request. You should contact Computershare for more information about the fees associated with a General Shareholder account.

- You may close your Plan account by having all shares of Stock in your account sold and the proceeds paid to you, or you can have certificates for full shares (and cash proceeds of any fractional shares paid to you) delivered to you instead. The proceeds of any sale of full or fractional shares will be net of brokerage commissions, sales fees and other applicable charges. Your account will be closed automatically if you terminate employment and there are no shares or fractional shares in your account.

If you die before your Plan account has been closed, your Plan account will be distributed per the legal documentation submitted to Computershare or to your estate, unless you had previously arranged with Computershare to have your stock held in a joint account. In the event you have a joint account, the joint account holder may either make arrangements with Computershare to move your shares into a General Shareholder account maintained by Computershare at his or her own expense or to have the Stock (or proceeds from the sale thereof) distributed, less any applicable fees or commissions.

If you established a joint tenant account prior to April 1, 2018, you may contact Computershare at **800-438-6278** to remove a joint tenant from your account.

Plan amendment and termination

The Plan has no set expiration date. The Board of Directors of the company, the Committee or any other duly appointed committee of the Board of Directors may amend or terminate the Plan at any time. However, if stockholder approval of an amendment is required under law or the applicable rules of a national stock exchange, the amendment will be subject to that approval. No amendment or termination of the Plan will cause you to forfeit: (1) any funds you have contributed to the Plan or matching funds the company has contributed that have not yet been used to purchase shares of Stock; (2) any shares (or fractional shares) of the Stock credited to your Plan account; or (3) any dividends or distributions declared with respect to the Stock after you have made a contribution to the Plan but before the effective date of the amendment or termination.

Tax information

The following summary of the U. S. income tax consequences of the Plan is based on the Internal Revenue Code and any regulations thereunder as in effect as of the date of this Prospectus. The summary does not cover any state or local income taxes or taxes in jurisdictions other than the United States. You should consult your tax advisor regarding individual tax consequences before purchasing Stock under the Plan.

STOCK PURCHASES UNDER THE STOCK PURCHASE PLAN

You have no federal income tax consequences when you enroll in the Plan or when shares of Stock are purchased for you under the Stock Purchase Plan either by payroll deduction or voluntary contribution. The amount of your payroll deductions and any voluntary contributions under the Plan are not deductible for purposes of determining your federal taxable income. The amount of your wages that you have deducted under the Plan and the full value of company matching contributions are ordinary income to you in the calendar year of deduction or the contribution, as the case may be, and will be reported on your pay stub and your W-2. The company deducts all applicable wage withholding and other required taxes from your other compensation (by increasing your payroll withholding and other tax deductions for such purposes) with respect to the amount of your wages deducted under the Plan and the matching contributions to your Plan account, if any. The company is entitled to a tax deduction for the amount of the matching contribution in the same year as you realize the income.

OUTSTANDING PERFORMANCE AWARDS UNDER THE OUTSTANDING PERFORMANCE AWARD PROGRAM

Stock grants under the Outstanding Performance Award Program are taxable as ordinary income in the calendar year of the award, regardless of whether the Stock certificates are given directly to you or the Stock is awarded to your Plan account. Your ordinary income will be the market value of a share of Stock on the date the award is granted, times the number of shares of Stock granted. The market value of any Stock awarded will be reported to you on your W-2. The company will deduct applicable wage withholding and other required taxes from your other compensation (by increasing your payroll deduction for such purposes). The company is entitled to a tax deduction in the same amount and in the same year as you realize the ordinary income.

STOCK SALES OR CERTIFICATE DISTRIBUTIONS

You will not recognize any taxable income when you request to have certificates delivered to you for some or all of the shares of Stock held in your Plan account. However, when you sell or otherwise dispose of your shares of Stock — whether through Computershare or later after you have received your Stock certificates — the difference between the fair market value of the Stock at the time of sale and the fair market value of the Stock on the date you acquired it will be taxed as a capital gain or loss. The holding period to determine whether the capital gain or loss is long-term

or short-term will begin on the date you acquire the Stock (i.e., the date the Stock is credited to your Plan account). The company will have no deduction as a result of your disposition of shares of Stock and will not be liable for the payment of any income or other taxes payable by you on any gain you may realize on the sale of the shares of Stock or imposed on or in connection with the sale transaction.

Available information

To obtain additional information about the Plan or its administrators, please call People Services at **800-421-1362**. You can also write to:

Walmart People Services
Walmart Inc.
508 SW 8th Street
Bentonville, Arkansas 72716-0295

Computershare may be contacted by calling **800-438-6278** (**800 GET-MART**), online at **computershare.com/walmart**, or by writing to the following address for all correspondence, including transactions, Stock certificate requests, Stock powers, voluntary purchases and any customer service inquiries:

Computershare
Attn: Walmart ASPP
P.O. Box 505042
Louisville, Kentucky 40233

Electronic delivery of prospectuses and other documents

To help reduce costs of operating the Plan and to help with our sustainability efforts, we ask you to allow us to deliver prospectuses and other documents related to the Plan electronically and that you access the prospectuses and documents we provide to participants in the Plan over **One.Walmart.com**. Your enrollment in the Plan will constitute your consent to receive or access communications from us about the Plan and prospectuses relating to the purchase of shares of Stock under the Plan electronically through access on **One.Walmart.com**, unless you affirmatively elect to receive paper copies of such communications. At any time after enrollment you may revoke that consent by sending a written revocation of the consent to receive Plan documents electronically to the Benefits Department at the address appearing below. In addition, you may request a paper copy of the then current prospectus relating to purchases of shares of Stock under the Plan and of our most recent Annual Report on Form 10-K by writing the Benefits Department and those documents will be provided to you free of charge.

Documents incorporated by reference

The following documents filed by the company with the Securities and Exchange Commission (the "Commission") (File No. 1-6991) are hereby incorporated by reference in and made a part of this Prospectus:

- The company's Annual Report on Form 10-K for the fiscal year ended January 31, 2018;
- The company's Quarterly Reports on Form 10-Q for the fiscal quarters ended April 30, 2018 and July 31, 2018
- The company's Current Reports on Form 8-K filed with the Commission on June 5, 2018 and June 26, 2018;
- The company's definitive Proxy Statement for the 2018 Annual Shareholders' Meeting, filed with the Commission on April 20, 2018; and
- Exhibit 99.1 to the Company's Registration Statement on Form S-8 (File No. 333-214060)

All documents filed by the company pursuant to Sections 13(a), 13(c), 14 and 15(d) of the Securities Exchange Act of 1934 (the "Exchange Act") on or after the date of this Prospectus shall be deemed to be incorporated by reference in this Prospectus and to be a part hereof from the date of filing of such documents, except for information furnished to the Commission that is not deemed to be "filed" for purposes of the Exchange Act (such documents, and the documents listed above, being hereinafter referred to as "Incorporated Documents"). Any statement contained in an Incorporated Document shall be deemed to be modified or superseded for purposes of this Prospectus to the extent that a statement contained herein or in any other subsequently filed Incorporated Document modifies or supersedes such statement. Any such statement so modified or superseded shall not be deemed, except as so modified or superseded, to constitute a part of the Section 10(a) prospectus of the company relating to purchases under the Plan of the shares of Stock described on the cover page of this Prospectus. This document and the documents incorporated by reference herein constitute such Section 10(a) prospectus.

These documents and the company's latest Annual Report to Stockholders and any other documents required to be delivered to you under Rule 428(b) under the Securities Act of 1933, as amended, are available to you without charge upon written or oral request. Please direct your requests for documents to:

Walmart Inc.
Benefits Department
508 SW 8th Street
Bentonville, Arkansas 72716-0295

Or you may call People Services at **800-421-1362**.

The Walmart 401(k) Plan

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The legal name of the Plan is the Walmart 401(k) Plan. This document is being provided solely by your employer. No affiliate of Bank of America Corporation has reviewed or participated in the creation of the information contained herein.

The Walmart 401(k) Plan

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Enroll in or change your pretax contribution and/or your catch-up contribution	Go to **One.Walmart.com** or **Workday** for Jet associates or the Plan's website at **benefits.ml.com**	Call the Customer Service Center at **888-968-4015**
• NEW for February 1, 2020: you can make Roth contributions • Enroll in or change your pretax, Roth, and/or your catch-up contributions • Request a rollover packet to make a rollover contribution • Get a fee disclosure sheet • Get information about your Plan accounts • Get a copy of your quarterly statement • Request a hardship withdrawal or a withdrawal after you reach age 59½ • Change your investment fund choices • Request a payout when you leave Walmart • Get information about your Plan investment options • Request a withdrawal of your rollover contributions • Request a loan from your Plan account	Go to **benefits.ml.com**	Call the Customer Service Center at **888-968-4015**
Designate a beneficiary	Go to **One.Walmart.com** or **Workday** for Jet associates	

What you need to know about the Walmart 401(k) Plan

- You are eligible to make your own contributions to the Plan as soon as administratively feasible after your hire date. You can contribute from 1% to 50% of your eligible pay each pay period.
- You can elect to make pretax salary deferral contributions and, beginning February 1, 2020, Roth salary deferral contributions. Pretax salary deferral contributions (and earnings thereon) are not subject to current federal income tax and, in most cases, state or local taxes, until distributed from the Plan. Roth salary deferral contributions are made on an after-tax basis, but the contributions and, in most cases, the earnings thereon are not subject to federal income tax when distributed to you (as long as the distribution meets certain requirements).
- If you are credited with at least 1,000 hours of service in your first year and contribute to your account, you begin receiving matching contributions on the first day of the calendar month following your first anniversary of employment.
- After you become eligible for matching contributions, Walmart matches each dollar you contribute, up to 6% of your eligible annual pay. (Contributions you make before you become eligible for matching contributions are not matched.)
- You are always 100% vested in the money you contribute and the money Walmart contributes to your Company Match Account.
- You choose how to invest all contributions to your Plan account.
- If you do not specify how your contributions will be invested, they are automatically invested in the Plan's default investment option, the myRetirement Funds.
- The Plan accepts rollover contributions from other eligible retirement plans. You can withdraw your rollover contributions at any time.
- You may request a loan from your Plan account, subject to Plan rules.

This is a summary of benefits offered under the Plan as of October 1, 2019. Should any questions arise about the nature and extent of your benefits, the formal language of the Plan document, not the informal wording of this summary, will govern.

Walmart 401(k) Plan eligibility

ASSOCIATES WHO ARE ELIGIBLE TO PARTICIPATE IN THE PLAN

All associates of Walmart Inc. or a participating subsidiary are eligible to participate in the Plan, except:

- Leased employees; nonresident aliens with no income from U.S. sources; independent contractors or consultants
- Anyone not treated as an employee of Walmart or its participating subsidiaries
- Associates covered by a collective bargaining agreement, to the extent that the agreement does not provide for participation in this Plan
- Associates represented by a collective bargaining representative after Walmart has negotiated in good faith to impasse with the representative on the question of benefits, and
- Certain other associates who may be jointly employed by Walmart and an affiliate that is not a participating affiliate in the Plan.

For purposes of this Summary Plan Description, all participating subsidiaries are referred to as "Walmart."

WHEN PARTICIPATION BEGINS

For purposes of your contributions. If you are an eligible associate, you may begin contributing to the Plan as soon as administratively feasible after your date of hire is entered into the payroll system. See **Enrolling in the Plan** later in this summary for details about the enrollment process.

For purposes of matching contributions. If you are an eligible associate, you will begin receiving matching contributions on the first day of the calendar month following your first anniversary of employment with Walmart if you are credited with at least 1,000 hours of service during your first year and are contributing your own contributions (both pretax contributions and Roth contributions) to the Plan. (Matching contributions are not made with respect to contributions you make before you become eligible for matching contributions.) For example, if your date of hire was December 15, 2018 and you are credited with 1,095 hours by December 15, 2019 (your first anniversary), then you will begin receiving matching contributions on January 1, 2020, with respect to any contributions you make to the Plan on or after that date.

If you are not credited with 1,000 hours of service during your first year, your eligibility for the matching contributions will be determined on hours worked during the Plan year, which runs from February 1 to January 31. You will be eligible to receive matching contributions on any contributions you make to the Plan on or after the February 1 that follows the Plan year in which you are credited with at least 1,000 hours of service. For example, if your date of hire is December 15, 2018, and you are credited with only 595 hours by December 15, 2019 (your first anniversary), but you work 1,095 hours during the February 1, 2019–January 31, 2020 Plan year, you will begin receiving matching contributions on February 1, 2020 with respect to any contributions you make to the Plan on or after that date.

HOW HOURS OF SERVICE ARE CREDITED UNDER THE PLAN

If you are an hourly associate, the hours counted toward the 1,000-hour requirement are credited as follows:

- Hours, including overtime hours, you work for Walmart or any subsidiary are counted.
- Hours for which you receive paid leave or personal time off are also counted.
- When a payroll period overlaps two Plan years, hours are credited toward the Plan year in which they are actually worked.

If you are a salaried associate or truck driver, the hours counted toward the 1,000-hour requirement are credited as follows:

- You are credited with 190 hours per month for each month in which you work at least one hour for Walmart or a subsidiary.
- In general, you must work at least six months of the Plan year to have 1,000 hours credited for the year. (Vacation paid to you in cash after you leave Walmart does not give you additional service for this purpose.)

If you become an associate of Walmart or any subsidiary as the result of the acquisition of your prior employer, special service crediting rules may apply to you.

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), veterans who return to Walmart or a subsidiary after a qualifying deployment may be eligible to have their qualified military service considered toward their hours of service under the Plan. Call People Services at **800-421-1362** for more details.

Enrolling in the Plan

Shortly after you become eligible to contribute to the Plan, (i.e., shortly after your date of hire), you will receive an enrollment packet at your home address on file. This packet tells you how you can make contributions from your pay into your 401(k) Account or Roth Account and explains how you can direct the investment of your Plan funds by choosing from among a menu of investment options with varying investment objectives and associated risks. Because the Plan is intended to be an important source for your financial security at retirement, you should read all information pertaining to the Plan carefully, and consult with your family, tax and financial advisors before making any decisions.

Once you satisfy the eligibility requirements for receiving matching contributions, Walmart will match all of your subsequent contributions dollar-for-dollar up to 6% of eligible annual pay, as explained in the **Walmart's contributions to your Company Match Account** section.

To begin contributing to the Plan, enroll online at **One.Walmart.com**, **Workday** for Jet associates, or **benefits.ml.com**. You can also call the Customer Service Center at **888-968-4015**. Note, however, that if you wish to make Roth contributions to the Plan, you must enroll at **benefits.ml.com**. You can enroll at any time after you become eligible.

When you enroll, you can choose:

- The percentage of your pay that you want to contribute on a per-pay-period basis and, after February 1, 2020, whether your contributions will be pretax contributions or Roth contributions (see **Making contributions to your account** later in this summary), and
- How to invest your accounts among the Plan's investment options. The Plan's investment options and procedures are described in your enrollment packet.

After you enroll, a confirmation notice will be mailed to your home address, or, if you have chosen electronic delivery of Plan materials, you will receive an email notification when the confirmation is available. The confirmation will show the percentage of your pay that you have chosen to contribute from each check, whether you elected to make pretax contributions or Roth contributions, and the investment options you have elected. Review the confirmation to make sure your enrollment information is correct.

Your contributions to the Plan will start as soon as administratively feasible, normally within two pay periods after you enroll. No contributions are taken from your pay before you become an eligible participant in the Plan. Only participants who contribute their own funds to the Plan will have those contributions matched by Walmart, subject to eligibility requirements outlined in the **Walmart's contributions to your Company Match Account** section.

It is your responsibility to review your paychecks to confirm that your election is implemented correctly. If you believe your election has not been implemented correctly, notify the Customer Service Center at **888-968-4015** in a timely manner so that corrective steps can be taken. Your notification will not be considered timely if it is made more than six months after the date you make your election.

Your Walmart 401(k) Plan accounts

The Walmart 401(k) Plan consists of several accounts. You will have some or all of the following accounts:

- **Pretax Account:** This account holds your pretax contributions to the Plan (including your catch-up contributions, if any), as adjusted for earnings or losses on those contributions.
- **Roth Account:** This account holds your Roth contributions to the Plan on or after February 1, 2020 (including your Roth catch-up contributions, if any), as adjusted for earnings or losses on those contributions.
- **Company Match Account:** This account holds Walmart's matching contributions, as adjusted for earnings or losses on those contributions.
- **Pretax Rollover Account:** This account holds any contributions that you rolled over to this Plan from another eligible retirement plan, as adjusted for earnings or losses on those contributions.
- **Roth Rollover Account:** This account holds any amounts you rolled over to this Plan from your designated Roth salary deferral account in another eligible retirement plan.
- **Company Funded 401(k) Account:** This account holds the discretionary Walmart contributions to the 401(k) portion of the Plan made for Plan years ended on or before January 31, 2011, as adjusted for earnings or losses on those contributions.
- **Company Funded Profit Sharing Account:** This account holds the discretionary Walmart contributions to the profit-sharing portion of the Plan made for Plan years ended on or before January 31, 2011, as adjusted for earnings or losses on those contributions.

The chart on the following page provides a summary of some of the differences between these accounts. These differences are discussed in more detail throughout this summary.

Note that if you become an associate of Walmart or any subsidiary as the result of the acquisition of your prior employer, and you participated in your prior employer's 401(k) plan, you may have other accounts in this Plan that hold amounts you contributed to your prior employer's plan.

Making a rollover from a previous employer's plan or IRA

When you come to work for Walmart, you may have funds owed to you from a previous employer's retirement plan (including a 401(k) plan, a profit-sharing plan, a 403(b) plan of a tax-exempt employer or a 457(b) plan of a governmental employer). If so, you may be able to roll over that money to this Plan. You may also roll over pretax funds you have in an individual retirement account (IRA). You may directly roll into the Plan amounts from a designated Roth salary deferral account in another qualified retirement plan. If you roll over funds to this Plan, keep these points in mind:

- Once you roll funds into the Walmart 401(k) Plan, those funds are subject to the rules of this Plan, including payout rules, and not the rules of your former employer's plan or your IRA
- Your rollover contribution will be placed in your Rollover Account and will be 100% vested, and
- You may withdraw all or any portion of your rollover contributions at any time.

If you're interested in making a rollover contribution to the Plan, contact the Customer Service Center at **888-968-4015** or visit **benefits.ml.com** to obtain a rollover packet.

Making contributions to your account

After you become a participant in the Plan, you may generally choose to contribute from 1% up to 50% of each paycheck to your Pretax Account and/or your Roth Account. Your contributions (including both pretax contributions and Roth contributions) in any calendar year, however, may not exceed a limit set by the IRS. For 2020, the limit is $19,500. This amount will be increased from time to time by the IRS.

The IRS also limits the amount of annual compensation that can be taken into account under the Plan for any participant. For 2020, this limit is $285,000.

On and after February 1,2020, you can choose whether your contributions will be "pretax contributions" and/or "Roth contributions." Together, these contributions are called your "401(k) contributions" in this summary. (Before February 1, 2020, all 401(k) contributions are pretax contributions.)

- Pretax contributions are deducted from your pay *before* federal income taxes are withheld. This means that you don't pay federal income taxes on amounts you contribute to the Plan. Earnings on these contributions accumulate tax-free and are not taxed until your Pretax Account is actually distributed to you from the Plan. You may also save on state and local taxes as well, depending on your location. Please note that your contributions are subject to Social Security taxes in the year the amount is deducted from your pay. Distributions from the Plan, however, are not subject to Social Security taxes.
- Roth contributions are deducted from your pay *after* federal income taxes are withheld. This means that you pay federal and state income taxes, and also Social Security taxes, on amounts you contribute to the Plan in the year the amount is deducted from your pay. Roth contributions, and earnings on those contributions, are normally not subject to federal and state income tax when your Roth Account is distributed to you from the Plan. In order for the earnings to be tax-free, the distribution must be a "qualified" distribution, as explained later. (Note that income limitations applicable to Roth IRAs are not applicable to Roth contributions to the Plan. You may choose to make Roth contributions regardless of your income.)

In addition, if you make contributions to the Plan, you may be eligible for a "Saver's Credit." If you are a married taxpayer who files a joint tax return and you have a modified adjusted gross income (MAGI) of $65,000 or less (for 2020) or a single taxpayer with $32,500 or less (for 2020) in MAGI on your tax return, you are eligible for this tax credit, which can reduce your taxes. For more details, your tax preparer may refer to IRS Announcement 2001-106.

PROFIT SHARING AND 401(K) ACCOUNT DIFFERENCES

	Source of contributions	May participants choose investments?	Vesting percentage	Are hardship withdrawals available?	Are in-service withdrawals available after age 59½?
Pretax Account/ Roth Account (including catch-up contributions)	You	Yes	100%	Yes	Yes
Company Match Account	Walmart	Yes	100%	Yes, beginning Feb. 1, 2020	Yes
All Rollover Accounts	You	Yes	100%	Yes	Yes
Company Funded 401(k) Account	Walmart	Yes	100%	Yes, beginning Feb. 1, 2020	Yes
Company Funded Profit Sharing Account	Walmart (except for rollovers you made to the Profit Sharing Plan)	Yes	2 years – 20% 3 years – 40% 4 years – 60% 5 years – 80% 6 years – 100% (Rollovers are immediately 100% vested)	Yes, beginning Feb. 1, 2020	Yes (to the extent vested)

HOW YOUR 401(k) CONTRIBUTION IS DETERMINED

The percentage of pay you elect to contribute to the Plan is applied to the following types of pay:

- Regular salary or wages, including bonuses and any pretax dollars you use for your pretax contributions or to purchase benefits available under the Walmart Inc. Associates' Health and Welfare Plan
- Overtime, paid time off (used and paid out), bereavement, jury duty, and premium pay
- Most incentive plan payments
- Holiday bonuses
- Special recognition awards, such as the Outstanding Performance Award
- Differential wage payments you receive from Walmart while you are on a qualified military leave. This means that the contribution you have in effect when you go on the leave will continue to be applied to your differential wage payments while you are on the leave unless you change your election, and
- Transition pay designated as relating to a WARN Act event.

The percentage of pay you elect to contribute to the Plan will not be applied to the following types of pay:

- The 15% Walmart match on the Associate Stock Purchase Plan
- Reimbursement for expenses like relocation
- Approved disability pay
- Equity income, including income from stock options or restricted stock rights, or
- Upon your termination of employment, a final paycheck paid prior to the end of a normal pay cycle (unless it is administratively practicable to withhold your contribution from that paycheck).

CHANGING YOUR 401(k) CONTRIBUTION AMOUNT

You can increase, decrease, stop, or begin your contributions at any time by logging on to **One.Walmart.com**, **Workday** for Jet associates, or **benefits.ml.com**. You may also call the Customer Service Center at **888-968-4015**. Your change will be effective as soon as administratively feasible, normally within two pay periods. If you change your contribution amount, a confirmation notice will be sent to your home address or, if you have chosen electronic delivery of Plan documents, you will receive an email notification when the confirmation is available. It is your responsibility to review your paychecks to confirm that your election is implemented correctly. If you believe your election has not been implemented correctly, notify the Customer Service Center at **888-968-4015** in a timely manner, so that corrective steps can be taken. Your notification will not be considered timely if it is more than six months after the date you make your election. If you do not notify the Customer Service Center in a timely manner, the amount that is being withheld from your paycheck will be treated as your deferral election.

IF YOU ARE AGE 50 OR OLDER (CATCH-UP CONTRIBUTIONS)

If you are age 50 or older (or will be age 50 by the end of the applicable calendar year) and you are contributing up to the Plan or legal limits, you are allowed to make additional contributions. These are called "catch-up contributions" and are made by payroll deduction just like your other contributions. You can choose whether your catch-up contributions will be either pretax contributions or Roth contributions. For 2020, your catch-up contributions may be any amount up to the lesser of $6,500 or 75% of your eligible annual pay. This amount may be adjusted from time to time by the IRS. Your catch-up contributions will be credited to your Pretax Account or your Roth Account, depending on which type of contributions you elect to make. Remember, Roth contributions can be made only at **benefits.ml.com**.

For example, if you elect to contribute the maximum amount of $19,500 in the 2020 calendar year, or if you elect to contribute the maximum percentage of your eligible annual pay allowed under the Plan, you could elect to contribute up to an additional $6,500 during the 2020 calendar year. If you are interested in making catch-up contributions, you can enroll online at **One.Walmart.com**, **Workday** for Jet associates, or **benefits.ml.com**, or by calling the Customer Service Center at **888-968-4015**.

CONTRIBUTING TO MORE THAN ONE PLAN DURING THE YEAR

The total amount you can contribute (including pretax contributions and Roth contributions) to this Plan and to any other employer plan (including 403(b) annuity plans, simplified employee pensions or other 401(k) plans) is $19,000 for the 2019 calendar year, or $25,000 if you are eligible for catch-up contributions. This amount may be increased from time to time by the IRS. If you contribute to more than one plan during the year, it is your responsibility to determine if you have exceeded the legal limit.

If your total contributions go over the legal limit for a calendar year, you should request that the excess amount be refunded to you. The excess amount (except as noted below with respect to Roth contributions) must be included in your income for that year and will be taxed. In addition, if the excess amount is not refunded to you by April 15 following the year the amount was deferred, you will be taxed a second time when the excess amount is distributed to you. To request that excess contributions be returned to you from this Plan, contact People Services at **800-421-1362** no later than April 1 following the calendar year in which the excess contributions

were made. The Administrator will establish procedures for determining whether your pretax contributions or Roth contributions will be returned to you, if you contributed both types of contributions during the calendar year. To the extent excess amounts are distributed from your Roth contributions, the Roth contributions will not be taxable to you, but related earnings that are distributed will be taxable to you. Any matching contributions related to refunded contributions will be forfeited.

IF YOU HAVE QUALIFIED MILITARY SERVICE

If you miss work because of qualified military service, you may be entitled under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) to make up contributions you miss during your military service (that is, to make contributions equal to the amount you would have been eligible to make if you were working for Walmart). For more information, contact People Services at **800-421-1362**.

Walmart's contributions to your Company Match Account

Once you are eligible to receive matching contributions, Walmart will make matching contributions to your Company Match Account equal to 100% of your subsequent contributions (including pretax, Roth, and catch-up contributions), up to 6% of your eligible annual pay. Matching contributions are not made with respect to contributions you make before you become eligible for matching contributions. After you become eligible for matching contributions, the company matching contribution will be made to your Company Match Account each pay period until you reach the full amount of the company matching contribution for which you are eligible for that Plan year. Your eligible annual pay for this purpose is the same as outlined above for determining your 401(k) contributions to the Plan, but does not include amounts paid to you before you become eligible to receive matching contributions.

As previously noted, if you miss work because of qualified military service, you may be entitled under USERRA to make up 401(k) contributions that you missed during your military service. If you do make up any 401(k) contributions, Walmart is required to make up matching contributions you would have received with respect to those contributions. If you think this rule applies to you, contact People Services at **800-421-1362**.

VESTING IN YOUR COMPANY MATCH ACCOUNT

You are always 100% vested in Walmart's matching contributions to your Company Match Account.

VESTING IN YOUR COMPANY FUNDED PROFIT SHARING ACCOUNT

If you have a Company Funded Profit Sharing Account (see **Your Walmart 401(k) Plan accounts** earlier in this summary), the vested percentage of your Company Funded Profit Sharing Account is the portion that you are entitled to receive if you leave Walmart. Your account statements show your vested percentage.

You become vested in your Company Funded Profit Sharing Account (other than rollovers in that account, which are always 100% vested) depending on your years of service with Walmart as follows:

PROFIT SHARING VESTING SCHEDULE*

Years of service	Vested percentage
Less than two	0%
2	20%
3	40%
4	60%
5	80%
6 or more	100%

* Applies to participants actively employed on or after January 31, 2008.

NOTE: If you terminated employment before February 1, 2007, your payout was based on the prior vesting schedule and not the vesting schedule shown above.

A year of service for this purpose is a Plan year (February 1–January 31) in which you are credited with at least 1,000 hours of service under the hours of service rules (see **How hours of service are credited under the Plan** earlier in this summary). If you are credited with less than 1,000 hours in a Plan year, your vesting does not increase for that year. (Note that years of service for this purpose are not determined by your anniversary date.)

If you leave Walmart because of retirement (at age 65 or older) or death, your Company Funded Profit Sharing Account will be 100% vested, regardless of your years of service. Your Company Funded Profit Sharing Account will also be 100% vested if the Plan is ever terminated.

VESTING IN YOUR COMPANY FUNDED 401(k) ACCOUNT

You are always 100% vested in Walmart's contributions to your Company Funded 401(k) Account.

Investing your account

YOUR INVESTMENT OPTIONS

You decide how your accounts will be invested. You can choose:

- **The myRetirement Funds.** The myRetirement Funds are a series of customized investment options created solely for Plan participants by the Benefits Investment Committee, and are commonly known as "target retirement date" funds. The myRetirement Funds are diversified investment options that automatically change their asset allocation over time to become more conservative as you get closer to retirement. This is done by shifting the amount of money invested in more aggressive investments, such as stocks, and allocating those amounts to more conservative investments, such as bonds, as you near retirement.
- **From among a menu of investment options made available under the Plan.** Note that Walmart stock is an investment option only for your Company Funded Profit Sharing Account. Walmart stock is not available for investment through any of your other Plan accounts (although to the extent these other accounts hold Walmart stock, you may always sell such shares, but no future purchases of Walmart stock are allowed).

You may choose one of the investment options or you may spread your money among the various investment options. The investment gains or losses on your accounts depend on the performance of the investments you choose.

If you do not make an investment choice for current contributions to your account, they will be invested in one of the myRetirement Funds based on your age. For more information, refer to the Qualified Default Investment Alternative (QDIA) notice and your enrollment packet. These documents can both be obtained by going to **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

Because the Company Funded Profit Sharing Account is an Employee Stock Ownership Plan, all or a significant portion of Walmart's profit-sharing contribution was invested in Walmart stock for Plan years ending prior to January 31, 2006. If you were a participant in the Plan prior to that date, you may have Walmart stock in your Company Funded Profit Sharing Account. For Plan years ending January 31, 2007 or later, Walmart's profit-sharing contribution was not invested in Walmart stock.

A description of all investment options, including the myRetirement Funds, is included in the enrollment packet you receive when you are eligible to enroll. You also may obtain additional information for each investment option by reviewing the Annual Participant Fee Disclosure Notice. You may obtain a copy free of charge by accessing your account online at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

Please note that this Plan is intended to be an "ERISA Section 404(c) plan." This means that you assume all investment risks connected with the investment options you choose in the Plan, or in which your funds are invested if you fail to make investment selections, including the increase or decrease in market value. Walmart Inc., the Benefits Investment Committee, and the trustee are not responsible for losses to your accounts which are the direct and necessary result of investment decisions you make or, if you fail to make an affirmative investment decision, as a result of your accounts being invested in a default fund.

If you have a Company Funded Profit Sharing Account (see **Your Walmart 401(k) Plan accounts** earlier in this summary) and you choose to invest some or all of your Company Funded Profit Sharing Account in Walmart stock or retain Walmart stock in your other accounts, be aware that since this option is a single stock investment, it generally carries more risk than the options offered through the Plan.

HOW TO OBTAIN MORE INVESTMENT INFORMATION

It is also important to periodically review your investment portfolio, your investment objectives, and the investment options under the Plan to help ensure that your investments are in line with your objectives and your risk tolerance. For more sources of information on individual investing and diversification, visit the website of the Department of Labor's Employee Benefits Security Administration at **www.dol/agencies/ebsa** and type "investing and diversification" in the search field.

You may obtain more specific information regarding your investment rights and investment options under the Plan at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

CHANGING YOUR INVESTMENT CHOICES

You can change your investment choices at any time online at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**. If you make an investment change, a confirmation notice will be sent to your home address or you will receive an email notification when the confirmation is available if you have chosen electronic delivery of your Plan materials. It is your responsibility to make sure your change is made. If you do not receive a confirmation notice or you do not see that your change has been applied, contact the Customer Service Center at **888-968-4015**.

If you call the Customer Service Center prior to 3:00 p.m. Eastern time, your investment change generally will be processed on the day you call. Depending on the investment change, there may be up to a three-day settlement period before your funds are invested in your new election.

DIVERSIFICATION

To help you diversify your retirement savings, the Plan offers a variety of investment options with different levels of risk and potential for increase in value. To "diversify" means that you spread your assets among different types of investments. To help achieve long-term retirement security, you should give careful consideration to the benefits of a well-balanced and diversified investment portfolio. This strategy can help reduce risk and may provide consistent returns because a decline in the value of one investment may potentially be offset by an increase in the value of another. If you invest more than 20% of your retirement savings in any one stock, such as Walmart stock, or any one industry, your savings may not be properly diversified. Although diversification cannot ensure a profit or protect against loss, it can be an effective strategy to help you manage investment risk.

When deciding how to invest your retirement savings, you should take into account all of your assets, including any retirement savings outside of the Plan. For example, you may own Walmart stock through other means. No single approach is right for everyone because, among other factors, individuals have different financial goals, different time horizons for meeting their goals, and different tolerances for risk. Keep in mind your rights to diversify your Plan account and carefully consider how you choose to invest your Plan account. For information about your right to diversify your account and all of the investment options available under the Plan, access your account online at **benefits.ml.com** or call the Customer Service Center at **888-968-4015**. It is also important to periodically review your investment portfolio, your investment objectives, and the investment options under the Plan to help ensure that your investments remain appropriate for your retirement goals and your tolerance for investment risk. For more sources on individual investing and diversification, visit the website of the Department of Labor's Employee Benefits Security Administration at **www.dol/agencies/ebsa** and type "investing and diversification" in the search field.

More about owning Walmart stock

VOTING

If any of your account is invested in Walmart stock through the Plan, each year you will receive all of the materials generally distributed to the shareholders of Walmart, including an instruction card telling the trustee how you would like the shares in your Plan account to be voted. The materials are mailed to your home address or sent electronically, based on your online elections.

You can instruct the trustee, through the company's transfer agent, to vote Walmart stock held in your Plan accounts. This usually occurs in May of each year. Your instructions to the transfer agent and the trustee are kept confidential at all times. You send your voting instructions directly to the transfer agent, who compiles the votes and notifies the Benefits Investment Committee of the total votes cast. The Benefits Investment Committee then notifies the Plan trustee of the total votes to be cast.

If you do not provide instruction to the trustee on how you would like your shares voted, the Benefits Investment Committee will vote those shares at its discretion. If neither you nor the Benefits Investment Committee exercise voting rights, the trustee or an independent fiduciary appointed by the trustee may vote the unvoted shares.

CONFIDENTIALITY

Procedures have been designed to protect the confidentiality of your rights with respect to shares of Walmart stock held under the Plan, including the right to purchase, sell, hold, or vote on proxy matters. For example, procedures with the Company's transfer agent for Walmart stock have been implemented that prevent Walmart Inc. and the Benefits Investment Committee from finding out how any individual participant or beneficiary voted (except as necessary to comply with securities laws) and from having access to your individual proxy cards or proxy card shareholder comments.

In addition, access to information about your decisions to buy, sell, or hold Walmart stock generally is limited to those assisting in the administration of the Plan. The Benefits Investment Committee is responsible for ensuring that these procedures are sufficient to protect the confidentiality of this information and that the procedures are being followed. If the Benefits Investment Committee determines that a situation has potential for undue influence by the Walmart with respect to your rights as shareholder (through your Plan Account), the Benefits Investment Committee will appoint an independent party to perform activities that are necessary to prevent undue influence.

DIVIDENDS ON YOUR WALMART STOCK

If you have Walmart stock in your accounts, your accounts will be credited with any dividends paid by Walmart Inc. with respect to its stock. Dividends allocated to your Pretax Account, your Company Funded 401(k) Account, or your 401(k) Rollover Account will be automatically reinvested in Walmart stock. Dividends allocated to your Company Funded Profit Sharing Account (and Profit Sharing Rollover Account) will also be reinvested in Walmart stock, except as noted below.

If you are an active participant (excludes beneficiaries and alternate payees, as defined in the **If you get divorced** section) with six or more years of service, you have an option to take a cash payout of any dividends paid on Walmart stock held in your Company Funded Profit Sharing Account or

Profit Sharing Rollover Account. Also, if you are a terminated participant who had more than six years of service when you terminated and you continue to maintain your accounts in the Plan after you leave, you will have the option to elect a cash payout of dividends paid on Walmart stock held in your Company Funded Profit Sharing Account or Profit Sharing Rollover Account. If you do not opt for the cash payout, your dividends will be reinvested in Walmart stock.

You may make an election any time by calling the Customer Service Center at **888-968-4015**. Your most recently filed election will apply to all subsequent dividends until you change your election. (You may change your election only once each business day.) Keep in mind that your election must be made no later than the close of business on the day prior to the record date for the dividend in order to be effective for that dividend. You will not be able to make any elections or election changes during the period from the record date of the dividend through the dividend pay date (which is usually three to four weeks after the record date).

Each year, Walmart Inc. releases the quarterly record dates for dividend payouts. You can find this information on **walmart.com**. You may also contact the Customer Service Center at **888-968-4015** if you need information about upcoming record dates for dividends. Keep in mind that a dividend payout is taxable to you.

Note that if you request a hardship payout from your 401(k) Account within five business days of the record date for a dividend and you have the right to elect a cash distribution of the dividend, tax laws require that the dividend be automatically paid to you in cash.

Account balances and statements

At least once a year, you'll receive a statement on your accounts showing contributions made by you and by Walmart, if any, the performance of your investment options, the values of your accounts, and fees assessed to your account. You can easily get information about your accounts, including a quarterly statement, at any time online at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**. You can also request a paper copy of any quarterly statement at any time free of charge by calling the Customer Service Center.

FEES CHARGED TO YOUR ACCOUNT

Administrative and investment fees may be assessed to your accounts. Information on fees can be found in the Annual Participant Fee Disclosure Notice and online at **benefits.ml.com**.

Receiving a payout while working for Walmart

Generally, you are not entitled to a payout from the Walmart 401(k) Plan until you stop working for Walmart. However, in the following limited situations you may be entitled to receive a payout or loan of some or all of your accounts while you're still working:

- In the case of a financial hardship or after you reach age 59½.
- Rollovers can be withdrawn at any time.
- You may request a loan from your Plan account.

It's important to understand how any type of payout or loan from the Walmart 401(k) Plan affects your tax situation. For more information, see **The income tax consequences of a payout** later in this summary.

FINANCIAL HARDSHIP WITHDRAWALS

You may withdraw some or all of your vested Account as necessary to meet a "financial hardship." (Prior to February 1, 2020, you may only withdraw your 401(k) Account, other than earnings on those contributions, and your 401(k) Rollover Account.)

Under IRS guidelines, a financial hardship may exist if the request is for:

- Payment of medical care expenses not covered by insurance for you, your spouse, your dependents, or your affirmatively designated primary beneficiary
- Costs directly related to the purchase of your primary residence
- Payment of tuition, fees, and room and board expenses for up to the next 12 months of post-high school education for you, your spouse, your dependents, or your affirmatively designated primary beneficiary
- Payments necessary to prevent eviction from, or foreclosure on, your primary residence
- Payment for burial or funeral expenses for your deceased parent, spouse, children, dependent, or your affirmatively designated primary beneficiary, or
- Expenses for the repair of damage to your principal residence that would qualify for a casualty deduction under federal income tax rules (determined without regard to whether the casualty was a federally-declared disaster and whether the loss exceeds 10% of your adjusted gross income).

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Federal tax law requires that you must have already obtained all in-service payouts available (including in-service withdrawals of rollover contributions, withdrawals after age 59½, and, prior to February 1, 2020, any nontaxable participant loans available to you under this Plan) before you can request a financial hardship payout. Also, please note

that if you request a financial hardship payout within five business days of the record date of a dividend and you are entitled to elect a cash payout of that dividend, the dividend will automatically be distributed to you in cash. For payouts on or after January 1, 2020, you will also be required to certify that you have insufficient cash or other liquid assets to satisfy the need.

Note that if your payout is processed before January 1, 2020, you will not be allowed to contribute to this Plan and certain other retirement or stock purchase plans (including the Associate Stock Purchase Plan) for six months after the date of your financial hardship payout. If you are a management associate with stock options, you may not exercise options during this six-month period. If your payout is processed on or after January 1, 2020, however, these restrictions do not apply.

A financial hardship payout is immediately taxable to you (other than Roth contributions and, if the payout is a qualified distribution, earnings on your Roth contributions), including a 10% penalty tax if you are under age 59½ or if the payout is not for certain medical purposes. For more information, see **The income tax consequences of a payout** later in this chapter.

You can make a request for a financial hardship payout online at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

WITHDRAWALS AFTER YOU REACH AGE 59½

Any time after you reach age 59½, you may elect to withdraw all or any portion of your Plan accounts, to the extent vested, even though you are still working for Walmart. You can make a request for a withdrawal online at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

WITHDRAWALS OF ROLLOVER CONTRIBUTIONS

You may withdraw all or any portion of your 401(k) Rollover Account and your Profit Sharing Rollover Account at any time even if you are still working for Walmart or its subsidiaries.

PLAN LOANS

You may apply for a loan from the vested portion of your Plan account while you are still working for Walmart. The Administrator has established a written loan program explaining the Plan's loan requirements in detail. You can request a copy of the loan program or make a request for a loan online at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

Generally, the rules for loans include the following:

- The maximum loan amount is limited by IRS rules, which generally limit your total loan balances to the lesser of (1) 50% of the total of your vested Plan account or (2) $50,000 (reduced by the excess, if any, of your highest outstanding loan balance during the one-year period prior to the date of the loan over your current outstanding balance of loans). The minimum loan amount is $1,000.
- All loans must be secured by a pledge of up to one-half of your vested Plan account.
- A fee will be charged to process your loan application. Additional fees may be accessed for residential loans. (Fee amounts may change from time to time.)
- All loans bear a commercially reasonable rate of interest set by the Administrator from time to time.
- Loans must be repaid in regular installments over a one- to five-year period, unless you are using the loan proceeds to buy a house for yourself, in which case the repayment period may be longer as set forth in the written loan program from time to time.
- You may have only one general purpose loan and one residential loan outstanding at any time.
- All loans are considered a directed investment from your account under the Plan. Your payments of principal and interest on the loan are credited to your Plan accounts.
- If you fail to make payments when due under the loan, you will be considered to be in default. Under certain circumstances, a loan that is in default may be considered a distribution from the Plan. The significance of the loan balance being treated as a distribution is that the amount of this distribution (other than Roth contributions) is taxable to you as ordinary income and could be subject to excise taxes. A Form 1099-R will be issued to you and the total amount of the distribution will be reported to the IRS.

When you are on an authorized unpaid leave of absence, you may be excused from making scheduled loan repayments for a period of up to one year. If you have an outstanding loan when you are called to qualified military service, special rules under USERRA may apply. Call the Customer Service Center at **888-968-4015** for more details.
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If you die: your designated beneficiary

In the event of your death, your entire Plan balance will be paid out to your beneficiary. It is very important for you to keep your beneficiary information up to date. Beneficiary choices must be made at **One.Walmart.com** or **Workday** for Jet associates. Starting February 1, 2020, only beneficiary designations made online will be accepted. (Note that your spouse's consent must still be completed on Form B, as explained below.) Since your spouse or partner has certain rights in the death benefit, you should immediately update your beneficiary election if there is a change in your relationship status.

If you have a spouse and wish to name someone other than your spouse as your designated beneficiary, your spouse

must consent to that designation. You must complete the Alternate Beneficiary Form for Married Participants Form B and your spouse must complete the Spousal Consent portion of that form. The Spousal Consent form must be notarized and must accompany the Form B in order to be valid. Form B and the Spousal Consent form can be found on **One.Walmart.com**. Any beneficiary designation you make will be effective for all of your Plan accounts.

If you do not designate a beneficiary, your death benefit will be distributed in accordance with the Plan's default provisions in the following order, as stated below:

- Spouse or partner (as defined below); if none, then
- Living children (stepchildren are not included); if none, then
- Living parents; if none, then
- Living siblings; if none, then
- Your estate.

Please note that if you designate your spouse as your beneficiary and you later divorce, your beneficiary designation will not be effective after the divorce unless you complete a new beneficiary designation form. Similarly, if you do not have a spouse and you later marry, your prior beneficiary designation will not be effective after the marriage unless you complete a new designation form with your spouse's consent.

Also, note that if you designate a beneficiary and your beneficiary dies before the benefit check is issued, the benefit will be paid to your contingent beneficiary or, if none, under the default rules above. If your beneficiary dies after the benefit check has been issued, the benefit will be paid to your beneficiary's estate. Note, however, that if your spouse or partner is your beneficiary, the benefit will always be paid to the spouse's or partner's estate if he or she dies after you but before the benefit is paid. Again, it is very important for you to keep your beneficiary information up to date. Beneficiary choices should be made at **One.Walmart.com** or **Workday** for Jet associates.

NOTE: Effective June 26, 2013, your same-sex spouse is treated in the same manner as an opposite-sex spouse for Plan purposes. Keep in mind that if you had a same-sex spouse on that date, any beneficiary designation you had in effect which designated someone other than your spouse as your beneficiary became invalid on that date. Your spouse will automatically be your beneficiary unless you make a new beneficiary designation with your spouse's consent.

Effective January 1, 2014, if you have a "partner" and you have not made an affirmative beneficiary designation, your partner will be your beneficiary unless you affirmatively designate a different beneficiary (regardless of whether the designation occurred before or after your partnership began). Your "partner" for Plan purposes means:

- Your domestic partner, as long as you and your domestic partner:
  - Are in an ongoing, exclusive and committed relationship similar to marriage and have been for at least 12 months and intend to continue indefinitely;
  - Are not married to each other or to anyone else;
  - Meet the age for marriage in your home state and are mentally competent to consent to contract in that state;
  - Are not related in a manner that would bar a legal marriage in the state in which you live, and
  - Are not in the relationship solely for the purpose of obtaining benefits coverage, or
- Any other person to whom you are joined in a legal relationship recognized as creating some or all of the rights of marriage in the state or country in which the relationship was created.

You should take action to ensure that your beneficiary under the Plan reflects your current intent. Beneficiary choices should be made at **One.Walmart.com** or **Workday** for Jet associates.

BENEFICIARY DESIGNATIONS MADE BEFORE OCTOBER 31, 2003

If you made a beneficiary designation under the 401(k) Plan on or before October 31, 2003, that designation will continue to apply to your Pretax Account, your Roth Account, your Company Funded 401(k) Account, your Company Match Account, and your Rollover Accounts. Similarly, if you made a beneficiary designation under the Profit Sharing Plan on or before October 31, 2003, that designation will continue to apply to your Company Funded Profit Sharing Account and Profit Sharing Rollover Account. If you change your beneficiary designation after October 31, 2003, it will apply to all Plan accounts and any prior designations will be ineffective.

Note that changes in your relationship status may affect your beneficiary designation, as explained above.

Again, it is very important for you to keep your beneficiary information up to date. Beneficiary designations should be made at **One.Walmart.com** or **Workday** for Jet associates.

If you get divorced

If you go through a divorce, all or part of your Plan balance may be awarded to an "alternate payee" in the court order, called a "qualified domestic relations order" (QDRO). An alternate payee may be your spouse or former spouse, child or other dependent. (Federal law at this time does not permit the recognition of a QDRO for a partner unless the partner is also a dependent of the participant.) Because there are very strict requirements for these

cases, you should contact the QDRO Administrator at **877-MER-QDRO** (**877-637-7376**) for a free copy of the procedures your attorney should use in drafting the court order. After the court order is received by the QDRO Administrator, it must be reviewed to determine if it meets legal requirements for this type of order and will take a period of time to be processed. The administrative fee for processing your QDRO will be charged to your account or as directed in the Order.

If you leave Walmart

When you stop working for Walmart, you are entitled to receive a payout of all of your vested accounts in the Plan.

It is important to understand how any type of payout from the Walmart 401(k) Plan affects your tax situation. For more information, see **The income tax consequences of a payout** later in this summary.

You may elect to receive your payout 30 calendar days after your termination is entered into the payroll system. For example, if your termination is entered into and processed by the payroll system on July 19, 2020, you may elect your payout on or after August 18, 2020.

A notice informing you that you are entitled to payment will normally be mailed to your home address or sent electronically, based on your delivery elections, after you leave Walmart and its subsidiaries. Please make sure that your address is correct on your payroll check when you leave Walmart and its subsidiaries or that you give a forwarding address during your exit interview. If you have not received any information regarding your payout within 60 days of your termination date, contact the Customer Service Center at **888-968-4015**. To request your payout, you will need to access your account on **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

Your consent to the payout is not required and your payout will automatically be made to you:

- **If your total vested Plan balance (excluding your 401(k) Rollover Account) is $1,000 or less at any time.** This automatic payout will be made as soon as possible after the last business day of the third calendar month following the calendar month in which your termination date is entered into the payroll system, unless you consent to an earlier payout, as described above. In the example above, if your account is eligible for automatic payout and you do not consent to payout on or after August 19, 2020, your payout will automatically be made to you as soon as possible after October 31, 2020, or
- **If you are over age 70, regardless of the amount of your total vested Plan balance.** This automatic payout will be made as soon as possible after the last business day of the second calendar month following the calendar month in which you turn age 70, unless you consent to an earlier payout, as described above. For instance, if you turn age 70 in July 2020 and your account is eligible for automatic payout, and you do not consent to payout, your payout would automatically be made on the first scheduled date after September 30, 2020, according to Plan provisions.

If your total vested Plan balance is more than $1,000 and you are under age 70, you must consent to your payout. Payout will be made as soon as possible after the Customer Service Center receives your consent, but no earlier than 30 calendar days after your termination is entered into the payroll system.

If your total vested Plan balance is more than $1,000, you can choose to delay your payout until any date up to age 70, but your Plan balance will be subject to an annual maintenance fee and possibly other expenses. For information regarding these charges, refer to the Annual Participant Fee Disclosure Notice. If you choose to delay your payout, you will be able to continue to make changes in your investment choices just as you did while you were an active participant in the Plan.

If you return to work with Walmart before your payout is completed, the payout will be canceled and no payout will be made from your account.

THE AMOUNT OF YOUR PAYOUT

The entire value of your Pretax Account, your Roth Account, your Company Funded 401(k) Account, your Rollover Accounts, and the Company Match Account will be paid out to you (alternatively, partial distributions will be available effective February 1, 2020, as explained on the next page). In addition, if you have a Company Funded Profit Sharing Account (see **Your Walmart 401(k) Plan accounts** earlier in this summary), you will also be paid the value of the vested portion of your Company Funded Profit Sharing Account. You will forfeit (give up) the nonvested portion of your Company Funded Profit Sharing Account, as explained in the **Vesting in your Company Funded Profit Sharing Account** earlier in this summary.

The amount you will receive will be based on the value of your accounts as of the date the payout is processed. If a cash payout is made directly to you rather than rolled over to an IRA or other employer plan, applicable taxes will be withheld from your check.

A check processing fee will be applied to your Plan balance when it is paid out to you.

HOW YOU RECEIVE YOUR PAYOUT

You have several options for receiving your payout.

Your accounts will normally be paid to you in cash. However, you may elect to have your Company Funded Profit Sharing Account (and Profit Sharing Rollover Account) distributed to you in the form of Walmart stock (even if it is not invested

in Walmart stock at the time your payout is processed) or partly in cash and partly in Walmart stock. You may also elect to have your Pretax Account, your Company Funded 401(k) Account, and your Rollover Accounts paid to you in Walmart stock to the extent those accounts are invested in Walmart stock at the time your payout is processed. Any part of those accounts not invested in Walmart stock at the time of your payout will be distributed in cash.

If the total of your vested accounts is $1,000 or less, or if you are over age 70 (regardless of the amount of your vested accounts), your payout will be made directly to you in a single cash payout. If you wish to take any of your payout in the form of Walmart stock or if you wish to roll over your payout to an IRA or other employer plan, you must contact the Customer Service Center at **888-968-4015** with your payout instructions within the time period shown in your payout notice. If you fail to contact the Customer Service Center in a timely manner, your payout will be made in a single cash payment to you.

If the total of your vested accounts in the Plan is more than $1,000, your payout will not be made until you make an election regarding the form of payout and consent to the distribution, or until you reach age 70.

Beginning February 1, 2020, you can choose to take all or any portion of your vested account. (Note, however, that if you take a partial payout of your account and the amount remaining in your account drops to $1,000 or less, it will be cashed-out as explained above.) To obtain your payout, contact the Customer Service Center at **888-968-4015**.

Your accounts normally will be distributed directly to you, unless you elect to roll them over to an IRA or to another employer's retirement plan.

If you leave and are rehired by Walmart

If you leave Walmart and its subsidiaries and are later rehired as an eligible associate, you will be immediately eligible to make your own contributions to the Plan on your date of rehire.

If you leave Walmart and its subsidiaries after you became eligible to receive matching contributions and are later rehired by Walmart, you will automatically be eligible to receive matching contributions on your rehire date. Similarly, if you leave Walmart and its subsidiaries after you have met the 1,000-hour requirement for matching contribution eligibility but before your actual participation date, you will be eligible to receive matching contributions beginning on the later of the date you would have initially become a participant or your rehire date (with respect to contributions you make after that date). If you were not a participant when you left, or had not satisfied the 1,000-hour requirement, you will be treated as a new associate when you are rehired and will be required to complete the eligibility requirements (see **When participation begins** earlier in this summary) in order to be eligible to receive matching contributions under the Plan.

THE NONVESTED PORTION OF YOUR COMPANY FUNDED PROFIT SHARING ACCOUNT

When you terminate employment, the portion of your Company Funded Profit Sharing Account that is not vested (if any) will not be paid to you. This nonvested amount is called a "forfeiture."

- If you receive a total payout of your vested Plan balance after your termination of employment and while your Company Funded Profit Sharing Account is partially vested, the nonvested portion of your Company Funded Profit Sharing Account will be forfeited on the date of your payout.
- If you do not receive a total payout of your vested Plan balance after your termination of employment, the nonvested portion of your Company Funded Profit Sharing Account will not be forfeited until you have five consecutive "breaks in service." A break in service is a Plan year (February 1–January 31) in which you are credited with 500 hours of service or less. If you are absent from work due to an FMLA leave and have worked 500 hours or less in the Plan year, you will be credited with enough hours to bring you up to 500.01 hours so that you will not incur a break in service.

The nonvested portion of your Company Funded Profit Sharing Account that was forfeited will be reinstated (at its former value) if you are rehired by Walmart or subsidiary before you have five consecutive breaks in service and you pay back to the Plan the total amount of your payout within five years after you are rehired. If you return to work with Walmart or a subsidiary after five or more consecutive breaks in service, or if you chose not to repay your payout as discussed above, the nonvested portion of your Company Funded Profit Sharing Account that was forfeited will not be reinstated.

If you were zero percent vested in your Company Funded Profit Sharing Account when you terminated employment, your nonvested Company Funded Profit Sharing Account will automatically be reinstated if you are rehired prior to five consecutive breaks in service.

Forfeitures of nonvested Company Funded Profit Sharing Accounts of terminated participants generally are used to pay Plan expenses and for certain other purposes, such as to restore account balances as discussed above.

When you are rehired, your years of service with Walmart before you left will be counted for purposes of determining your vesting in Walmart's contributions to your Company Funded Profit Sharing Account.

The income tax consequences of a payout

The tax consequences of your participation in the Plan are your responsibility. This explanation is only a brief description of the U.S. federal tax consequences related to your participation in the Plan. This description is based on current law and current interpretations of the law by the Internal Revenue Service. Because the law is subject to change and because the application of the law may vary depending on your particular circumstances, this description is general in nature and you should not rely on it in determining your tax consequences. You are strongly urged to consult a tax advisor.

Walmart is entitled to a deduction on the amount of its contributions, as well as your contributions, to the Plan. Your pretax contributions and Walmart's contributions to the Plan, as well as earnings on those contributions, generally are not subject to federal income taxes until they are paid to you. You are taxed on your Roth contributions when you contribute them to the Plan. Earnings on Roth contributions are not taxed unless you take a distribution that is not a qualified distribution. (See **Taxation of payouts of Roth contributions** below.)

POSTPONE PAYING TAXES ON PAYOUTS THROUGH A ROLLOVER (OTHER THAN A ROTH ACCOUNT)

Although payouts from the Plan (other than from your Roth Account) are subject to federal income taxes, the Internal Revenue Code provides favorable tax treatment to payouts in certain circumstances. For example, you can postpone paying taxes on your payout if you direct the Plan to issue your payout directly to an IRA or to another employer's qualified retirement plan, a 403(b) plan, or a governmental 457 plan. This is called a direct rollover. (The check will be made payable to the IRA or other plan trustee and will be delivered to you or your IRA or rollover institution. If the check is mailed to you, you will be responsible for delivering it to the IRA or other plan trustee within 60 days.)

If you elect this method for your payout, no taxes will be withheld from the amount you are rolling over. It will not be taxed until you later receive a payout from the IRA or other plan.

If you do not elect to have your payout directly rolled over, federal law requires that Walmart withhold 20% of the payout for federal taxes, in addition to any required state withholding. In some cases, 20% withholding may not be enough, which could mean that you will owe additional taxes when you file your income tax return.

If you do not elect a direct rollover (and instead receive an actual payout from the Plan), you may still roll over those funds to an IRA or an employer's qualified retirement plan, 403(b) plan, or governmental 457 plan, as long as you do so within 60 calendar days after you received the distribution. The amount rolled over will not be subject to federal income tax until you take it out of the IRA or other plan. If you want to roll over 100% of your payout to an IRA or other plan, however, you will have to use other money to replace the 20% that was withheld from your payout. If you roll over only the 80% that you received, you will be taxed on the 20% that was withheld.

NOTE: You may roll over all or any portion of your account that is eligible for rollover to a Roth IRA. Any amount rolled over that would have been taxable if not rolled over will be taxable at the time of the rollover to the Roth IRA. (Note that you may voluntarily choose to have taxes withheld from amounts at the time you roll over to a Roth IRA.)

For more information regarding these rollover rules, review the **Special tax notice addendum** that follows. Retain this addendum for review when you are eligible to take a distribution.

TAXATION OF PAYOUTS OF ROTH CONTRIBUTIONS

Your Roth contributions and earnings on those contributions are not taxed when distributed from the Plan as long as the distribution is a "qualified" distribution. A "qualified" distribution is a distribution that is made: (1) on account of your death, disability, or after you attain age 59½, and (2) after you have completed a five-year participation period. The five-year participation period is the five-year period beginning with the first calendar year in which in which you first make a Roth contribution to the Plan (or to another 401(k) plan or 403(b) plan, if such amount was rolled over to this Plan) and ending on the last day of the fourth calendar year thereafter. For instance, if you make your first Roth contribution in July 2020, your five-year participation period will end on December 31, 2024. It is not necessary that you make a Roth contribution in each of the five years.

If you receive a distribution from your Roth contributions and earnings on those contributions that is not a "qualified" distribution, the earnings on your Roth contributions will be taxable to you at the time of distribution (unless you roll over the distribution to a Roth IRA or a designated Roth account in another employer plan). If you do roll over your Roth contributions and earnings, you will not have to pay taxes currently on the earnings and you will not have to pay taxes later on payouts that are qualified distributions.

Your Roth contributions may be rolled over only to a Roth IRA or a designated Roth account in another employer plan. If the rollover is to a designated Roth account in another employer plan, the rollover generally must be a direct rollover (unless the amount being rolled over includes only amounts that would have been taxable if distributed to you).

For more information regarding these rollover rules, review the **Special tax notice addendum: Roth contributions** that follows. Retain this addendum for review when you are eligible to take a distribution.

EARLY WITHDRAWAL PENALTY

If you take a payout prior to age 59½ rather than rolling it over, in most cases you will be subject to a 10% early withdrawal penalty by the IRS on the taxable portion of your payout. Thus, Roth contributions and, if they are distributed in a "qualified" distribution, earnings on those contributions, are not subject to the 10% early withdrawal penalty. There are some exceptions to the penalty, such as death, disability, retirement after age 55, and payouts for certain medical expenses. Special rules also apply to distributions made to reservists who are called to active military duty.

TAXATION OF PAYOUTS OF WALMART STOCK

There are also special rules for distributions of Walmart common stock. If you receive cash (in excess of $200) in addition to Walmart stock and the cash is not directly rolled over, some withholding may apply, but the withheld amount will not be greater than the amount of cash you receive.

Generally, if you receive Walmart common stock as part of your payout that is not rolled over, you are taxed only on the value of the stock at the time it was purchased by the Plan.

Keep in mind that if you elect cash payouts of dividends paid on Walmart stock held in your Company Funded Profit Sharing Account, the dividend is taxable to you and is not eligible for rollover. The dividend is also taxable if you request a financial hardship payout from your account within five business days of the record date for a dividend and the dividend is automatically paid out to you in cash. The dividend payout is not subject to the 10% early withdrawal penalty discussed above. In some cases, Walmart Inc. will be entitled to deduct dividends paid on shares subject to this election.

TAXATION OF PAYOUTS TO BENEFICIARIES AND ALTERNATE PAYEES

The tax treatment discussed above applies only to payouts to participants. Different rules may apply to payouts to beneficiaries of deceased participants. In general, if your spouse is your beneficiary, he or she will have the same federal income tax treatment and rollover options that you would have had. Other beneficiaries, including partners, will only be entitled to a direct rollover to an inherited IRA or Roth IRA. The 10% early withdrawal penalty does not apply to payouts to your beneficiary.

The spouses or former spouse of a participant who receives a payout from the Plan under a qualified domestic relations order (QDRO) generally have the same federal income tax treatment and options as the participant would have had. In some cases, however, a payout on behalf of a non-spouse dependent, including a partner, pursuant to a QDRO (e.g., state-ordered child support) may result in federal income taxation to the participant even though the payout is made to or on behalf of the dependent alternate payee.

TAXATION OF LOANS

Under current tax law, loans made from the Plan, regardless of their purpose, are not considered taxable income to the participant unless a default occurs. If you default on a loan from the Plan (as discussed above), your tax statement will show the amount of income to report for the year of the default. You may also be subject to 10% early withdrawal penalty.

Filing a Walmart 401(k) Plan claim

If you think you are entitled to a benefit beyond that processed by the Plan's recordkeeper (Merrill Lynch), you may file a claim with the Administrator or its delegate at:

Walmart Inc.
Attn: Financial Benefits
508 SW 8th Street
Bentonville, Arkansas 72716-0295

For questions about filing a claim, contact People Services at **800-421-1362**.

If your claim is partially or fully denied, you will receive written notice of the decision within a reasonable time, but no later than 90 days after the Administrator receives your claim. The Administrator or its delegate can extend this period for up to an additional 90 days if it determines that special circumstances require an extension. You will receive notice of any extension before the expiration of the original 90-day period. The written notice you receive will state the specific reasons for the denial of your claim, a specific reference to the provisions of the Plan upon which the denial is based, and a description of the review procedures and the time limits applicable to such procedures, including your right to bring a court action following a denial on appeal.

If you do not agree with the decision of the Administrator or its delegate, you can request a review of the decision by the Administrator. The Administrator has discretionary authority to resolve all questions concerning administration, interpretation, or application of the Plan. Your request must be made in writing and sent to the Administrator at:

Walmart Inc.
Attn: Financial Benefits
508 SW 8th Street
Bentonville, Arkansas 72716-0295

Your request must be made within 60 calendar days of the denial. Your written request must contain all additional information that you wish the Administrator to consider. If you do not request a review within this time period, you will be deemed to have waived your right to a review.

The Administrator will promptly conduct the review. Written notice of the Administrator's decision on review will be provided to you within 60 calendar days after the receipt of your request, unless special circumstances require an extension of up to 60 additional days. In those circumstances where the review is delayed to allow you to provide additional information necessary for a proper review, the length of the delay will not be included in the calculation of the 60-day deadline and extension periods set forth above. The written notice of the Administrator's decision will include specific reasons for the decision and will refer to the specific provisions of the Plan on which the decision is based.

You must exhaust these procedures before you can file a lawsuit with respect to your Plan benefits. If you file a lawsuit, it must be filed within one year from the date of your payout or, if no payout is made, the date your request for benefits is denied, in whole or in part, by the Administrator on appeal (or, if earlier, the date the Administrator fails to respond to your claim or appeal within the time periods provided above).

Administrative information

PLAN NAME

The legal name of the Plan is the Walmart 401(k) Plan.

PLAN SPONSOR AND ERISA PLAN ADMINISTRATOR

Walmart Inc. is the Plan Sponsor. Its contact information for matters pertaining to the Plan is:

Walmart Inc.
Attn: Financial Benefits
508 SW 8th Street
Bentonville, Arkansas 72716-0295
800-421-1362

As the ERISA Plan Administrator, Walmart Inc. is responsible for reporting and disclosure obligations under the Employee Retirement Income Security Act of 1974 (ERISA) and all other obligations required to be performed by plan administrators under the Internal Revenue Code and ERISA, except for those obligations delegated to the Administrator, the Benefits Investment Committee or the trustee of the Trust. ERISA is the federal law that imposes certain responsibilities on Walmart Inc., the Administrator, the Benefits Investment Committee, and the trustee with respect to your retirement benefits.

Subsidiaries of Walmart Inc. are permitted to participate in the Plan. You may obtain a list of subsidiaries currently participating in the Plan by contacting People Services.

PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER

71-0415188

NAMED ADMINISTRATIVE FIDUCIARY

The individual from time to time holding the position of Senior Vice President, Global Benefits Division, of Walmart is the Administrator. The Administrator is the named administrative fiduciary of the Plan. As the named administrative fiduciary of the Plan, the Administrator is generally responsible for the management, interpretation, and administration of the Plan, including but not limited to eligibility determinations, benefit payments, and other functions required, necessary or advisable to carry out the purpose of the Plan.

You may contact the Administrator at the following address:

Senior Vice President, Global Benefits Division/Administrator
Walmart Inc.
508 SW 8th Street
Bentonville, Arkansas 72716-0295

NAMED INVESTMENT FIDUCIARY

The Benefits Investment Committee is the named investment fiduciary of the Plan. The Committee is responsible for the Plan's investment policies, including selection of investment options to be made available under the Plan and the selection of the default investment option.

You may contact the Benefits Investment Committee at the following address:

Benefits Investment Committee
Walmart Inc.
508 SW 8th Street
Bentonville, Arkansas 72716-0295

PLAN TRUSTEE

Northern Trust Company
50 S. LaSalle Street
Chicago, Illinois 60603

One or more trusts hold all Plan assets, such as contributions by participants and Walmart's contributions. As trustee of the Trust, Northern Trust Company receives and holds contributions made to the Plan in trust and invests those contributions according to the policies established under the Plan.

AGENT FOR SERVICE OF LEGAL PROCESS

Corporation Trust Company
1209 Orange Street
Corporation Trust Center
Wilmington, Delaware 19801

Service of legal process may also be made on the ERISA Plan Administrator or the trustee.

PLAN NUMBER

003

PLAN YEAR

February 1 through January 31

TYPE OF PLAN

The Walmart 401(k) Plan is a defined contribution plan (401(k), profit sharing, and employee stock ownership plan).

ASSIGNMENT

Because this is a retirement plan governed by ERISA and other federal laws, your accounts cannot be assigned or used as collateral for a loan, nor can your accounts be garnished or be subject to bankruptcy proceedings. They can, however, be part of a divorce settlement, as explained in the **If you get divorced** section earlier in this summary.

NO PBGC COVERAGE

ERISA created a governmental agency called the Pension Benefit Guaranty Corporation (PBGC). One of the purposes of the PBGC is to insure the benefits payable under defined benefit plans. The PBGC does not, however, provide coverage for defined contribution plans. Because the Plan is a defined contribution plan, it is not eligible for coverage by the PBGC.

PLAN AMENDMENT OR TERMINATION

Walmart reserves the right to amend or terminate the Plan at any time. Amendments are made by Walmart's Board of Directors or by its Executive Vice President, Global People Division. Neither the Plan nor the benefits described in this summary may be orally amended. All oral statements and representations have no force or effect, even if the statements and representations are made by a management associate of Walmart or a participating subsidiary, by the Administrator, by any member of the Benefits Investment Committee, or by Merrill Lynch.

You may obtain a copy of the formal Plan document by writing to:

Walmart Inc.
Attn: People Services
508 SW 8th Street
Bentonville, Arkansas 72716-0295

You can also contact the Customer Service Center at **888-968-4015**.

MISTAKEN PAYOUTS

If any payout is made under the Plan to the wrong party, or if a payout is made to the right party but in the wrong amount, the Administrator can recover the mistaken payout from the recipient by either reducing his or her Plan account or future payouts due to the recipient, or may demand that the recipient promptly repay the Plan.

STATEMENT OF ERISA RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the ERISA Plan Administrator's office and at other specified facilities, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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 Employee Benefits Security Administration.
- Obtain, upon written request to the ERISA Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The ERISA Plan Administrator may make a reasonable charge for the copies. Your request must be mailed to:

  Walmart Inc. — ERISA Section 104(b) Request
  Attn: People Services
  508 SW 8th Street
  Bentonville, Arkansas 72716-0295

- Receive a summary of the Plan's annual financial report. The ERISA Plan Administrator is required by law to furnish each participant with a copy of the summary financial report.
- Obtain a statement telling you the current balance of your account and the portion of your account that is nonforfeitable (vested). This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

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

If your claim for a 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 from 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 ERISA Plan Administrator or the 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 ERISA Plan Administrator or the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a 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.

If you have any questions about the Plan, you should contact the ERISA Plan Administrator or the Administrator. If you have any questions about this statement or about your rights under ERISA, 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 NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Special tax notice addendum

YOUR ROLLOVER OPTIONS

The law requires that participants receive this notice before receiving a distribution from the Plan that is eligible to be rolled over to an IRA or an employer plan. You may or may not currently be eligible to receive a distribution from the Plan. If you are eligible for a distribution, however, you should review this notice carefully before you elect a distribution from the Plan. This notice is intended to help you decide whether to elect a rollover. If you are not currently eligible for a distribution, you should retain this notice and review it when you are eligible for a distribution.

Rules that apply to most payments from the Plan are described in the **General information about rollovers** section. Special rules that only apply in certain circumstances are described in the **Special rules and options** section.

This notice describes the rollover rules that apply to payouts from the Plan, other than those from a designated Roth account. If you also receive a payment from your Roth Account in the Plan (or any Roth amounts that were merged into or rolled over to the Plan from your prior employer's plan), see the **Special tax notice: Roth contributions addendum** that follows this notice.

GENERAL INFORMATION ABOUT ROLLOVERS

How can a rollover affect my taxes? You will be taxed on a payment from the Plan if you do not roll it over. If you are under age 59½ and do not do a rollover, you will also have to pay a 10% additional income tax on early distributions (unless an exception applies, as explained below). If you do a rollover, however, you will not have to pay tax until you receive payment later and the 10% additional income tax will not apply if the payment is made after you are age 59½ (or if an exception applies).

Where may I roll over the payment? You may roll over the payment to either an IRA (an individual retirement account or individual retirement annuity, including a Roth IRA) or an employer plan (a tax-qualified plan, section 403(b) plan, or governmental section 457(b) plan) that will accept the rollover. The rules of the IRA or employer plan that holds the rollover will determine your investment options, fees, and rights to payment from the IRA or employer plan (for example, no spousal consent rules apply to IRAs and IRAs may not provide loans). Further, the amount rolled over will become subject to the tax rules that apply to the IRA or employer plan.

How do I do a rollover? There are two ways to do a rollover. You can do either a "direct rollover" or a "60-day rollover."

If you do a "direct rollover," the Plan will make the payment directly to your IRA or an employer plan. Contact the IRA sponsor or the administrator of the employer plan for information on how to do a direct rollover.

If you do not do a direct rollover, you may still do a "60-day rollover" by making a deposit into an IRA or eligible employer plan that will accept it. You will have 60 days after you receive the payment to make the deposit. If you do not do a direct rollover, the Plan is required to withhold 20% of the payment for federal income taxes (up to the amount of cash received). This means that, in order to roll over the entire payment in a 60-day rollover, you must use other funds to make up for the 20% withheld. If you do not roll over the entire amount of the payment, the portion not rolled over will be taxed and will be subject to the 10% additional income tax on early distributions if you are under age 59½ (unless an exception applies).

How much may I roll over? If you wish to do a rollover, you may roll over all or part of the amount eligible for rollover. Generally, any payment from the Plan is eligible for rollover, except:

- Required minimum distributions after age 70½ (or after death)
- Hardship distributions
- ESOP dividends
- Corrective distributions of contributions that exceed tax law limitations
- Loans treated as deemed distributions (for example, loans in default due to missed payments before your employment ends)

The Plan Administrator or the payer can tell you what portion of a payment is eligible for rollover.

If I don't do a rollover, will I have to pay the 10% additional income tax on early distributions? If you are under age 59½, you will have to pay the 10% additional income tax on early distributions for any payment from the Plan (including amounts withheld for income tax) that you do not roll over, unless one of the exceptions listed below applies. This tax is in addition to the regular income tax on the payment not rolled over.

The 10% additional income tax does not apply to the following payments from the Plan:

- Payments made after you separate from service if you will be at least age 55 in the year of the separation
- Payments made due to disability
- Payments after your death
- Payments of ESOP dividends
- Corrective distributions of contributions that exceed tax law limitations
- Payments made directly to the government to satisfy a federal tax levy
- Payments made under a qualified domestic relations order (QDRO)
- Certain payments made while you are on active duty if you were a member of a reserve component called to duty after September 11, 2001 for more than 179 days

If I do a rollover to an IRA, will the 10% additional income tax apply to early distributions from the IRA? If you receive a payment from an IRA when you are under age 59½, you will have to pay the 10% additional income tax on early distributions from the IRA, unless an exception applies. In general, the exceptions to the 10% additional income tax for early distributions from an IRA are the same as the exceptions listed above for early distributions from a plan. However, there are a few differences for payments from an IRA, including:

- There is no exception for payments after separation from service that are made after age 55.
- The exception for qualified domestic relations orders (QDROs) does not apply (although a special rule applies under which, as part of a divorce or separation agreement, a tax-free transfer may be made directly to an IRA of a spouse or former spouse).
- An exception for payments made at least annually in equal or close to equal amounts over a specified period applies (without regard to whether you have had a separation from service).
- There are additional exceptions for (1) payments for qualified higher education expenses, (2) payments up to $10,000 used in a qualified first-time home purchase, and (3) payments after you have received unemployment compensation for 12 consecutive weeks (or would have been eligible to receive unemployment compensation but for self-employed status).

Will I owe state income taxes? This notice does not describe any state or local income tax rules (including withholding rules).

SPECIAL RULES AND OPTIONS

If your payment includes after-tax contributions: If you have after-tax contributions that were merged into the Walmart 401(k) Plan, those contributions are subject to special tax rules when they are distributed from the Walmart 401(k) Plan. (See below if you have made Roth contributions to the Plan.)

In general, after-tax contributions included in a payment are not taxed. If a payment is only part of your benefit, an allocable portion of your after-tax contributions is

included in the payment, so you cannot take a payment of only after-tax contributions. However, if you have pre-1987 after-tax contributions maintained in a separate account, a special rule may apply to determine whether the after-tax contributions are included in a payment. In addition, special rules apply when you do a rollover, as described below.

You may roll over to an IRA a payment that includes after-tax contributions through either a direct rollover or a 60-day rollover. You must keep track of the aggregate amount of the after-tax contributions in all of your IRAs (in order to determine your taxable income for later payments from the IRAs). If you do a direct rollover of only a portion of the amount paid from the Plan and at the same time the rest is paid to you, the portion directly rolled over consists first of the amount that would be taxable if not rolled over. For example, assume you are receiving a distribution of $12,000, of which $2,000 is after-tax contributions. In this case, if you directly roll over $10,000 to an IRA that is not a Roth IRA, no amount is taxable because the $2,000 amount not directly rolled over is treated as being after-tax contributions. If you do a direct rollover of the entire amount paid from the Plan to two or more destinations at the same time, you can choose which destination receives the after-tax contributions.

If you do a 60-day rollover to an IRA of only a portion of a payment made to you, the after-tax contributions are treated as rolled over last. For example, assume you are receiving a distribution of $12,000, of which $2,000 is after-tax contributions, and no part of the distribution is directly rolled over. In this case, if you roll over $10,000 to an IRA that is not a Roth IRA in a 60-day rollover, no amount is taxable because the $2,000 amount not rolled over is treated as being after-tax contributions.

You may roll over to an employer plan all of a payment that includes after-tax contributions, but only through a direct rollover (and only if the receiving plan separately accounts for after-tax contributions and is not a governmental section 457(b) plan). You can do a 60-day rollover to an employer plan of part of a payment that includes after-tax contributions, but only up to the amount of the payment that would be taxable if not rolled over.

If you miss the 60-day rollover deadline: Generally, the 60-day rollover deadline cannot be extended. However, the IRS has the limited authority to waive the deadline under certain extraordinary circumstances, such as when external events prevented you from completing the rollover by the 60-day rollover deadline. To apply for a waiver, you must file a private letter ruling request with the IRS. Private letter ruling requests require the payment of a nonrefundable user fee. For more information, see IRS Publication 590, *Individual Retirement Arrangements (IRAs)*.

If your payment includes employer stock that you do not roll over: If you do not do a rollover, you can apply a special rule to payments of employer stock that are paid in a lump sum after separation from service (or after age 59½, disability, or the participant's death). Under the special rule, the net unrealized appreciation on the stock will not be taxed when distributed from the Plan and will be taxed at capital gain rates when you sell the stock. Net unrealized appreciation is generally the increase in the value of employer stock after it was acquired by the Plan. If you do a rollover for a payment that includes employer stock (for example, by selling the stock and rolling over the proceeds within 60 days of the payment), the special rule relating to the distributed employer stock will not apply to any subsequent payments from the IRA or employer plan. The Plan Administrator can tell you the amount of any net unrealized appreciation.

If you have an outstanding loan that is being offset: If you have an outstanding loan from the Plan, your Plan benefit may be offset by the amount of the loan, typically when your employment ends. The loan offset amount is treated as a distribution to you at the time of the offset. Generally, you may roll over all or any portion of the offset amount. Any offset amount that is not rolled over will be taxed (including the 10% additional income tax on early distributions, unless an exception applies). You may roll over offset amounts to an IRA or an employer plan (if the terms of the employer plan permit the plan to receive plan loan offset rollovers).

How long you have to complete the rollover depends on what kind of plan loan offset you have. If you have a qualified plan loan offset, you will have until your tax return due date (including extensions) for the tax year during which the offset occurs to complete your rollover. A qualified plan loan offset occurs when a plan loan in good standing is offset because your employer plan terminates, or because you sever from employment. If your plan loan offset occurs for any other reason, then you have 60 days from the date the offset occurs to complete your rollover.

If you were born on or before January 1, 1936: If you were born on or before January 1, 1936 and receive a lump sum distribution that you do not roll over, special rules for calculating the amount of the tax on the payment might apply to you. For more information, see IRS Publication 575, *Pension and Annuity Income*.

If you roll over your payment to a Roth IRA: If you roll over a payment to a Roth IRA, a special rule applies under which the amount of the payment rolled over will be taxed. However, the 10% additional income tax on early distributions will not apply (unless you take the amount rolled over out of the Roth IRA within five years, counting from January 1 of the year of the rollover). If you roll over the payment to a Roth IRA, later payments from the Roth IRA that are qualified distributions will not be

taxed (including earnings after the rollover). A qualified distribution from a Roth IRA is a payment made after you are age 59½ (or after your death or disability, or as a qualified first-time homebuyer distribution of up to $10,000) and after you have had a Roth IRA for at least five years. In applying this five-year rule, you count from January 1 of the year for which your first contribution was made to a Roth IRA. Payments from the Roth IRA that are not qualified distributions will be taxed to the extent of earnings after the rollover, including the 10% additional income tax on early distributions (unless an exception applies). You do not have to take required minimum distributions from a Roth IRA during your lifetime. For more information, see IRS Publication 590, *Individual Retirement Arrangements (IRAs)*.

If you are not a plan participant

Payments after death of the participant. If you receive a distribution after the participant's death that you do not roll over, the distribution will generally be taxed in the same manner described elsewhere in this notice. However, the 10% additional income tax on early distributions does not apply, and the special rule described under the section **If you were born on or before January 1, 1936** applies only if the participant was born on or before January 1, 1936.

If you are a surviving spouse: If you receive a payment from the Plan as the surviving spouse of a deceased participant, you have the same rollover options that the participant would have had, as described elsewhere in this notice. In addition, if you choose to do a rollover to an IRA, you may treat the IRA as your own or as an inherited IRA.

An IRA you treat as your own is treated like any other IRA of yours, so that payments made to you before you are age 59½ will be subject to the 10% additional income tax on early distributions (unless an exception applies) and required minimum distributions from your IRA do not have to start until after you are age 70½.

If you treat the IRA as an inherited IRA, payments from the IRA will not be subject to the 10% additional income tax on early distributions. However, if the participant had started taking required minimum distributions, you will have to receive required minimum distributions from the inherited IRA. If the participant had not started taking required minimum distributions from the Plan, you will not have to start receiving required minimum distributions from the inherited IRA until the year the participant would have been age 70½.

If you are a surviving beneficiary other than a spouse: If you receive a payment from the Plan because of the participant's death and you are a designated beneficiary other than a surviving spouse, the only rollover option you have is to do a direct rollover to an inherited IRA or Roth IRA. Payments from the inherited IRA or Roth IRA will not be subject to the 10% additional income tax on early distributions. You will have to receive required minimum distributions from the inherited IRA or Roth IRA.

Payments under a qualified domestic relations order: If you are the spouse or former spouse of the participant who receives a payment from the Plan under a qualified domestic relations order (QDRO), you generally have the same options the participant would have (for example, you may roll over the payment to your own IRA or an eligible employer plan that will accept it). Payments under the QDRO will not be subject to the 10% additional income tax on early distributions.

If you are a nonresident alien: If you are a nonresident alien and you do not do a direct rollover to a U.S. IRA or U.S. employer plan, instead of withholding 20%, the Plan is generally required to withhold 30% of the payment for federal income taxes. If the amount withheld exceeds the amount of tax you owe (as may happen if you do a 60-day rollover), you may request an income tax refund by filing Form 1040NR and attaching your Form 1042-S. See Form W-8BEN for claiming that you are entitled to a reduced rate of withholding under an income tax treaty. For more information, see also IRS Publication 519, *U.S. Tax Guide for Aliens*, and IRS Publication 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*.

OTHER SPECIAL RULES

If your payments for the year are less than $200, the Plan is not required to allow you to do a direct rollover and is not required to withhold for federal income taxes. However, you may do a 60-day rollover.

You may have special rollover rights if you recently served in the U.S. Armed Forces. For more information on special rollover rights related to the U.S. Armed Forces, see IRS Publication 3, *Armed Forces' Tax Guide*. You also may have special rollover rights if you were affected by a federally declared disaster (or similar event), or if you received a distribution on account of a disaster. For more information on special rollover rights related to disaster relief, see the IRS website at **www.irs.gov**.

FOR MORE INFORMATION

You may wish to consult with the Plan Administrator or payer, or a professional tax advisor, before taking a payment from the Plan. Also, you can find more detailed information on the federal tax treatment of payments from employer plans in IRS Publication 575, *Pension and Annuity Income*; IRS Publication 590, *Individual Retirement Arrangements (IRAs)*; and IRS Publication 571, *Tax-Sheltered Annuity Plans (403(b) Plans)*. These publications are available from a local IRS office, on the web at **www.irs.gov**, or by calling **800-TAX-FORM**.

Special tax notice addendum: Roth contributions

YOUR ROLLOVER OPTIONS

The law requires that participants receive this notice before receiving a distribution from the Plan from your Roth Account (or any Roth amounts that were merged into to the Plan from your prior employer's plan). You may or may not currently be eligible to receive a distribution from the Plan. If you are eligible for a distribution, however, you should review this notice carefully before you elect a distribution from the Plan. This notice is intended to help you decide whether to elect a rollover. If you are not currently eligible for a distribution, you should retain this notice and review it when you are eligible for a distribution.

Rules that apply to most payments from your Roth Account (or any Roth amounts that were merged into or rolled over to the Plan from your prior employer's plan, referred to collectively in this addendum as your "Roth Account") are described in the **General information about rollovers** section. Special rules that only apply in certain circumstances are described in the **Special rules and options** section.

Rules that apply to payments from the Plan, other than from your Roth Account (or any Roth amounts that were merged into or rolled over to the Plan from your prior employer's plan) are described in the separate **Special tax notice addendum** above.

GENERAL INFORMATION ABOUT ROLLOVERS

How can a rollover affect my taxes? After-tax contributions included in a payment from your Roth Account are not taxed, but earnings might be taxed. The tax treatment of earnings included in the payment depends on whether the payment is a qualified distribution. If a payment is only part of your Roth Account, the payment will include an allocable portion of the earnings in your Roth Account.

If the payment from the Plan is not a qualified distribution and you do not do a rollover to a Roth IRA or a designated Roth account in an employer plan, you will be taxed on the earnings in the payment. If you are under age 59½, a 10% additional income tax on early distributions (generally, distributions made before age 59½) will also apply to the earnings (unless an exception applies). However, if you do a rollover, you will not have to pay taxes currently on the earnings and you will not have to pay taxes later on payments that are qualified distributions.

If the payment from the Plan is a qualified distribution, you will not be taxed on any part of the payment even if you do not do a rollover. If you do a rollover, you will not be taxed on the amount you roll over and any earnings on the amount you roll over will not be taxed if paid later in a qualified distribution.

A qualified distribution from your Roth Account in the Plan is a payment made after you are age 59½ (or after your death or disability) and after you have had a Roth Account in the Plan for at least 5 years. In applying the 5-year rule, you count from January 1 of the year your first contribution was made to the Roth Account. However, if you did a direct rollover to a Roth Account in the Plan from a designated Roth account in another employer plan, your participation will count from January 1 of the year your first contribution was made to the Roth Account in the Plan or, if earlier, to the designated Roth account in the other employer plan.

What types of retirement accounts and plans may accept my rollover? You may roll over the payment to either a Roth IRA (a Roth individual retirement account or Roth individual retirement annuity) or a designated Roth account in an employer plan (a tax-qualified plan, section 403(b) plan, or governmental section 457 plan) that will accept the rollover. The rules of the Roth IRA or employer plan that holds the rollover will determine your investment options, fees, and rights to payment from the Roth IRA or employer plan (for example, no spousal consent rules apply to Roth IRAs and Roth IRAs may not provide loans). Further, the amount rolled over will become subject to the tax rules that apply to the Roth IRA or the designated Roth account in the employer plan. In general, these tax rules are similar to those described elsewhere in this notice, but differences include:

- If you do a rollover to a Roth IRA, all of your Roth IRAs will be considered for purposes of determining whether you have satisfied the 5-year rule (counting from January 1 of the year for which your first contribution was made to any of your Roth IRAs).
- If you do a rollover to a Roth IRA, you will not be required to take a distribution from the Roth IRA during your lifetime and you must keep track of the aggregate amount of the after-tax contributions in all of your Roth IRAs (in order to determine your taxable income for later Roth IRA payments that are not qualified distributions).
- Eligible rollover distributions from a Roth IRA can only be rolled over to another Roth IRA.

How do I do a rollover? There are two ways to do a rollover. You can either do a direct rollover or a 60-day rollover.

If you do a direct rollover, the Plan will make the payment directly to your Roth IRA or designated Roth account in an employer plan. You should contact the Roth IRA sponsor or the administrator of the employer plan for information on how to do a direct rollover.

If you do not do a direct rollover, you may still do a rollover by making a deposit (generally within 60 days) into a Roth IRA, whether the payment is a qualified or nonqualified distribution. In addition, you can do a rollover by making a deposit within 60 days into a designated Roth account in an employer plan if the payment is a nonqualified distribution and the rollover does not exceed the amount of the earnings in the payment. You cannot do a 60-day rollover to an employer plan of any part of a qualified distribution. If you receive a distribution that is a nonqualified distribution and you do not roll over an amount at least equal to the earnings allocable to the distribution, you will be taxed on the amount of those earnings not rolled over, including the 10% additional income tax on early distributions if you are under age 59½ (unless an exception applies).

If you do a direct rollover of only a portion of the amount paid from the Plan and a portion is paid to you at the same time, the portion directly rolled over consists first of earnings. If you do not do a direct rollover and the payment is not a qualified distribution, the Plan is required to withhold 20% of the earnings for federal income taxes (up to the amount of cash and property received other than employer stock). This means that, in order to roll over the entire payment in a 60-day rollover to a Roth IRA, you must use other funds to make up for the 20% withheld.

How much may I roll over? If you wish to do a rollover, you may roll over all or part of the amount eligible for rollover. Any payment from the Plan is eligible for rollover, except:

- Required minimum distributions after age 70½ (or after death);
- Hardship distributions;
- ESOP dividends;
- Corrective distributions of contributions that exceed tax law limitations; and
- Loans treated as deemed distributions (for example, loans in default due to missed payments before your employment ends).

The Administrator or the payor can tell you what portion of a payment is eligible for rollover.

If I don't do a rollover, will I have to pay the 10% additional income tax on early distributions? If a payment is not a qualified distribution and you are under age 59½, you will have to pay the 10% additional income tax on early distributions with respect to the earnings allocated to the payment that you do not roll over (including amounts withheld for income tax), unless one of the exceptions listed below applies. This tax is in addition to the regular income tax on the earnings not rolled over.

The 10% additional income tax does not apply to the following payments from the Plan:

- Payments made after you separate from service if you will be at least age 55 in the year of the separation;
- Payments made due to disability;
- Payments after your death;
- Payments of ESOP dividends;
- Corrective distributions of contributions that exceed tax law limitations;
- Payments made directly to the government to satisfy a federal tax levy;
- Payments made under a qualified domestic relations order (QDRO);
- Certain payments made while you are on active duty if you were a member of a reserve component called to duty after September 11, 2001 for more than 179 days; and
- Payments for certain distributions relating to certain federally declared disasters.

If I do a rollover to a Roth IRA, will the 10% additional income tax apply to early distributions from the IRA? If you receive a payment from a Roth IRA when you are under age 59½, you will have to pay the 10% additional income tax on early distributions on the earnings paid from the Roth IRA, unless an exception applies or the payment is a qualified distribution. In general, the exceptions to the 10% additional income tax for early distributions from a Roth IRA listed above are the same as the exceptions for early distributions from a plan. However, there are a few differences for payments from a Roth IRA, including:

- The exception for payments made after you separate from service if you will be at least age 55 in the year of the separation (or age 50 for qualified public safety employees) does not apply.
- The exception for qualified domestic relations orders (QDROs) does not apply (although a special rule applies under which, as part of a divorce or separation agreement, a tax-free transfer may be made directly to a Roth IRA of a spouse or former spouse).
- An exception for payments made at least annually in equal or close to equal amounts over a specified period applies without regard to whether you have had a separation from service.
- There are additional exceptions for (1) payments for qualified higher education expenses, (2) payments up to $10,000 used in a qualified first-time home purchase, and (3) payments for health insurance premiums after you have received unemployment compensation for 12 consecutive weeks (or would have been eligible to receive unemployment compensation but for self-employed status).

Will I owe state income taxes? This notice does not describe any state or local income tax rules (including withholding rules).

SPECIAL RULES AND OPTIONS

If you miss the 60-day rollover deadline: Generally, the 60-day rollover deadline cannot be extended. However, the IRS has the limited authority to waive the deadline under certain extraordinary circumstances, such as when external events prevented you from completing the rollover by the 60-day rollover deadline. Under certain circumstances, you may claim eligibility for a waiver of the 60-day rollover deadline by making a written self-certification. Otherwise, to apply for a waiver from the IRS, you must file a private letter ruling request with the IRS. Private letter ruling requests require the payment of a nonrefundable user fee. For more information, see IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs).*

If you have an outstanding loan that is being offset: If you have an outstanding loan from the Plan, your Plan benefit may be offset by the outstanding amount of the loan, typically when your employment ends. The offset amount is treated as a distribution to you at the time of the offset. Generally, you may roll over all or any portion of the offset amount. If the distribution attributable to the offset is not a qualified distribution and you do not roll over the offset amount, you will be taxed on any earnings included in the distribution (including the 10% additional income tax on early distributions, unless an exception applies). You may roll over the earnings included in the loan offset to a Roth IRA or designated Roth account in an employer plan (if the terms of the employer plan permit the plan to receive plan loan offset rollovers). You may also roll over the full amount of the offset to a Roth IRA.

How long you have to complete the rollover depends on what kind of plan loan offset you have. If you have a qualified plan loan offset, you will have until your tax return due date (including extensions) for the tax year during which the offset occurs to complete your rollover. A qualified plan loan offset occurs when a plan loan in good standing is offset because your employer plan terminates, or because you sever from employment. If your plan loan offset occurs for any other reason, then you have 60 days from the date the offset occurs to complete your rollover.

If you receive a nonqualified distribution and you were born on or before January 1, 1936: If you were born on or before January 1, 1936, and receive a lump sum distribution that is not a qualified distribution and that you do not roll over, special rules for calculating the amount of the tax on the earnings in the payment might apply to you. For more information, see IRS Publication 575, *Pension and Annuity Income.*

If you are not a Plan participant

Payments after death of the participant. If you receive a distribution after the participant's death that you do not roll over, the distribution will generally be taxed in the same manner described elsewhere in this notice. However, whether the payment is a qualified distribution generally depends on when the participant first made a contribution to the designated Roth account in the Plan. Also, the 10% additional income tax on early distributions and the special rules for public safety officers do not apply, and the special rule described under the section "If you receive a nonqualified distribution and you were born on or before January 1, 1936" applies only if the participant was born on or before January 1, 1936.

If you are a surviving spouse: If you receive a payment from the Plan as the surviving spouse of a deceased participant, you have the same rollover options that the participant would have had, as described elsewhere in this notice. In addition, if you choose to do a rollover to a Roth IRA, you may treat the Roth IRA as your own or as an inherited Roth IRA.

A Roth IRA you treat as your own is treated like any other Roth IRA of yours, so that you will not have to receive any required minimum distributions during your lifetime and earnings paid to you in a nonqualified distribution before you are age 59½ will be subject to the 10% additional income tax on early distributions (unless an exception applies).

If you treat the Roth IRA as an inherited Roth IRA, payments from the Roth IRA will not be subject to the 10% additional income tax on early distributions. An inherited Roth IRA is subject to required minimum distributions. If the participant had started taking required minimum distributions from the Plan, you will have to receive required minimum distributions from the inherited Roth IRA. If the participant had not started taking required minimum distributions, you will not have to start receiving required minimum distributions from the inherited Roth IRA until the year the participant would have been age 70½.

If you are a surviving beneficiary other than a spouse: If you receive a payment from the Plan because of the participant's death and you are a designated beneficiary other than a surviving spouse, the only rollover option you have is to do a direct rollover to an inherited Roth IRA. Payments from the inherited Roth IRA, even if made in a nonqualified distribution, will not be subject to the 10% additional income tax on early distributions. You will have to receive required minimum distributions from the inherited Roth IRA.

Payments under a qualified domestic relations order: If you are the spouse or a former spouse of the participant who receives a payment from the Plan under a qualified domestic relations order (QDRO), you generally have

the same options and the same tax treatment that the participant would have (for example, you may roll over the payment as described in this notice).

If you are a nonresident alien: If you are a nonresident alien and you do not do a direct rollover to a U.S. IRA or U.S. employer plan, instead of withholding 20%, the Plan is generally required to withhold 30% of the payment for federal income taxes. If the amount withheld exceeds the amount of tax you owe (as may happen if you do a 60-day rollover), you may request an income tax refund by filing Form 1040NR and attaching your Form 1042-S. See Form W-8BEN for claiming that you are entitled to a reduced rate of withholding under an income tax treaty. For more information, see also IRS Publication 519, *U.S. Tax Guide for Aliens*, and IRS Publication 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*.

OTHER SPECIAL RULES

If your payments for the year (only including payments from the designated Roth account in the Plan) are less than $200, the Plan is not required to allow you to do a direct rollover and is not required to withhold federal income taxes. However, you can do a 60-day rollover.

You may have special rollover rights if you recently served in the U.S. Armed Forces. For more information on special rollover rights related to the U.S. Armed Forces, see IRS Publication 3, *Armed Forces' Tax Guide*. You also may have special rollover rights if you were affected by a federally declared disaster (or similar event), or if you received a distribution on account of a disaster. For more information on special rollover rights related to disaster relief, see the IRS website at **www.irs.gov**.

FOR MORE INFORMATION

You may wish to consult with the Plan Administrator or payor, or a professional tax advisor, before taking a payment from the Plan. Also, you can find more detailed information on the federal tax treatment of payments from employer plans in IRS Publication 575, *Pension and Annuity Income*; IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*; IRS Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*; and IRS Publication 571, *Tax-Sheltered Annuity Plans (403(b) Plans)*. These publications are available from a local IRS office, on the web at **www.irs.gov**, or by calling **800-TAX-FORM**.

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Claims and appeals

As a participant in the Associates' Health and Welfare Plan, you have the right to appeal a decision regarding Plan eligibility and benefits. This chapter describes the process and the deadlines for appealing a claim that has been partially or fully denied in the areas of eligibility, medical, pharmacy, dental, vision, HMO plans, life insurance, AD&D, disability, or critical illness and accident insurance.

RESOURCES	
Find What You Need	
Submit a claim for benefits	For medical, pharmacy, dental, and vision claims, see your plan ID card for the claims address or call your health care advisor at the number on your plan ID card. Submit Centers of Excellence claims to the administrator as shown in the chart later in the chapter. Submit all other claims to the Plan's third-party administrators as shown later in this chapter.
Appeal a denied claim	Submit appeals to the addresses provided in this chapter for the Plan's third-party administrators and/or People Services, depending on the nature of your appeal. Your initial denial letter will also specify where to file an appeal.
Appeal a decision on eligibility for coverage or enrollment status	Write to: **Walmart People Services** **Attn: Internal Appeals** **508 SW 8th Street** **Bentonville, Arkansas 72716-3500** Or fax to **888-715-4154** Or for COBRA appeals, write to: **WageWorks (COBRA Appeals)** **P.O. Box 226591** **Dallas, Texas 75222-6591**
Designate an authorized representative to submit appeals on your behalf	Call the number on your plan ID card or call People Services at **800-421-1362**

What you need to know about claims and appeals

- You have the right to appeal an adverse eligibility decision affecting your coverage.
- You have the right to appeal an adverse preauthorization decision regarding your requested benefits.
- You must submit claims for benefits directly to the third-party administrator or provider of the Plan.
- You have the right to appeal a benefit claim that has been partially or fully denied.
- You can appoint another party to appeal on your behalf by completing the Plan's authorized representative form.
- After a final decision of an appeal of a medical, pharmacy, or Centers of Excellence claim is made, you may have the right to request an independent external review of the decision if your claim involves medical judgment.
- Decisions regarding enrollment, eligibility status, and questions related to eligibility waiting periods are not eligible for external review, but are eligible for voluntary review under the Plan. In addition, for the medical, dental, and vision plans, appeals denied for nonmedical administrative reasons (e.g., because you exceeded the Plan's visit limits) are eligible for voluntary review under the Plan.
- You have the right to bring legal action if a claim is denied on appeal, but only after you have exhausted the Plan's claims and appeals procedures.

Deadlines to file a claim or bring legal action

Unless otherwise specified in the chapter describing the applicable benefit, initial claims for benefits under the Plan must be filed within 18 months from the date of service. Since procedures for filing a claim or an appeal are different for different benefit plans and third-party administrators, be sure to review the relevant section of this chapter for detailed information. You must complete the required claims and appeals process described in this **Claims and appeals** chapter before you may bring legal action or, for certain medical, pharmacy, dental, or Centers of Excellence claims, pursue external review. You may not file a lawsuit for benefits if the initial claim or appeal is not made within the time periods set forth in the claims procedures of the Plan.

You must file any lawsuit for benefits within 180 days after the final decision on appeal (whether by the Plan or after external review). You may not file suit after the end of that 180-day period. You are not required to request a voluntary review by the Plan or an external review of the decision on appeal before filing a lawsuit. If you request a voluntary review or an external review of the decision on appeal, where applicable, the time taken by the voluntary review or external review is not counted against the 180 days you have to file a lawsuit.

BENEFITS MAY NOT BE ASSIGNED

You may not assign your legal rights or rights to any payments under this Plan. However, the Plan may choose to remit payments directly to health care providers with respect to covered services, but only as a convenience to you and only if you authorize the Plan to do so. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) you or your dependents under any circumstances.

Appealing an enrollment or eligibility status decision

This section describes the appeal process that applies to enrollment and eligibility only.

If you disagree with the Plan Administrator's determination regarding your enrollment or eligibility status, you have 365 days from your eligibility enrollment event to appeal in writing to People Services, attention Internal Appeals, at the address in the **Resources** chart at the beginning of this chapter.

Eligibility decisions regarding the transplant and weight loss surgery benefit waiting period are determined under the claims and appeals time frames for medical claims, as described in the section that follows.

COBRA participants should send the appeal, in writing, to WageWorks at the address the **Resources** chart at the beginning of this chapter.

Your appeal will be handled within 60 days from the date it is received (30 days for COBRA appeals), unless an extension is required.

The 60-day period may be extended if it is determined that an extension is necessary due to matters beyond the Plan's control. You will be notified prior to the end of the 60-day period if an extension or additional information is required. Appeals of enrollment or eligibility decisions are not eligible for external review but are eligible for voluntary review.

Medical, pharmacy, Centers of Excellence, dental, and vision benefits claims process

This section describes the claims process that will be used for the following benefits only:

- Medical, pharmacy, and Centers of Excellence benefits except for HMO Plans and the eComm PPO Plan; see **HMO plan claims and appeals procedures and eComm PPO Plan claims and appeals procedures** later in this chapter
- Dental benefits (through Delta Dental)
- Vision benefits (through VSP), and
- A rescission of coverage, which is a cancellation of coverage that has a retroactive effect, except where cancellation of coverage is due to failure to pay required contributions or premiums in a timely manner.

If you choose to prenotify the third-party administrator of a scheduled medical service before you receive treatment or file a claim for benefits, and prenotification is not otherwise required under the Plan, the third-party administrator's response is nonbinding on the Plan and not subject to appeal. However, if the third-party administrator requires you or your provider to preauthorize services (including under the Centers of Excellence program and local plans), and your request for prior authorization is denied, that decision is subject to appeal.

Refer to the respective chapters in this Summary Plan Description for information on filing your initial claim. Initial claims will be determined by Plan Administrators as listed in the chart on the following page.

CLAIMS AND APPEALS ADMINISTRATION: ROUTINE MEDICAL, PHARMACY, DENTAL, AND VISION	
Medical (For Centers of Excellence claims, see below)	**Your third-party administrator** (see your plan ID card) Including services performed at a Centers of Excellence facility but not covered under the Centers of Excellence program and transplant claims not required to be performed at Mayo Clinic. If you are a participant in one of the Mercy local plans, Mercy will handle prior authorizations and HealthSCOPE Benefits will process claims. If you are a participant in the UnityPoint Local Plan, Precedence Inc. will handle prior authorizations and HealthSCOPE Benefits will process claims.
Pharmacy	**OptumRx**
Dental	**Delta Dental**
Vision	**VSP**
CENTERS OF EXCELLENCE **NOTE:** If you are enrolled in a local plan, please call your health care advisor to be directed to the appropriate administrator.	
Heart surgery	**Contigo Health (formerly Health Design Plus)**
Cancer medical record review	**HealthSCOPE Benefits**
Outpatient kidney dialysis or ESRD medical record review	**HealthSCOPE Benefits**
Spine surgery	**Contigo Health (formerly Health Design Plus)**
Hip and knee replacement	**Contigo Health (formerly Health Design Plus)**
Transplant	**HealthSCOPE Benefits**
Weight loss surgery	**Contigo Health (formerly Health Design Plus)**

The time period in which your claim is determined depends on the type of claim. The Plan requires prior authorization for all Centers of Excellence services and certain other services, as described in the **Preauthorization** section of **The medical plan** chapter. For these benefits, you or your provider must file a claim for approval before you receive treatment, or your claim may not be paid. These are called "pre-service claims." If your pre-service claim is urgent, your claim will be decided under the time frames applicable to urgent care. A claim is urgent where making a determination under the normal time frames could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

If you are filing a claim after you have already received services, your claim is a post-service claim. If your claim arises when there is a reduction in ongoing care, your claim is a concurrent care claim.

The chart on the following page shows deadlines for claims determinations for these types of claims.

CLAIMS PROCESS AND TIMING	
Urgent claims Any claim for medical care or treatment where making a determination under the normal time frames could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.	Notice will be sent as soon as possible, taking into account the medical circumstances, and in no case later than 72 hours after receipt of the claim. You may receive notice orally, in which case a written notice will be provided within three days of the oral notice. If your urgent claim is determined to be incomplete, you will receive a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information. If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request.
Pre-service claims A claim for services that have not yet been rendered and for which the Plan requires prior authorization.	If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the claim. If an extension is necessary due to matters beyond the Plan's control, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Plan expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Plan then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information. If your pre-service claim is improperly filed, you will be sent notification within five days of receipt of the claim.
Post-service claims A claim for services that already have been rendered, or where the Plan does not require prior authorization.	A notice will be sent within a reasonable time period, but not longer than 30 days from receipt of the claim. If an extension is necessary due to matters beyond the Plan's control, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Plan expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Plan then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.
Concurrent care claims A claim related to a reduction of ongoing services.	You will be notified in advance of any decision to reduce or terminate coverage for ongoing care so that you will be able to appeal the decision before the coverage is reduced or terminated, unless such a reduction or termination is due to a Plan amendment or termination of the Plan.

If your claim is denied, the denial will include the following information:

- The specific reasons for the denial
- Reference to Plan provisions on which the denial was based
- Information regarding time limits for appeal
- A description of any additional information necessary to consider your claim and why such information is necessary
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitation, an explanation of this rule (or a statement that it is available upon request), and
- Notice regarding your right to bring legal action following a denial on appeal.

For medical, pharmacy, Centers of Excellence, and vision benefits, the denial also will include:

- Information sufficient to identify the claim involved, including, as applicable, the date of service, health care provider, and claim amount
  - Upon written request, the Plan will provide you with the diagnosis and treatment codes (and their corresponding meanings) associated with any denied claim or appeal.
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal, and
- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist participants with the internal and external appeals process.

Internal appeal process

APPEALING A CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED: MEDICAL, CENTERS OF EXCELLENCE, PHARMACY, DENTAL, OR VISION CLAIMS

You may request an appeal of the decision. In order for your appeal to be considered, it must:

- Be in writing
- Be sent to the correct address
- Be submitted within 365 days of the date of the initial denial (for medical, Centers of Excellence, and dental claims) or 180 days (for pharmacy and vision claims), and
- Contain any additional information/documentation you would like considered.

If your appeal involves an urgent claim, please contact your third-party administrator for information about how to file your claim orally.

Aetna and OptumRx allow two levels of review. The second appeal must be submitted within 60 days of the date of the first appeal denial. All other third-party administrators have one level of appeal.

Send your written request for review of the initial claim to the third-party administrator that administers your claims, as listed in the chart that follows.

MAILING ADDRESSES FOR APPEALS	
MEDICAL SERVICES (Including services performed at a Centers of Excellence facility but not covered under the Centers of Excellence program) *Refer to your plan ID card for the name of your third-party administrator.*	
Aetna	Aetna Attn: National Account CRT P.O. Box 14463, Lexington, Kentucky 40512 **855-548-2387**
BlueAdvantage Administrators of Arkansas	BlueAdvantage Administrators P.O. Box 1460, Little Rock, Arkansas 72203-1460 **866-823-3790**
HealthSCOPE Benefits	HealthSCOPE Benefits Attn: Appeals P.O. Box 2359, Little Rock, Arkansas 72203 **800-804-1272**
UnitedHealthcare	UnitedHealthcare National Appeals Service Center P.O. Box 30575, Salt Lake City, Utah 84130-0575 **888-285-9255**
CENTERS OF EXCELLENCE SERVICES *Note that there is a special claims and appeals process for certain Centers of Excellence benefits. See details later in this chapter.*	
Contigo Health (formerly Health Design Plus) • Heart, spine, and hip and knee replacement surgeries • Weight loss surgery	Contigo Health Centers of Excellence: Walmart Attn: Appeals Coordinator 1755 Georgetown, Hudson, Ohio 44236
HealthSCOPE Benefits, Inc. • Heart and weight loss surgery at Emory Local Plan • Weight loss surgery at Mercy Local Plan • Cancer care • Mayo Clinic transplant appeals	HealthSCOPE Benefits, Inc. Attn: Appeals Coordinator 27 Corporate Hill Drive, Little Rock, Arkansas 72205
PHARMACY	
OptumRx	OptumRx Attn: Appeals Coordinator P.O. Box 25184. Santa Ana, California 92799
DENTAL	
Delta Dental of Arkansas	Delta Dental of Arkansas Appeals Committee P.O. Box 15965, Little Rock, Arkansas 72231-5965
VISION	
VSP	VSP Member Appeals 3333 Quality Drive, Rancho Cordova, California 95670

Your appeal will be conducted without regard to your initial determination, by someone other than the party who decided your initial claim. No deference will be afforded to the initial determination. You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You have the right to request copies, free of charge, of all documents, records, or other information relevant to your claim. The third-party administrator, on behalf of the Plan, will provide you with any new or additional evidence or rationale considered in connection with your claim sufficiently in advance of the appeals determination date to give you a reasonable opportunity to respond.

If your claim involves a medical judgment question, the Plan 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, the Plan will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

A final decision on appeal will be made within the time periods specified in the chart that follows, depending on the type of claim:

APPEAL PROCESS AND TIMING	
Urgent claims	You will be notified of the determination as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of the claim (36 hours for Aetna appeals).
Pre-service claims	You will be notified of the determination within a reasonable period of time, taking into account the medical circumstances, but no later than 30 days from the date your request is received (15 days for Aetna appeals).
Post-service claims	You will be notified of the determination within a reasonable period of time, but no later than 60 days from the date your request is received (30 days for Aetna appeals).

If your claim is denied on appeal, you will receive a denial notice that includes:

- The specific reasons for the denial
- Reference to Plan provisions on which the denial was based
- A statement describing your right to request copies, free of charge, of all documents, records, or other information relevant to your claim
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on a medical necessity or similar limitation, an explanation of this rule (or a statement that it is available upon request)
- A description of any voluntary review procedures available, and
- Notice regarding your right to bring legal action following a denial on appeal.

For medical, pharmacy, and Centers of Excellence benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider, and claim amount (if applicable)
  - Upon written request, the Plan will provide you with the diagnosis and treatment codes (and their corresponding meanings) associated with any denied claim or appeal.
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal, and
- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist participants with the internal and external appeals process.

SPECIAL PROCEDURES FOR APPROVAL OF A TRANSPLANT LOCATION OTHER THAN MAYO CLINIC

As described in **The medical plan** chapter, all eligible transplant recipients under the Centers of Excellence program must undergo a pre-transplant evaluation at Mayo Clinic. For these transplants, Mayo Clinic will make a recommendation regarding transplant services at Mayo Clinic. You may file a prior authorization request to receive a transplant at a facility other than Mayo Clinic if there is significant risk that travel to Mayo Clinic could result in death. In addition, if Mayo Clinic recommends that a transplant is not an appropriate medical course of treatment or the patient is not an appropriate candidate, you may file a prior authorization request with the Plan.

These requests will be considered by an Independent Review Organization appointed by the Plan Administrator, which may approve the request for transplant services at a different facility.

The Independent Review Organization will not include any employee of Walmart, Mayo Clinic, or a third-party administrator of the Plan. The Independent Review Organization will review any pertinent medical files reviewed or generated by Mayo Clinic, as well as any additional materials you submit, and will consider your condition, alternative courses of treatment, scientific

studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures, and the potential benefit of the transplant.

Send your written request for review of preauthorization transplant claims to:

Walmart People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500
800-421-1362

Or fax to **888-715-4154**

If you are filing a claim for services at a facility other than Mayo Clinic because there is significant risk that travel to Mayo Clinic could result in death, you should file as soon as possible. If you are filing a claim because Mayo Clinic has determined that the transplant is not an appropriate medical course of treatment, your claim must be received by the Plan within 120 calendar days of Mayo Clinic's initial denial of transplant treatment. If the claim is urgent, the Independent Review Organization will make its determination within 72 hours after receipt of the claim (otherwise, the Independent Review Organization will make its determination within 15 days of receipt of the claim).

If the urgent claim is determined to be incomplete, you will receive a notice within 24 hours of receipt of the claim, and you will have 48 hours to provide additional information.

For non-urgent claims, the deadline to decide the claim may be extended 15 days, and the Independent Review Organization will send a notice explaining the extension. If the extension is necessary to request additional information, the extension notice will describe the required information and you will be given at least 45 days to submit the information. The Plan will make a determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.

You will have 180 days to request internal review of a denial by the Independent Review Organization. The Independent Review Organization will decide a request for urgent review within 72 hours and non-urgent review within 30 days after receipt. You then may appeal a denial of an internal review appeal under the external appeal process described in this section if your claim involves medical judgment.

Cornea and intestinal transplants, and any other transplant service or claim where treatment already has been rendered, will be decided under the regular medical claims and appeals procedures for post-service claims outlined earlier in this chapter.

SPECIAL PROCEDURES FOR APPROVAL OF EXCEPTIONS TO PLAN COVERAGE TERMS FOR SPINE SURGERY AND HIP AND KNEE REPLACEMENT

As described in **The medical plan** chapter, spine surgery and hip and knee replacements that are eligible to be performed at a Centers of Excellence facility must be pre-approved by the administrator of the program and performed at a Centers of Excellence facility in order for Centers of Excellence benefits to be payable. You may file a prior authorization request (a "pre-service" claim) to receive services at a non-Centers of Excellence facility and receive in-network benefits if there is significant risk that travel could result in paralysis or death, or where a Centers of Excellence facility determines that the procedure is not the appropriate medical course of treatment or that you are not an appropriate candidate for surgery.

In addition, if you have already received surgical treatment because your circumstances called for immediate surgery, without which you would likely have suffered paralysis or loss of life, you may request that the services you received at a non-Centers of Excellence facility be covered as in-network services (a "post-service" claim).

Pre-service claims will be considered by Contigo Health (formerly Health Design Plus), the administrator of the Centers of Excellence for spine surgery and hip and knee replacement, which may approve coverage at the in-network level for spine surgery or hip or knee replacement at a non-Center of Excellence facility.

Send your written request for a pre-service exception to the Plan's coverage terms for spine surgery or hip or knee replacement to:

Centers of Excellence: Walmart
Attn: Appeals Coordinator
1755 Georgetown
Hudson, Ohio 44236

Contigo Health (formerly Health Design Plus) will utilize an Independent Review Organization which will not include any associate of Walmart or the Centers of Excellence facility for spine surgery or hip or knee replacement. The Independent Review Organization will review any pertinent medical files that were reviewed or generated by the Centers of Excellence facility, as well as any additional materials you submit, and will consider your condition, alternative courses of treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures, and the potential benefit the surgical procedure would have.

Post-service claims will be considered by an Independent Review Organization appointed by the Plan Administrator, which may approve coverage at the in-network level for the spine surgery or hip or knee replacement at a non-Centers of Excellence facility.

The Independent Review Organization will not include any associate of Walmart, the Centers of Excellence facility for spine surgery or hip or knee replacement, or a third-party administrator of the Plan. The Independent Review Organization will review any pertinent medical files that were reviewed or generated by the Centers of Excellence facility, as well as any additional materials you submit, and will consider your condition, alternative courses of treatment, scientific studies and evidence, other medical professionals' opinions, the investigational or experimental nature of the proposed procedures, and the potential benefit the surgical procedure would have.

Send your written request for a post-service exception to the Plan's coverage terms for spine surgery or hip or knee replacement to:

Walmart People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500
800-421-1362

Or fax to **888-715-4154**

If you are filing a pre-service claim for services at a non-Centers of Excellence facility because there is significant risk that travel could result in paralysis or death, you should file as soon as possible. If you are filing a pre-service claim because a Centers of Excellence facility determined that the surgery is not an appropriate medical course of treatment, your claim must be received by the Plan within 120 calendar days of the initial denial by the Centers of Excellence facility. If you are filing a post-service claim because you already received surgery elsewhere, as described above, you must file your claim within 120 calendar days of the date of service.

If a pre-service claim is urgent, Contigo Health (formerly Health Design Plus) will make its determination within 72 hours after receipt of the claim (otherwise, Contigo Health (formerly Health Design Plus) will make its determination within 15 days of receipt of a pre-service claim). If the urgent claim is determined to be incomplete, you will receive a notice within 24 hours of receipt of the claim, and you will have 48 hours to provide additional information. For non-urgent claims, the deadline to decide the claim may be extended 15 days, and Contigo Health (formerly Health Design Plus) will send a notice explaining the extension. If the extension is necessary to request additional information, the extension notice will describe the required information and you will be given at least 45 days to submit the information. Contigo Health (formerly Health Design Plus) will make a determination within 15 days from the date Contigo Health (formerly Health Design Plus) receives your information, or, if earlier, the deadline to submit your information.

If you file a post-service claim, the Independent Review organization will make its determination within 30 days of receipt of the post-service claim. For post-service claims, the deadline to decide the claim may be extended 15 days, and the Independent Review Organization will send a notice explaining the extension. If the extension is necessary to request additional information, the extension notice will describe the required information and you will be given at least 45 days to submit the information. The Independent Review Organization will make a determination within 15 days from the date the Independent Review Organization receives your information, or, if earlier, the deadline to submit your information.

You will have 180 days to request that an Independent Review Organization conduct an internal review of a denial of a pre-service claim by the Independent Review Organization designated by Contigo Health (formerly Health Design Plus), or a post-service claim of an Independent Review Organization. The Independent Review Organization will decide a request for urgent review of a pre-service claim within 72 hours after receipt, non-urgent review of a pre-service claim within 30 days after receipt, and review of a post-service claim within 60 days of receipt. You then may appeal a denial of an internal review appeal under the external appeal process described in this section if your claim involves medical judgment.

REQUESTING TO WAIVE THE ONE-YEAR WAITING PERIOD FOR TRANSPLANT BENEFITS

If the treating physician certifies that, absent the transplant, the individual's death is imminent within 48 hours, the otherwise applicable 12-month waiting period for transplant benefits may be waived. To request this waiver, the claimant must file a prior-authorization request.

Send your request and supporting documentation to Walmart People Services:

By email: **ghappeal@wal-mart.com**
By fax: **888-715-4154**
By mail: **Walmart People Services**
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Your request will be treated as an urgent or pre-service claim. See the **Appeal process and timing** chart earlier in this chapter for details on the time frames under which the Plan Administrator will notify you of its determination in response to your request.

REQUESTING A VOLUNTARY REVIEW OF A DENIED APPEAL: ENROLLMENT OR ELIGIBILITY STATUS DETERMINATIONS (INCLUDING COBRA)

If you have additional information that was not in your appeal, you may ask for a voluntary review of the decision on your appeal within 180 days of the date on the appeal

denial letter. The same criteria and response times that applied to your appeal are generally applied to this voluntary level of review.

Send a written request for a voluntary appeal for enrollment or eligibility status to:

Walmart People Services
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Or fax to **888-715-4154**

See **Deadlines to file a claim or bring legal** action earlier in this chapter regarding the deadline to bring legal action.

REQUESTING A VOLUNTARY REVIEW OF AN APPEAL DENIED FOR ADMINISTRATIVE REASONS: MEDICAL, DENTAL, AND VISION APPEALS

You may request a voluntary review of the decision on your appeal of a denied medical, dental, or vision benefit claim if your appeal was denied for an administrative reason, such as if you exceeded the number of allowed visits, rather than for a medical judgment reason. You must file your request within 180 days of the date on the appeal denial letter. The same criteria and response times that applied to your appeal are generally applied to this voluntary level of review.

Send a written request for a voluntary appeal for administrative denial to:

Walmart People Services
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Or fax to **888-715-4154**

External appeal process for medical, pharmacy, or Centers of Excellence benefits

If your internal appeal for medical, pharmacy, or Centers of Excellence benefits under the Plan is denied based on medical judgment, you may have the right to further appeal your claim in an independent external review process.

Your external appeal will be conducted by an independent review organization not affiliated with the Plan. If this independent review organization overturns the Plan's decision, the independent review organization's decision will be binding on the Plan. Your internal appeal denial notice will include information about your right to file a request for an external review as well as contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Send a written request for an external medical appeal to:

Walmart People Services
Attn: External Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500
800-421-1362

Or fax to **888-715-4154**

Send a written request for an external pharmacy appeal to:

OptumRx
Attn: Appeals Coordinator
P.O. Box 25184
Santa Ana, California 92799

Rights related to medical, pharmacy, Centers of Excellence, dental, vision, and short-term disability benefits

THE PLAN'S RIGHT TO REQUEST MEDICAL RECORDS

The Plan has the right to request medical records for any associate or covered individual.

THE PLAN'S RIGHT TO RECOVER OVERPAYMENT

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan has the right to recover the overpayment. The Plan (or the third-party administrator) will try to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from any participant, beneficiary, or dependent. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan's collection effort is not successful. The Plan may also bring a lawsuit to enforce its rights to recover overpayments.

If the overpayment is made to a provider, the Plan (or any third-party administrator) may reduce or deny benefits, in the amount of the overpayment, for otherwise covered services for current or future claims with the provider on behalf of any participant, beneficiary, or dependent in the Plan. If a provider to whom an overpayment was made has patients who are participants in other health and welfare plans administered by the third-party administrator, the third-party administrator may reduce payments otherwise owed to the provider from such other health plans by the amount of the overpayment.

YOUR RIGHT TO RECOVER OVERPAYMENT

If you overpay your contributions or premiums for any coverage under the Plan (except COBRA), the Plan will refund excess contributions or premiums to you upon request. In this circumstance, any refunds you receive may be offset by any benefits paid during this period by the Plan if you or a dependent was not eligible for such coverage.

THE PLAN'S RIGHT TO AUDIT

The Plan has the right to audit your claims, including claims of medical providers. The Plan (or the third-party administrator) may reduce or deny benefits for otherwise covered services for all current or future claims with the provider made on your behalf or a participant in any other health and welfare plan administered by the third-party administrator based on the results of an audit. The Plan may also reduce or deny benefits for otherwise covered services for all current or future claims you file.

THE PLAN'S RIGHT TO SALARY/WAGE DEDUCTION

To the extent that the Plan may recover from you or your dependents all or part of benefits previously paid, you shall be deemed, by virtue of your enrollment in any health and welfare coverage under the Plan, to have agreed that the company may deduct such amounts from your wages or salary and pay the same to the Plan until recovery is complete. If you enroll for coverage under the Plan, you will be treated by the Plan as if you had consented to the applicable payroll deductions for such coverage. In addition, if you fail to affirmatively enroll or reenroll during Annual Enrollment, you will be treated by the Plan as if you had consented to the automatic reenrollment described in the **Eligibility and enrollment** chapter, including the applicable payroll deductions.

The Plan's subrogation and reimbursement rights

If you or a covered dependent is injured or otherwise harmed due to the conduct of another party, the Plan Administrator has the right to recover payments it makes on your behalf from you or any party responsible for compensating you or your dependent for your illnesses or injuries. The legal term for this right of recovery is "subrogation." The Plan shall have a first-priority lien for the full amount of the benefits that are paid to you and/or your covered dependents and against future benefits due under the Plan in the amount of any claims paid, should you seek to recover any monies from the third party that caused the injuries.

The Plan has the right to:

- Reduce or deny benefits otherwise payable by the Plan, and
- Recover or subrogate 100% of the benefits paid or to be paid by the Plan for covered persons, to the extent of any and all of the following payments:
  - Any judgment, settlement, or payment made or to be made because of an accident or malpractice (except for malpractice that results in paraplegia/quadriplegia, severe burns, total and permanent physical or mental disability, or death), including other insurance
  - Any auto or recreational vehicle insurance coverage or benefits, including uninsured/underinsured motorist coverage
  - Business medical and/or liability insurance coverage or payments, and
  - Attorney fees.

The Plan's lien exists at the time the Plan pays any benefits. If a covered person files a petition for bankruptcy, the covered person agrees that the Plan's lien existed prior to the creation of the bankruptcy estate.

Also note that:

- "Covered person" means any participant (as defined by ERISA) or dependent of a participant who is entitled to benefits under the Plan
- The Plan has first priority with respect to its right to reduction, reimbursement, and subrogation
- The Plan has the right to recover interest on the amount paid by the Plan because of the accident
- The Plan has the right to 100% reimbursement in a lump sum
- The Plan is not subject to any state laws or equitable doctrine, including the common fund doctrine, which would purport to require the Plan to reduce its recovery by any portion of a covered person's attorney's fees and costs
- The Plan is not responsible for the covered person's attorney's fees, expenses, or costs
- The right of reduction, reimbursement, and subrogation is based on the Plan language in effect at the time of judgment, payment, or settlement
- The Plan's right to reduction, reimbursement, and subrogation applies to any funds recovered from another party, by or on behalf of the estate of any covered person, and
- The Plan's right to first priority shall not be reduced due to the participant's own negligence.

The Plan will not pursue reduction, reimbursement, or subrogation where the injury or illness that is the basis of the covered person's recovery from any party results in:

- Paraplegia or quadriplegia
- Severe burns
- Total and permanent physical or mental disability, or
- Death.

The Plan Administrator has the authority, in its sole discretion, to determine not to pursue the Plan's rights to reduction, reimbursement, or subrogation. For more information, contact the Plan Administrator.

Whether a covered person has a "total and permanent physical or mental disability" will be determined based on criteria developed and applied by the Plan Administrator in its sole discretion. One way of demonstrating total and permanent physical or mental disability is for a covered person to show that the covered person has qualified for Social Security disability income benefits. The Plan Administrator will consider claims for physical and mental disability, even if the covered person does not qualify for Social Security disability income benefits, under criteria developed by the Plan Administrator.

Even in circumstances where the Plan is not prohibited from seeking reduction, reimbursement, or subrogation based on the exceptions described previously, the Plan's right to reduction, reimbursement, or subrogation will be limited to no more than 50% of the total amount recovered by or on behalf of the covered person from any party (which shall not be reduced for the covered person's attorney's fees or costs). The Plan requires all covered persons and their representatives to cooperate to guarantee reimbursement to the Plan from third-party benefits. Failure to comply will entitle the Plan to withhold benefits due to you under the Plan. You and your representatives must not do anything to hinder reimbursement of overpayment to the Plan after benefits have been accepted by you or your representatives.

The Plan's rights to reduction, reimbursement, and subrogation apply regardless of any allocation or designation of your settlement (e.g., pain and suffering or medical benefits). The Plan's rights apply regardless of whether you have been made whole or fully compensated for your injuries.

Additionally, the Plan has the right to file suit on your behalf for the condition related to the expenses to recover benefits paid or to be paid by the Plan.

Claims for benefits and right to appeal reduction, reimbursement, and subrogation decisions

The Plan's decision to seek reduction, reimbursement, or subrogation is a determination of benefits under the Plan and may be appealed in accordance with the procedures below.

For purposes of the claims procedures specified below, a "claim for benefits" means a request by a participant, beneficiary, or dependent ("claimant") to have the benefits provided under the Plan not reduced through the application of the Plan's right to reduction, reimbursement, or subrogation.

INITIAL CLAIM FOR BENEFITS

If the Plan decides to seek reduction, reimbursement, or subrogation, the claimant will be notified of the Plan's decision in a written notice from the Plan or a party acting on behalf of the Plan.

If you receive a notice that your benefit is subject to reduction, reimbursement, or subrogation and you believe that your case falls within one of the exceptions or limitations to the Plan's right to reduction, reimbursement, or subrogation, you may file a claim for benefits with the Plan. You may also designate an authorized representative to submit claims for benefits or appeals on your behalf.

For an initial claim for benefits to be considered, it must:

- Be in writing
- Be sent to the correct address
- Be submitted within 12 months of the date of the notice that a benefit is subject to reduction, reimbursement, or subrogation
- Identify the exception or limitation to the Plan's right to reduction, reimbursement, or subrogation that you believe applies to your case, and
- Include documentation that will assist the Plan in making its decision (e.g., medical and hospital records, physician letters).

Send a written request for review of the initial claim for benefits to:

Walmart People Services
Attn: Subrogation Review
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Within a reasonable time, but no later than 30 days after your initial claim for benefits is made, the Plan will provide written notice of its decision. If the claim for benefits is partially or fully denied, the notice will include the following information:

- The specific reasons for the denial
- Reference to provisions of the Plan on which the denial was based
- A description of any additional material or information necessary to perfect your claim for benefits and an explanation of why such material or information is necessary
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making the Plan's determination
- A description of the Plan's appeal procedures and the time limits for appeal, and
- Notice regarding your right to bring a court action following a denial on appeal.

The 30-day period may be extended for 15 days if it is determined that an extension is necessary due to matters beyond the Plan's control. The Plan will notify you prior to the end of the 30-day period if an extension or additional information is required. If asked to provide additional information, you will have 45 days from the date notified to provide the information. The time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

IF A CLAIM RELATED TO A REDUCTION, REIMBURSEMENT, OR SUBROGATION DECISION IS FULLY OR PARTIALLY DENIED

The claimant may request an appeal of the decision. For your appeal to be considered, it must:

- Be in writing
- Be sent to the correct address
- Be submitted within 180 days of the date of the initial denial, and
- Contain any additional information/documentation you would like considered.

Send a written request for an appeal to:

Walmart People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Or fax to **888-715-4154**

The appeal will be conducted without regard to the initial determination by someone other than the party who decided the initial claim for benefits. You have the right to request copies, free of charge, of all documents, records, or other information relevant to the claimant's claim for benefits. You also have the right to submit written comments, documents, records, and other information, which the Plan will take into account in making its decision on appeal. In deciding any claim for benefits that is based in whole or in part on a medical judgment, the Plan's claims fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be an individual who is neither an individual who was consulted in connection with the Plan's decision on the initial claim for benefits, nor the subordinate of the health care professional. If the advice of a health care professional is obtained in deciding an appeal, the name of the health care professional will be provided to you upon request, regardless of whether the Plan relied on the advice. The Plan must provide you written notice of the Plan's decision on review within 60 days following the Plan's receipt of your appeal.

If the claim for benefits is denied on appeal, the Plan will provide a denial notice to you that includes:

- The specific reason(s) for the denial
- Specific reference to provisions of the Plan on which the denial was based
- A statement describing your right to request copies, free of charge, of all documents, records, or other information relevant to your claim for benefits
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- A description of available voluntary review procedures, if any, and
- Notice regarding your right to bring a court action following a denial on appeal.

The only method by which you can request the Plan not to reduce benefits is to file a claim for benefits. An initial claim for benefits must be filed within 12 months from the date of the notice. You must complete the required claims and appeals process described in these claims procedures before bringing legal action. You may not file a lawsuit for benefits if your initial claim for benefits or appeal is not made within the time periods set forth in these claims procedures. You must file any lawsuit for benefits within 180 days after the decision on appeal. You may not file suit after that 180-day period expires.

YOUR RESPONSIBILITY REGARDING RIGHT OF REDUCTION AND/OR RECOVERY

To aid the Plan in its enforcement of its right of reduction, recovery, reimbursement, and subrogation, you or your designated representative must, at the Plan's request and at its discretion:

- Take actions necessary to enable the Plan to exercise its rights of recovery
- Give information, or
- Sign documents so required by the Plan.

Failure to aid the Plan and to comply with such requests may result in the Plan's withholding or recovering benefits, services, payments, or credits due or paid under the Plan.

The Plan can seek reimbursement of 100% of medical benefits paid from any judgment, payment, or settlement that is made on behalf of the covered person for whom the medical benefits were paid. Reimbursement to the Plan of 100% of these charges shall be made at the time the payment is received by you or your representative.

HMO plan claims and appeals procedures

In some facilities, Walmart offers health insurance coverage through a health maintenance organization (HMO) as part of the Associates' Health and Welfare Plan. If you participate in an HMO, the HMO will provide a benefit booklet that, together with this document, will serve as the Summary Plan Description for the HMO coverage and will describe its claims and appeals procedures. Contact your HMO for additional information.

eComm PPO Plan claims and appeals procedures

In some facilities, Walmart offers the eComm PPO Plan as part of the Associates' Health and Welfare Plan. If you participate in the eComm PPO Plan, Aetna, the Plan's third-party administrator, will provide a booklet that, together with this document, will serve as the Summary Plan Description for the eComm PPO Plan coverage and describe its claims and appeals procedures. Contact Aetna for additional information.

Accident and critical illness insurance claims process

Accident and critical illness insurance claims should be submitted within 60 days of the occurrence or commencement of any covered accident or critical illness to:

Allstate Benefits
Walmart Claims Unit
P.O. Box 414848
Jacksonville, Florida 32203-1488

You may also provide notice of claim as follows:
Online: **allstatebenefits.com/mybenefits**
By phone: **800-514-9525**
By fax: **877-423-8804**

Be sure to provide the following information for the covered person:

- Name
- Walmart identification number (WIN), and
- Date the covered illness or accident occurred or commenced.

You may request a claim form from Allstate Benefits or visit **One.Walmart.com** or **AllstateBenefits.com/Walmart** to obtain a copy. If you do not receive a claim form within 15 days of your request, you may send a notice of the claim to Allstate Benefits by providing Allstate Benefits with a statement of the nature and extent of the loss.

CRITICAL ILLNESS

When you submit a claim to Allstate Benefits and your claim is denied, a notice will be sent within a reasonable time period, but no later than 30 days after Allstate Benefits receives the claim (filed in accordance with the Critical Illness Certificate of Insurance). In special circumstances, an extension of time may be needed to make a decision. In that case, Allstate Benefits may take a 15-day extension. You will receive written notice of the extension before the end of the 30-day period.

If your claim is denied, your denial will consist of a written explanation, which will include:

- The specific reasons for the denial
- Reference to provisions of the Plan on which the denial was based
- Information regarding time limits for appeal
- A description of additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that it is available upon request), and
- Notice regarding your right to bring a court action following a denial on appeal.

APPEALING A CRITICAL ILLNESS CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

You may appeal any denial of a claim for benefits by filing a written request with Allstate Benefits. In connection with an appeal, you may request, free of charge, all documents that are relevant (as defined by ERISA) to your claim. You may also submit with your appeal any comments, documents, records, and issues that you believe support your claim, even if you have not previously submitted such documentation. You may have representation throughout the review procedure.

An appeal must be filed with Allstate Benefits in accordance with the claim filing procedures described in your denial letter within 180 days of receipt of the written notice of denial of a claim. Allstate Benefits will render a decision no later than 60 days after receipt of your written appeal. The decision after your appeal will be in writing and will include:

- The specific reasons for the denial
- Reference to provisions of the Plan on which the denial was based
- A statement that you have the right 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

- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that is available upon request)
- A description of any voluntary review procedures offered by the Plan and your right to obtain information about such procedures, and
- A statement regarding your right to bring court action following a denial on appeal.

You also will receive a notice if the claim on appeal is approved. If your claim is denied, you have the right to bring action in federal court in accordance with ERISA Section 502(a), but only after you have followed the Plan's claims and appeals procedures.

ACCIDENT INSURANCE

When you submit a claim to Allstate Benefits and your claim is denied, a notice will be sent within a reasonable time period, but no later than 90 days after Allstate Benefits receives the claim (filed in accordance with the Accident Certificate of Insurance). In special circumstances, an extension of time may be needed to make a decision. In that case, Allstate Benefits may take a 90-day extension. You will receive written notice of the extension before the end of the 90-day period.

If your claim is denied, your denial will consist of a written explanation, which will include:

- The specific reasons for the denial
- Reference to provisions of the Plan on which the denial was based
- Information regarding time limits for appeal
- A description of additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that it is available upon request), and
- Notice regarding your right to bring a court action following a denial on appeal.

You also will receive a notice if the claim on appeal is approved.

APPEALING AN ACCIDENT CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

You may appeal any denial of a claim for benefits by filing a written request with Allstate Benefits. In connection with an appeal, you may request, free of charge, all documents that are relevant (as defined by ERISA) to your claim. You may also submit with your appeal any comments, documents, records, and issues that you believe support your claim, even if you have not previously submitted such documentation. You may have representation throughout the review procedure.

An appeal must be filed with Allstate Benefits in accordance with the claim filing procedures described in your denial letter within 60 days of receipt of the written notice of denial of a claim. Allstate Benefits will render a decision no later than 60 days after receipt of your written appeal. In special circumstances, an extension of time may be necessary to make a decision. In that case, Allstate Benefits may take a 60-day extension. The decision after your appeal will be in writing and will include:

- The specific reasons for the denial
- Reference to provisions of the Plan on which the denial was based
- A statement that you have the right 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
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- If your denial is based on medical necessity or similar limitations, an explanation of this rule (or a statement that is available upon request)
- A description of any voluntary review procedures offered by the Plan and your right to obtain information about such procedures, and
- A statement regarding your right to bring court action following a denial on appeal.

You also will receive a notice if the claim on appeal is approved. If your claim is denied, you have the right to bring action in federal court in accordance with ERISA Section 502(a), but only after you have followed the Plan's claims and appeals procedures.

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadlines to bring legal action.

Company-paid life insurance, optional associate and dependent life insurance, business travel accident insurance, and AD&D claims process

Claims for company-paid life, optional associate and dependent life, business travel accident, and AD&D insurance can be initiated by calling Prudential at **877-740-2116**.

See the applicable insurance chapter for details on the information required to file each type of claim. When you submit a claim to Prudential and your claim is denied, a notice will be sent within a reasonable time period, but not longer than 90 days from receipt of the claim. If Prudential determines that an extension is necessary due to matters beyond Prudential's control, this time may be extended for an additional 90-day period. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which Prudential expects to render a determination.

If your claim is in part or wholly denied, you will receive notice of an adverse benefit determination that will:

- State the specific reasons for the adverse benefit determination
- Reference the specific plan provisions on which the determination is based
- Describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary, and
- Describe Prudential's claims review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

APPEALING A PRUDENTIAL CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for benefits is denied and you would like to appeal, you must send a written appeal to Prudential at the address below within 180 days of the denial. Your appeal should include any comments, documents, records, or any other information you would like considered.

Send your written appeal to:

Prudential Insurance Companies of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, Pennsylvania 19176

You will have the right to request copies, free of charge, of all documents, records, or other information relevant to your claim. Your appeal will be reviewed without regard to your initial determination by someone other than the party who decided your initial claim. Prudential will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial that will include:

- The specific reasons for the adverse determination
- Reference to the specific plan provisions on which the determination was based
- A statement describing your right to request copies, free of charge, of all documents, records, or other information relevant to your claim
- A description of Prudential's review procedures and applicable time limits
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- A statement describing any appeals procedures offered by the Plan and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned earlier, the claim shall be deemed denied on appeal.

VOLUNTARY SECOND APPEAL OF LIFE INSURANCE, AD&D, OR BUSINESS TRAVEL ACCIDENT CLAIMS

If your appeal is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a voluntary second appeal of your denial in writing to Prudential. You must submit your second appeal within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit any written comments, documents, records, and any other information relating to your claim. The same criteria and response times that applied to your first appeal are generally applied to this voluntary second appeal.

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

Claims and appeals process for disability coverage claims

NOTE: This section describes the claims and appeals process for the short-term disability plan for full-time hourly associates (basic and enhanced), the long-term disability plan, and the truck driver long-term disability plan. For claims and appeals information for the short-term disability plans for salaried associates and truck drivers, refer to the respective chapters.

FILING A CLAIM

Notify Sedgwick to apply for a leave of absence and file a short-term disability claim as soon as you know you will be absent from work due to an illness, injury, or pregnancy. You may do this by visiting **One.Walmart.com** > **mySedgwick**, or by calling **800-492-5678**.

Claims under the short-term disability plan for full-time hourly associates for all states except California and Rhode Island should be submitted to:

Sedgwick Claims Management Services, Inc.
P.O. Box 14748
Lexington, Kentucky 40512-4748

For associates in states or localities with legally mandated plans, such as California, Rhode Island, and Washington, you should submit your claim directly to the state or local government. For information, including filing timelines, call the appropriate phone number listed in the **Resources** chart at the beginning of the **Short-term disability for full-time hourly associates** chapter.

Claims under the long-term disability and truck driver long-term disability plans should be submitted to:

Group Benefits Claims
Lincoln Financial Group
Group — Charlotte WM **See page 332**
P.O. Box 7216
London, Kentucky 40742-7216

FILING DEADLINES

Claims for short-term disability benefits in Hawaii, New Jersey, and New York must be submitted to Sedgwick within 30 days of the date your disability begins. Sedgwick will notify Lincoln of your disability claim.

For all other states (with the exception of California and Rhode Island, as noted above), you must submit your short-term disability claim to Sedgwick within 90 days of the date your disability begins in order to assure consideration for benefits. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.

If you are on an approved short-term disability claim and are enrolled in long-term disability (LTD) or truck driver LTD, your claim will automatically be transitioned to Lincoln for consideration.

Once a claim has been filed, a decision will be made in no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for up to two additional 30-day periods, provided that, prior to any extension period, you are notified in writing that an extension is necessary due to matters beyond control, those matters are identified, and you are given the date by which a decision will be rendered. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date your response is received. If your claim is approved, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and will include:

- Specific reasons for the decision
- Specific reference to the Plan provisions on which the decision is based
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by you to the Plan of health care professionals treating you and vocational professionals evaluated by you
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the benefit determination, and
  - A disability determination regarding you made by the Social Security Administration and presented by you to the Plan.
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits
- A description of the review procedures and time limits applicable to such procedures, and
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA after you appeal the decision if you receive a written denial on appeal.

APPEALING A DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for disability benefits is denied and you would like to appeal, you must submit a written or oral appeal to Sedgwick or Lincoln (as applicable) within 180 days of the denial.

For associates in states or localities with legally mandated plans, such as California, Rhode Island, and Washington, you should submit your appeal directly to the state or local government. For information, including filing timelines, call the appropriate phone number listed in the **Resources** chart at the beginning of the **Short-term disability for full-time hourly associates** chapter.

Your appeal will be conducted without regard to your initial determination by someone other than the party who decided your initial claim or a subordinate of the individual who decided your initial claim. No deference will be afforded to the initial determination. You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You have the right to request copies, free of charge, of all documents, records, or other information relevant to your claim. The third-party administrator, on behalf of the Plan, will provide you with any new or additional evidence or rationale considered in connection with your claim sufficiently in advance of the appeals determination date to give you a reasonable opportunity to respond.

If your claim involves a medical judgment question, the Plan 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, the Plan will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

Sedgwick or Lincoln (as applicable) will make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if it is determined that special circumstances require an extension of time. You will be notified prior to the end of the 45-day period if an extension is required. If you are asked to provide additional information, you will have 45 days from the date you are notified to provide the information, and the time to make a determination will be suspended until you provide the requested information (or the deadline to provide the information, if earlier).

If your appeal is denied in whole or in part, you will receive a written notification of the denial that will include:

- The specific reasons for the adverse determination
- Reference to the specific Plan provisions on which the determination was based
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, regardless of whether the advice was relied upon in making the benefit determination, and
  - A disability determination regarding you made by the Social Security Administration and presented by you to the Plan.
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits, and
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA (including a description of any contractual limitation period that applies and the date on which the contractual limitation period expires).

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

Appeals under the short-term disability plan for full-time hourly associates for all states except California, Hawaii, New Jersey, New York, and Rhode Island should be submitted to:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14028
Lexington, Kentucky 40512

For salaried associates and truck drivers, see the **Salaried short-term disability plan** chapter or the **Truck driver short-term disability plan** chapter, as appropriate, for detailed information on the appeals process for those plans.

Appeals for short-term disability benefits in Hawaii, New Jersey, and New York, and long-term disability and truck driver long-term disability appeals, should be sent to:

Group Benefits Claims Appeal Unit
Lincoln Financial Group
Group — Charlotte WM **See page 332**
P.O. Box 7216
London, Kentucky 40742-7216

VOLUNTARY SECOND APPEAL OF A CLAIM FOR BENEFITS UNDER THE FULL-TIME HOURLY SHORT-TERM DISABILITY PLAN

If you are a full-time hourly associate whose short-term disability coverage is administered through Sedgwick and your appeal is denied, you may make a voluntary second appeal of your denial orally or in writing to Sedgwick. You must submit your second appeal within 180 days of the receipt of the written notice of denial. You may submit any written comments, documents, records, and any other information relating to your claim. The same criteria and response times that applied to your first appeal, as described earlier, are generally applied to this voluntary second appeal.

Voluntary second appeals for short-term disability benefits should be sent to:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadlines to bring legal action.

Resources for Living benefits

You do not have to file a claim or appeal for Resources for Living benefits. You may access the Resources for Living website or call Resources for Living at **800-825-3555** at any time.

However, if you have a question about your benefits, or disagree with the benefits provided, you may contact People Services or file a claim or appeal by writing to the following address:

Walmart People Services
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Any claims or appeals will be determined under the time frames and requirements applicable to medical benefits.

International business travel medical insurance

Claim forms are generally not required for GeoBlue services. However, if you have a question about your benefits or disagree with the benefits provided, you may contact GeoBlue or file a claim. To submit a claim via email or fax, download a claim form and view detailed instructions in the Member Hub at **geo-blue.com**. Submit your claim by email to **claims@geo-blue.com** or by fax to **610-482-9623**.

You may also submit claims by post. Download a claim form from the Member Hub at geo-blue.com and send your completed form to:

GeoBlue
Claims Department
P.O. Box 1748
Southeastern, Pennsylvania 19399-1748

Any claims and appeals will be determined under the time frames and requirements set out in the GeoBlue policy. Contact GeoBlue at any time by calling **888-412-6403**. Outside the U.S. call collect: **610-254-5830**.

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Legal information

This document includes the Summary Plan Description (SPD) for the Associates' Health and Welfare Plan (the Plan). The SPD describes benefits offered to you by Walmart Inc. and the steps you need to follow to take full advantage of the Plan. The previous chapters describe the most important features of the Plan; in this chapter you'll find important administrative information and facts about your rights as a participant in the Plan.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Contact the Plan Administrator		Write to: **Walmart** **Plan Administrator** **Associates' Health and Welfare Plan** **508 SW 8th Street** **Bentonville, Arkansas 72716-3500** Call **479-621-2058**
Answers to questions about the HIPAA Privacy Notice	Email your question to **AHWPrivacy@walmart.com**	Call People Services at **800-421-1362**
Answers to questions about Medicare Part D	Visit **medicare.gov**	**800-MEDICARE** (**800-633-4227**) TTY users should call **877-486-2048**
Answers to your questions about Medicaid/CHIP	Visit **insurekidsnow.gov**	**877-KIDSNOW** (**877-543-7669**)

What you need to know about the legal information for the Associates' Health and Welfare Plan

- As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.
- The HIPAA privacy notice in this chapter describes how medical information about you may be used and disclosed and how you can get access to this information.
- The **Medicare and your prescription drug coverage** section in this chapter explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.
- The Medicaid/Children's Health Insurance Program (CHIP) notice explains special enrollment and premium assistance rights for individuals eligible for these programs.

Associates' Health and Welfare Plan

The Plan is an employer-sponsored health and welfare employee benefit plan governed by ERISA.

The terms and conditions of the Plan are set forth in this SPD, in the Associates' Health and Welfare Plan Wrap Document (Wrap Document), and in the insurance policies and other welfare program documents incorporated into the Wrap Document (such as the Annual Enrollment materials you are provided and the Summaries of Benefits and Coverage). The Wrap Document, together with this book and the other incorporated documents, constitutes the written instrument under which the Plan is established and maintained.

Plan Year: January 1 through December 31

Plan Number: 501

Type of Plan: Welfare, including medical, dental, vision, short-term disability, long-term disability, business travel accident insurance, accidental death and dismemberment (AD&D) insurance, company-paid life insurance, optional associate and dependent life insurance, accident insurance, critical illness insurance, and Resources for Living (the associate assistance program).

Type of Administration: The Plan Administrator (or its delegates, including third-party administrators deciding claims and appeals) has complete discretion to interpret and construe the provisions of the Plan, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Plan Administrator (or a delegate) made pursuant to the Plan shall be final, conclusive and binding on all persons, and may not be overturned unless found by a court to be arbitrary and capricious. Benefits will be paid only if the Plan Administrator (or a delegate) determines in its sole discretion that the claimant is entitled to them.

Plan Sponsor:
Walmart Inc.
702 SW 8th Street
Bentonville, Arkansas 72716-0295

Plan Administrator/Named Fiduciary:
Senior Vice President, Global Benefits Division,
Walmart Inc.
Associates' Health and Welfare Plan
508 SW 8th Street
Bentonville, Arkansas 72716-3500
479-621-2058

Agent for Service of Legal Process:
Corporation Trust Company
1209 Orange Street Corporation Trust Center
Wilmington, Delaware 19801

Legal process may also be served on the Plan Administrator or Trustee.

Plan Sponsor's EIN: 71-0415188

FUNDING FOR THE PLAN

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

Plan Trustee:
J. P. Morgan
4 New York Plaza, 15th Floor
New York, New York 10004-2413

Plan amendment or termination

Walmart reserves the right within its sole discretion to amend or terminate any benefit or provision under the Plan, at any time and for any reason, as it relates to any current, past, or future participant or beneficiary under the Plan.

Neither the Plan nor the benefits described in this book 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 or by a management associate of the company. Only written statements by the Plan Administrator shall bind the Plan.

Your rights under ERISA

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified facilities, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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 Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The 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 furnish each participant with a copy of this annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You have the right to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights. (See the **COBRA** chapter for more information.)

You should be provided a certificate of creditable coverage, free of charge, from the Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage.

Note that the Associates' Medical Plan does not have a pre-existing condition exclusion.

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. The people who operate the 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 your employer, your union, or any other person, can fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have the 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 from the Plan and do not receive them within 30 days, you can 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 Administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you can file suit in a state or federal court. Generally, you must complete the appeals process before filing a lawsuit against the Plan. However, you should consult with your own legal counsel in determining when it is proper to file a lawsuit 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 can file suit in a 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 can seek assistance from the U.S. Department of Labor, or you can 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 the 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 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 NW
Washington, DC 20210

You can also obtain certain publications about your rights under ERISA by calling the Employee Benefits Security Administration publications hotline at **866-444-3272** or by going to **dol.gov/ebsa**.

HIPAA notice of privacy practices

This notice was updated August 1, 2019

THIS NOTICE APPLIES TO THE ASSOCIATES' MEDICAL PLAN (AMP), DENTAL PLAN, AND RESOURCES FOR LIVING (RFL), REFERRED TO COLLECTIVELY AS THE "PLANS"

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. You have certain rights under the Health Insurance Portability and Accountability Act (HIPAA). HIPAA governs when and how your medical health information held by the AMP, dental plan, and RFL may be used and disclosed and how you can get access to this information. Please share a copy of this notice with your family members who are covered under the AMP, dental plan, and RFL.

THE PLANS' COMMITMENT TO YOUR PRIVACY

References to "we" and "us" throughout this notice mean the Plans. Walmart also provides benefits for some associates through a Health Maintenance Organization (HMO), a fully insured PPO Plan and a fully insured international business travel medical plan. For these benefit options, the insurer of the HMO or PPO Plan or international business travel medical plan is responsible to protect your health information under the HIPAA rules, including providing you with its own notice of privacy practices.

The Plans are dedicated to maintaining the privacy of your health information for as long as the Plans hold your health information or for fifty years after your death. In operating the Plans, we create records regarding you and the benefits we provide to you. This notice will tell you about the ways in which we may use and disclose health information about you. We will also describe your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to:

- Maintain the privacy of your health information, also known as Protected Health Information (PHI)
- Provide you with this notice
- Comply with this notice, and
- Notify you if there is a breach of your unsecured PHI.

The Plans reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you before the change. If there is a material revision to this notice, the new notice will be distributed to you. You may obtain a paper copy of the current notice by contacting the Plans using the contact information listed at the end of this notice. The most current notice is also available on One.Walmart.com.

HOW THE AMP, DENTAL PLAN, AND RFL MAY USE AND DISCLOSE YOUR PHI

The law permits us to use and disclose your protected health information (PHI) for certain purposes without your permission or authorization. The following gives examples of each of these circumstances:

1. **For Treatment.** We may use or disclose your PHI for purposes of treatment. For example, we may disclose your PHI to physicians, nurses, and other professionals who are involved in your care.
2. **For Payment.** We may use or disclose your PHI to provide payment for the treatment you receive under the Plans. For example, we may contact your health care provider to certify that you have received treatment (and for what range of benefits), and we may request details regarding your treatment to determine if your benefits will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members or other insurance companies.
3. **For Health Care Operations.** We may use or disclose your PHI for our health care operations. For example, our claims administrators in some states or the Plans may use your PHI to conduct cost-management and planning activities. Any information which we use or disclose for underwriting purposes will not include any of your PHI which is genetic information.
4. **To the Plans' Sponsor.** The Plans may use or disclose your PHI to Walmart, the Plan Sponsor. The Plans' Sponsor will only use your PHI as necessary to administer the Plans. The law only permits the Plans to disclose your PHI to Walmart, in its role as the Plans' Sponsor, if Walmart certifies, among other things, that it will only use or disclose your PHI as permitted by the Plan, will restrict access to your PHI to those Walmart employees whose job it is to administer the Plan, and will not use PHI for any employment-related actions.
5. **For Health-Related Programs and Services.** The Plans may contact you about information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.
6. **To Individuals Involved in Your Care or Payment for Your Care.** The Plans may disclose your PHI to a third party involved in your health care including a family member, close friend, or a person you identified to the Plan as involved in your health care, provided that you agree to this disclosure. If you are not present or available to

agree or disagree to disclose your PHI to a third person requesting the PHI, then the Plans may use professional judgment to determine if the disclosure of PHI is in your best interests. If it is determined that a disclosure of PHI is then in your best interest, the Plans may disclose the minimum amount of PHI necessary to meet the need. Additionally, you have the right to request that the Plans limit any disclosure of PHI to specific individuals involved in your health care.

OTHER USES OR DISCLOSURES OF YOUR PHI WITHOUT AN AUTHORIZATION

The law allows us to disclose your PHI in the following circumstances without your permission or authorization:

1. **When Required by Law.** The Plans will use and disclose your PHI when we are required to do so by federal, state, or local law.
2. **For Public Health Risks.** The Plans may disclose your PHI for public health activities, such as those aimed at preventing or controlling disease, preventing injury, reporting reactions to medications or problems with products, and reporting the abuse or neglect of children, elders, and dependent adults.
3. **For Health Oversight Activities.** The Plans may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include investigations, inspections, audits, and licensure.
4. **For Lawsuits and Disputes.** The Plans may use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we receive satisfactory assurances from the party seeking the information that reasonable efforts have been made to inform you of the request and given you the opportunity to raise an objection to the court or obtain an order protecting the information the party has requested.
5. **To Law Enforcement.** The Plans may release your PHI if asked to do so by a law enforcement official in certain circumstances, including but not limited to the following:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe might have resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena, or similar legal process
   - To identify/locate a suspect, material witness, fugitive, or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime or the description, identity, or location of the person who committed the crime), and
   - In cases where a law enforcement agency has requested PHI for purposes of identifying or locating an individual, HIPAA permits that if certain specific situations are met, the Plans must disclose to the law enforcement agency limited information such as name, address, Social Security number, ABO blood type, type of injury, date and time of treatment or death, and distinguishing physical characteristics.
6. **To Avert a Serious Threat to Health or Safety.** The Plans may use or disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
7. **For Military Functions.** The Plans may use or disclose your PHI if you are a member of the U.S. or foreign military forces (including veterans), and if required to assure the proper execution of a military mission if the appropriate military authority has published the required information in the Federal Register.
8. **For National Security.** The Plans may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state or to conduct investigations.
9. **Inmates.** The Plans may disclose your health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: for the institution to provide health care services to you; for the safety and security of the institution; and/or to protect your health and safety or the health and safety of other individuals.
10. **To Workers' Compensation Programs.** The Plans may release your health information for workers' compensation and similar programs.
11. **For Services Related to Death.** The Plans may disclose your PHI upon your death to a coroner, funeral director, or to tissue or organ donation services, as necessary to permit them to perform their functions.
12. **Research.** HIPAA permits the Plans to disclose PHI for government-approved research purposes. It is the policy of the Plans not to disclose PHI for research purposes and will not disclose your PHI for such purposes unless the PHI is required to be disclosed under law.
13. **Psychotherapy Notes.** An authorization is always required to use or disclose psychotherapy notes to a third person unless the use or disclosure is permitted under HIPAA

regulations. Permissible uses or disclosures include: use for treatment, payment, or health care operations; use by the originator of the notes for treatment; use by the Plans to defend themselves in a lawsuit that you initiate; when required by the Secretary of the Department of Health and Human Services; when such disclosure is required by law; for health oversight activities as permitted under the regulations; disclosure to a person who can reasonably prevent serious harm to an individual or the public; and disclosure to a medical examiner or coroner for the purpose of identifying a deceased person, determining cause of death, or such other purposes permitted by law. While the regulations permit covered entities to use and disclose psychotherapy notes for purposes of training health professionals or students, the Plans do not engage in such training exercises and cannot disclose the information for these purposes.

14. **Victims of Abuse, Neglect, or Domestic Violence.** The Plans may disclose your PHI if there is reasonable belief that you are a victim of abuse, neglect, or domestic violence. Such disclosure is permitted under HIPAA only if required by law or with your permission or to the extent the disclosure is expressly authorized by statute and only if, in the Plan's best judgment, the disclosure is necessary to prevent serious harm to you or other potential victims.
15. **Health Oversight Activities and Joint Investigations.** The Plans must disclose PHI requested of health oversight agencies for purposes of legally authorized audits, investigations including joint investigations, inspections, licensure, disciplinary actions, or other oversight activities of authorized entities.
16. **Disaster Relief Efforts.** The Plans may use or disclose your PHI to notify a family member or other individual involved in your care of your location, general condition or death, or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notification.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

The Plans will obtain your written authorization for any other uses or disclosures of your PHI, including for most uses and disclosures of psychotherapy notes (except in situations noted above), uses and disclosures of PHI for marketing purposes, and uses or disclosures that are a sale of PHI. The Plan will not condition your eligibility to participate in the Plan or payment of benefits under the Plan upon your authorization, except where allowed by law. If you give us written authorization for a use or disclosure of your PHI, you may revoke that authorization at any time in writing. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization, except for where we have taken action in reliance on your authorization before we received your written revocation.

STRICTER STATE PRIVACY LAWS

Under the HIPAA Privacy Regulations, the Plan is required to comply with state laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter). The Plan maintains a policy to ensure compliance with these laws.

YOUR RIGHTS RELATED TO YOUR PHI

You have the following rights regarding your PHI that we maintain:

1. **Right to Request Confidential Communications.** You have the right to request that the Plans communicate with you about your health and related issues in a particular manner or at a certain location if you feel that your life may be endangered if communications are sent to your home. For example, you may ask that we contact you at work rather than home. In order to request a type of confidential communication, you must make a written request to the address at the end of this section specifying the requested method of contact or the location where you wish to be contacted. For us to consider granting your request for a confidential communication, your written request must clearly state that your life could be endangered by the disclosure of all or part of this information.
2. **Right to Request Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. We generally are not required to agree to your request except in limited circumstances; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. To request a restriction in our use or disclosure of your PHI, you must make your request in writing to the address at the end of this section. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit the Associates' Medical Plan's, dental plan's, or RFL's use, disclosure, or both; and (c) to whom you want the limits to apply.
3. **Right to Inspect and Copy.** Except for limited circumstances, you have the right to inspect and copy the PHI that may be used to make decisions about you. Usually, this includes medical and billing records. To inspect or copy your PHI, you must submit your request in writing to the address listed at the end of this section. The Plans must directly provide to you, and/or the individual you designate, access to the electronic PHI in the electronic form and format you request, if it is readily producible, or, if not, then in a readable electronic format as agreed to between you and the Plan. The Plans

may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances, in which case you may submit a request to the Plan at the address in the next column that the denial be reviewed.

4. **Right to Request Amendment.** You have the right to request that we amend your PHI if you believe it is incorrect or incomplete. To request an amendment, you must submit a written request to the address listed at the end of this section. You must provide a reason that supports your request for amendment. We may deny your request if you ask us to amend PHI that is: (a) accurate and complete; (b) not part of the PHI kept by or for the Plan; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by the Plan, unless the individual or entity that created the PHI is not available to amend it. Even if we deny your request for amendment, you have the right to submit a statement of disagreement regarding any item in your record you believe is incomplete or incorrect. If you request, it will become part of your medical record and we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.
5. **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures. An accounting of disclosures is a list of certain disclosures we have made of your PHI, for most purposes other than treatment, payment, health care operations, and other exceptions pursuant to law or pursuant to your authorization. To request an accounting of disclosures, you must submit a written request to the address at the end of this section. You must specify the time period, which may not be longer than the six-year period prior to your request. We will notify you of the cost involved in complying with your request and you may choose to withdraw or modify your request at that time.
6. **Paper Notice.** You have a right to request a paper copy of this notice, even if you have agreed to receive this notice electronically.

If you believe your privacy rights have been violated, you may file a complaint with the Associates' Medical Plan, dental plan, or RFL, or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, you must submit it in writing to the address listed at the end of this section. Neither Walmart nor the Plans will retaliate against you for filing a complaint. You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Associates' Medical Plan, dental plan, or RFL, or with the U.S. Department of Health and Human Services.

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If you have questions about this notice or would like to exercise one or more of the rights listed in this notice, please contact:

Walmart People Services
Attn: HIPAA Compliance Team
508 SW 8th Street
Mail Stop #3500
Bentonville, Arkansas 72716-3500

Email your questions to: **AHWPrivacy@walmart.com**
Telephone: **800-421-1362**

Medicare and your prescription drug coverage

Please read this notice about Medicare and your prescription drug coverage carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage under the Associates' Health and Welfare Plan (the Plan) and your prescription drug coverage option under Medicare. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

There are important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Some of the Walmart prescription drug plans (as described later in this notice under the heading **Which Walmart plans are considered creditable coverage?**) are, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and are therefore considered creditable coverage. If you are a participant in one of these plans, you may keep your current coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
- Other Walmart plan options (as described later in this notice under the heading **Which Walmart plans are considered non-creditable coverage?**) are, on average for all Plan participants, not expected to pay out as much as the standard Medicare prescription drug coverage will pay. If you are a participant in one of these plans, your coverage is non-creditable coverage. This is important because for

See page 332

most people enrolled in these plan options, enrolling in Medicare prescription drug coverage means you will get more help with drug costs than if you had prescription drug coverage exclusively through the Plan. This is also important because it may mean that you pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

If you have non-creditable coverage under the Plan, it may affect how much you pay for Medicare D drug coverage in the future. When you become eligible for Medicare D, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offered by Medicare prescription drug coverage in your area. Read this notice carefully — it explains your options.

CREDITABLE AND NON-CREDITABLE COVERAGE

What is the meaning of the term "creditable coverage"? Creditable coverage means that your current prescription drug coverage is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Prescription drug coverage that does not satisfy this requirement is not creditable coverage.

WHICH WALMART PLANS ARE CONSIDERED CREDITABLE COVERAGE?

Walmart has determined that the following Plans' prescription drug coverages are considered creditable according to Medicare guidelines:

- Premier Plan
- Contribution Plan
- Local Plans
- HMO Plans
- eComm PPO Plan

If your coverage is creditable, you can keep your existing coverage and not pay extra if you later decide to enroll in Medicare coverage.

If you are enrolled in any of the Plans listed above, you can choose to join a Medicare prescription drug plan later without paying extra because you have existing prescription drug coverage that, on average, is as good as Medicare's coverage.

If you are enrolled in Medicare Part D, you are not eligible to enroll in any of the Plans listed above. If your dependent is enrolled in Medicare Part D and you are not, you are eligible to enroll in a Walmart medical or HMO plan, but your dependent would not be eligible for coverage.

If you drop your medical coverage with Walmart and enroll in a Medicare prescription drug plan, you and your eligible dependents will have the option of reenrolling in the Walmart Plan during Annual Enrollment or with a valid status change event. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

WHICH WALMART PLANS ARE CONSIDERED NON-CREDITABLE COVERAGE?

The following Plan's prescription drug coverage is considered non-creditable according to Medicare guidelines:

- Saver Plan

If your coverage is non-creditable, you might want to consider enrolling in Medicare prescription drug coverage or a Walmart creditable Plan listed above because the coverage you have is, on average for all participants, not expected to pay out as much as the standard Medicare prescription drug coverage will pay.

WHEN CAN I ENROLL FOR MEDICARE PRESCRIPTION DRUG COVERAGE?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

If you have creditable prescription drug coverage and you lose it through no fault of your own, you will be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you have non-creditable prescription drug coverage and you drop coverage under the Plan, because your coverage is employer-sponsored group coverage, you will be eligible for a two-month SEP to join a Medicare drug plan. However, you may pay a higher premium (a penalty) because you did not have creditable coverage under the Plan.

WHEN WILL I PAY A HIGHER PREMIUM (A PENALTY) TO JOIN A MEDICARE DRUG PLAN?

If you have creditable coverage and drop or lose your coverage under the Plan and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join the Medicare drug plan later.

If you have non-creditable coverage, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan.

Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without

creditable coverage, your premium may always be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following Medicare annual enrollment period beginning in October to join.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current coverage under the Associates' Medical Plan (AMP) will be affected. Plan guidelines restrict you from enrolling in the AMP if you are enrolled in Medicare Part D. If your dependent is enrolled in Medicare Part D and you are not, you are able to enroll in the AMP, but your dependent would not be eligible for coverage.

If you decide to join a Medicare drug plan and drop your coverage under the Walmart AMP, be aware that you and your dependents will be able to get your AMP coverage back, but only during Annual Enrollment or due to a status change event.

If you enroll in a Medicare Part D plan and decide within 60 days to switch back to a plan under the Walmart AMP, you will automatically be reenrolled for the same coverage you had prior to the status change event. See the **Eligibility and enrollment** chapter for further details.

FOR MORE INFORMATION ABOUT MEDICARE AND YOUR PRESCRIPTION DRUG COVERAGE

- You will get this notice each year before your Medicare enrollment period.
- If we make a plan change that affects your creditable coverage, you will receive another notice.
- If you need a copy of this notice, you can request one from People Services at **800-421-1362**.

ADDITIONAL INFORMATION AVAILABLE

More detailed information about Medicare plans that offer prescription drug coverage is available through the *Medicare & You* handbook from Medicare. You may also be contacted directly by Medicare-approved prescription drug plans. You will get a copy of the handbook in the mail every year from Medicare. You can also get more information about Medicare prescription drug plans from these sources:

- Visit **medicare.gov**.
- Call your state health insurance assistance program for personalized help. (See your copy of the *Medicare & You* handbook for its telephone number.)
- Call **800-MEDICARE (800-633-4227)**. TTY users should call **877-486-2048**.

For people with limited income and resources, extra help paying for the Medicare prescription drug plan is available. For more information about this resource, visit the Social Security Administration online at **socialsecurity.gov**, or call **800-772-1213** (TTY **800-325-0778**).

REMEMBER

Keep this notice. If you enroll in one of the Medicare prescription drug plans, you may need to provide a copy of this notice when you join to show whether or not you have creditable coverage and therefore whether or not you are required to pay a higher premium (a penalty).

Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from Walmart Inc., your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed on the following pages, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial **877-KIDS NOW** or **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for the Plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Walmart Inc. Plan, the Plan must allow you and your dependents to enroll in the Plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **866-444-EBSA (3272)**.

See pages 334-335

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your state for more information on eligibility.

ALABAMA – Medicaid
Website: **http://myalhipp.com**
Phone: **855-692-5447**

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: **http://myakhipp.com**
Phone: **866-251-4861**
Email: **CustomerService@MyAKHIPP.com**
Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: **http://myarhipp.com**
Phone: **855-MyARHIPP** (**855-692-7447**)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado website:
https://www.healthfirstcolorado.com
Health First Colorado Member Contact Center:
800-221-3943 State Relay 711
CHP+:
https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: **800-359-1991** / **State Relay 711**

FLORIDA – Medicaid
Website: **http://flmedicaidtplrecovery.com/hipp**
Phone: **877-357-3268**

GEORGIA – Medicaid
Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: **678-564-1162** ext. **2131**

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19–64
Website: **http://www.in.gov/fssa/hip/**
Phone: **877-438-4479**
All other Medicaid
Website: **http://www.indianamedicaid.com**
Phone: **800-403-0864**

IOWA – Medicaid
Website: **http://dhs.iowa.gov/Hawki**
Phone: **800-257-8563**

KANSAS – Medicaid
Website: **http://www.kdheks.gov/hcf**
Phone: **785-296-3512**

KENTUCKY – Medicaid
Website: **http://chfs.ky.gov**
Phone: **800-635-2570**

LOUISIANA – Medicaid
Website: **http://dhh.louisiana.gov/index.cfm/subhome/1/n/331**
Phone: **888-695-2447**

MAINE – Medicaid
Website:
http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: **800-442-6003**
TTY: **Maine relay 711**

MASSACHUSETTS – Medicaid and CHIP
Website:
http://www.mass.gov/eohhs/gov/departments/masshealth
Phone: **800-862-4840**

MINNESOTA – Medicaid
Website: **http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp**
Phone: **800-657-3739**

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: **573-751-2005**

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: **800-694-3084**

NEBRASKA – Medicaid
Website: **http://www.ACCESSNebraska.ne.gov**
Phone: **855-632-7633**
Lincoln: **402-473-7000**
Omaha: **402-595-1178**

NEVADA – Medicaid
Medicaid website: **https://dhcfp.nv.gov/**
Medicaid phone: **800-992-0900**

NEW HAMPSHIRE – Medicaid
Website: h**ttps://www.dhhs.nh.gov/oii/documents/hipp.htm**
Phone: **603-271-5218**
Toll-free for HIPP program: **800-852-3345** ext. **5218**

NEW JERSEY – Medicaid and CHIP
Medicaid website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid
Medicaid phone: **609-631-2392**
CHIP website: **http://www.njfamilycare.org/index.html**
CHIP phone: **800-701-0710**

NEW YORK – Medicaid
Website: **https://www.health.ny.gov/health_care/medicaid/**
Phone: **800-541-2831**

NORTH CAROLINA – Medicaid
Website: **https://medicaid.ncdhhs.gov**
Phone: **919-855-4100**

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid
Phone: **844-854-4825**

OKLAHOMA – Medicaid and CHIP
Website: **http://www.insureoklahoma.org**
Phone: **888-365-3742**

OREGON – Medicaid
Website: **http://healthcare.oregon.gov/Pages/index.aspx**
http://www.oregonhealthcare.gov/index-es.html
Phone: **800-699-9075**

PENNSYLVANIA – Medicaid
Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: **800-692-7462**

RHODE ISLAND – Medicaid and CHIP
Website: **http://www.eohhs.ri.gov**
Phone: **855-697-4347**
or **401-462-0311** (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: **https://www.scdhhs.gov**
Phone: **888-549-0820**

SOUTH DAKOTA – Medicaid
Website: **http://dss.sd.gov**
Phone: **888-828-0059**

TEXAS – Medicaid
Website: **http://gethipptexas.com**
Phone: **800-440-0493**

UTAH – Medicaid and CHIP
Medicaid website: **https://medicaid.utah.gov**
CHIP website: **http://health.utah.gov/chip**
Phone: **877-543-7669**

VERMONT– Medicaid
Website: **http://www.greenmountaincare.org**
Phone: **800-250-8427**

VIRGINIA – Medicaid and CHIP
Medicaid/CHIP website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid phone: **800-432-5924**
CHIP phone: **855-242-8282**

WASHINGTON – Medicaid
Website: **http://www.hca.wa.gov**
Phone: **800-562-3022** ext. **15473**

WEST VIRGINIA – Medicaid
Website: **http://mywvhipp.com**
Phone: **855-MyWVHIPP** (**855-699-8447**)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: **800-362-3002**

WYOMING – Medicaid
Website: **https://wyequalitycare.acs-inc.com**
Phone: **307-777-7531**

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, Menu Option 4, Ext. **61565**

See page 336

Valued Plan Participant

THE ASSOCIATES' HEALTH AND WELFARE PLAN (AHWP) RESPECTS THE DIGNITY OF EACH INDIVIDUAL WHO PARTICIPATES IN THE PLAN.

The AHWP does not discriminate on the basis of race, color, national origin, sex, age, or disability and strictly prohibits retaliation against any person making a complaint of discrimination. Additionally, we gladly provide our participants with language assistance, auxiliary aids, and services at no cost. We value you as our participant and your satisfaction is important to us.

If you need such assistance or have concerns with your Plan services, please call the number on the back of your plan ID card. If you have any questions or concerns, please use one of the methods below so that we can better serve you.

For assistance, call the number on the back of your plan ID card.

To learn about or use our grievance process, contact People Services at **1-800-421-1362**.

To file a complaint of discrimination, contact the U.S. Department of Health and Human Services, Office of Civil Rights:

Phone: **1-800-368-1019** or **1-800-537-7697** (TDD)

Website:
https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf

Email: **OCRCompliant@hhs.gov**

Interpreter services are available at no cost: **1-800-421-1362**

عربي
خدمات الترجمة الفورية متاحة دون تكلفة. 1-800-421-1362.

မြန်မာ
စကားပြန်ဝန်ဆောင်မှုများကို အခမဲ့ ရရှိနိုင်ပါသည်။ 1-800-421-1362

汉语普通话
翻译服务免费提供。1-800-421-1362.

فارسی
خدمات مترجم بدون هیچ هزینه ای در دسترس می باشد. 1-800-421-1362

Français
Des services d'interprètes sont disponibles sans frais.
1-800-421-1362.

kreyòl ayisye
Gen Sèvis entèprèt ki disponib gratis. 1-800-421-1362.

日本人
通訳サービスは無料でご利用いただけます。1-800-421-1362.

한국어
통역 서비스를 무료로 이용하실 수 있습니다. 1-800-421-1362.

Polski
Usługi tłumacza dostępne są bez żadnych kosztów.
1-800-421-1362.

Português (Brasil)
Serviços de interprete estão disponíveis grátis.
1-800-421-1362.

ਪੰਜਾਬੀ
ਦੋਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। 1-800-421-1362.

Română
Serviciile de interpretariat sunt disponibile gratuit.
1-800-421-1362.

Русский
Переводческие Услуги оказываются бесплатно. 1-800-421-1362.

Af-Soomaali
Adeegyada Turjumaanka waxaa lagu heli karaa kharash la'aan.
1-800-421-1362.

Español
Los servicios de interpretación están disponibles de manera gratuita. 1-800-421-1362.

Kiswahili
Huduma za tafsiri zipo bila malipo. 1-800-421-1362.

Tiếng Việt
Dịch Vụ Thông Dịch có sẵn miễn phí. 1-800-421-1362.

Glossary

Active work or **actively at work:** For medical, dental, vision, Resources for Living, critical illness, accidental death and dismemberment, and accident insurance coverage, "active work" means you have reported to work for Walmart.

For company-paid life insurance, optional associate life insurance, optional dependent life insurance, business travel accident insurance, and all types of disability coverage, "active work" means you are actively at work with the company on a day that is one of your scheduled work days and you are performing all of the regular duties of your job on a full-time basis or a part-time basis (depending on your classification as a full-time or part-time associate). You will be deemed to be actively at work on a day that is not one of your scheduled work days only if you were actively at work on the preceding scheduled work day.

Annual Enrollment: The period, usually in the fall of each year, during which associates make benefit elections for the next Plan year.

Associates' Health and Welfare Plan (the Plan): The employer-sponsored health and welfare employee benefit plan sponsored by Walmart Inc. and governed under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Associates' Medical Plan (AMP): Refers to the medical plans offered by Walmart (the Premier Plan, Contribution Plan, Saver Plan, and local plans). See **The medical plan** chapter for more information.

Behavioral health benefits: The benefits for mental health and substance abuse, including alcohol and drug abuse.

Catch-up contributions: Additional contributions allowed by the IRS to an associate's health savings account if the account holder is age 55 or older. Catch-up contributions are also allowed by the IRS to an associate's 401(k) plan if the associate is age 50 or older.

COBRA: The Consolidated Omnibus Budget Reconciliation Act, which allows associates and their eligible dependents who experience a loss in coverage due to a qualifying event to continue medical, dental, and vision coverage.

Coinsurance: The amount you pay for certain eligible expenses after you've met your annual deductible. See **The medical plan** and **The dental plan** chapters for specific coinsurance details.

Company: Walmart Inc. and its participating subsidiaries.

Coordination of benefits: When two benefit plans insure the same participant and coordinate coverage, the process of designating one plan as primary and the other as secondary.

Copay or **copayment:** A fixed dollar amount required for certain covered services or supplies. For details about services subject to copays, see **The medical plan**, **The pharmacy benefit**, and **The vision plan** chapters.

Covered expenses: Charges for procedures, supplies, equipment, or services covered under the Associates' Medical Plan that are:

- Medically necessary
- Not in excess of the maximum allowable charge
- Not excluded under the Plan, and
- Not otherwise in excess of Plan limits.

Deductible: The amount you pay each calendar year for eligible charges before the AMP pays a portion of certain covered expenses. For details, see **The medical plan**, **The pharmacy benefit**, and **The dental plan** chapters.

Disability or **disabled:** Referring to a medical condition or injury that impairs your ability to perform the duties of your job. See the individual short-term and long-term disability chapters for detailed definitions and related terms and conditions.

Eligibility waiting period: The time between an associate's hire date and the date the associate is eligible to enroll for benefits.

Eligible dependents: An eligible associate's spouse, partner, or child who satisfies the dependent eligibility requirements listed in the **Dependent eligibility** section of the **Eligibility and enrollment** chapter.

Evidence of Insurability: See *Proof of Good Health*.

Explanation of benefits (EOB): A document sent to Plan participants explaining how a claim was paid or applied.

Health care advisor: For associates who enroll in the Associates' Medical Plan, a resource who serves as a single point of contact for all inquiries and communication with your third-party administrator.

Health Reimbursement Account (HRA): An "account" to which the company allocates a specific sum of money to help pay your eligible medical expenses before you have to pay toward the costs of covered medical expenses (except prescriptions).

Health savings account (HSA): A tax-advantaged custodial account you can open with HealthEquity, if you are enrolled in the Saver Plan, which can be used to pay for qualified medical expenses (as defined by the IRS), tax-free.

Initial enrollment period: The first time you are eligible to enroll for benefits under the Plan. Initial enrollment periods may vary by job classification. See the charts in the **Eligibility and enrollment** chapter.

Leave of absence: Provides associates with needed time away from work while maintaining eligibility for benefits and continuity of employment. To accommodate situations that necessitate absence from work, the company provides three types of leave:

- Family and Medical Leave Act (FMLA)
- Personal, and
- Military.

The decision to grant a request for leave shall be based on applicable laws, the nature of the request, the effect on work requirements, and consistency with the policy guidelines and procedures.

Maximum allowable charge (MAC): MAC is the maximum amount the medical plan will cover or pay for any health care services, drugs, medical devices, equipment, or supplies covered by the AMP. For details, see **The medical plan** chapter.

Maximum plan allowance (MPA): The MPA is the maximum amount the dental plan will cover or pay for dental services covered by the dental plan. For details, see **The dental plan** chapter.

Network providers: Health care providers that have a written agreement with third-party administrators to provide services at discounted rates.

Non-network providers: Health care providers that do not have a written agreement with third-party administrators to provide services at discounted rates.

Out-of-network benefits: Payment for covered expenses that are provided by a non-network provider and do not meet the criteria outlined under **When network benefits are paid for out-of-network expenses** in **The medical plan** chapter. (Out-of-network benefits are not provided under certain plan options available under the AMP except in cases of emergency, as described in **The medical plan** chapter.)

Out-of-pocket maximum: The most you will pay each year for eligible network services, including prescriptions.

Partner: For purposes of determining dependent eligibility, an associate's domestic partner or other person to whom the associate is joined in a legal relationship recognized as creating some or all of the rights of marriage, meeting the eligibility requirements listed in the **Dependent eligibility** section of the **Eligibility and enrollment** chapter.

Preauthorization or **prior authorization:** A notification that may be required as a condition to coverage for certain services by network providers. See the **Preauthorization** and **Centers of Excellence** sections of **The medical plan** chapter or contact the applicable administrator for more information.

Premium: The amount you pay for the benefits you choose, generally out of each paycheck.

Prenotification: A notification voluntarily made by enrollees/providers to advise third-party administrators of any upcoming hospital admissions or outpatient services. As described in the **Prenotification** section of **The medical plan** chapter, responses by third-party administrator to prenotification inquiries are not binding on the Associates' Medical Plan.

Proof of Good Health or **"Evidence of Insurability":** Evidence of your health condition, which includes completing a questionnaire regarding your medical history and possibly having a medical exam.

Qualified medical expense: An expense that meets the definition of medical expenses under Internal Revenue Code Sec. 213(d). Examples are provided in IRS Publication 502, *Medical and Dental Expenses*.

Qualified Medical Child Support Order (QMCSO): A final court or administrative order requiring an associate to carry health care coverage for eligible dependents under the Associates' Medical Plan, usually following a divorce or child custody proceeding.

Status change event: An event that allows you to make changes to your coverage outside of the initial enrollment period or Annual Enrollment, and in accordance with federal law. These events are listed in the **Eligibility and enrollment** chapter.

Third-party administrator (TPA): A third party that provides administrative services to the Plan, including making claims and internal appeals determinations, pursuant to a contractual arrangement with the Plan. Third-party administrators do not insure any benefits under the Plan.

United States: For self-insured benefits, the 48 contiguous states, Hawaii, Alaska, and the District of Columbia.

Walmart: Walmart Inc. and its participating subsidiaries.

2021 Summaries of Material Modifications

This document contains the following benefits-related information:

- Summary of Material Modifications for the Walmart 401(k) Plan
- Summary of Material Modifications for the Associates' Health and Welfare Plan *including* Additional Benefits/Extensions During Covid-19 National Emergency
- Legal Notices for the Associates' Health and Welfare Plan

This document contains the 2021 Summary of Material Modifications ("SMM") to the Walmart 401(k) Plan and the 2021 SMM to the Associates' Health and Welfare Plan. The 2020 *Associate Benefits Book*, which serves as the summary plan description for each of these plans, has been revised. Please read each plan's SMM, which explains these revisions. You will not receive a new *Associate Benefits Book* for 2021. Instead, you should review your 2020 *Associate Benefits Book*, along with these SMMs. The current summary plan description for each plan is comprised of the original printing of the 2020 *Associate Benefits Book* and this SMM.

2021 SUMMARY OF MATERIAL MODIFICATIONS TO THE WALMART 401(k) PLAN

February 1, 2020

The revisions and page numbers listed below refer to the initial printing of the 2020 *Associate Benefits Book* and the electronic version distributed during the 2020 online Annual Enrollment session. Unless otherwise indicated, the revisions to the Walmart 401(k) Plan will be effective as of February 1, 2021.

Page 243—RECEIVING A PAYOUT WHILE WORKING FOR WALMART: Effective April 20, 2020, add an additional bullet point to the list:

- Between the dates of April 20, 2020 and December 31, 2020, as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, participants eligible for a Coronavirus Relief Distribution may take up to $100,000 from all eligible accounts without incurring the usual 10% early withdrawal penalty. Taxes related to Coronavirus Relief Distributions may also be spread over a three-year period. Also, remember that you may repay some or all of your withdrawal within three years; repayments will be treated like a rollover contribution.

Page 243—FINANCIAL HARDSHIP WITHDRAWALS: Effective February 1, 2021, add an additional bullet point to the list:

- Expenses and losses (including loss of income) incurred by you on account of a disaster declared by the Federal Emergency Management Act (FEMA) under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, provided your principal residence or principal place of employment at the time of the disaster was in an area designated for individual assistance with respect to disaster.

Page 244—PLAN LOANS: Add the following text to the end of the section:

Effective Apr. 20, 2020 as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act:

- You may be eligible to borrow up to 100% of your vested 401(k) plan account balance, not to exceed $100,000, subject to normal Plan rules under the Walmart 401(k) Plan. To take advantage of the higher loan limits, this loan must be made within 180 days of March 27, 2020, when the CARES Act was enacted. Loans must be requested by September 21, 2020.
- You are also able to delay loan payments that would otherwise be due through December 31, 2020. During this period, payments will be on hold, but interest on the loan will continue to accrue. Repayments will commence as soon as administratively possible in 2021 and the original loan pay-off date will be extended by 12 months. This may result in a different loan payment amount than the original loan payment.

2021 SUMMARY OF MATERIAL MODIFICATIONS TO THE ASSOCIATES' HEALTH AND WELFARE PLAN

January 1, 2021

The revisions and page numbers listed below refer to the initial printing of the 2020 *Associate Benefits Book* and the electronic version distributed during the 2020 online Annual Enrollment session. Unless otherwise indicated, the revisions to the Associates' Health and Welfare Plan ("AHWP" or "Plan") will be effective as of January 1, 2021. Coverage will continue to be subject to the Plan's otherwise applicable eligibility terms, exclusions, limitations, and cost-sharing as described in the 2020 *Associate Benefits Book*.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 32 of this SMM for more details.

ADDITIONAL BENEFITS/EXTENSIONS DURING COVID-19 NATIONAL EMERGENCY

During the COVID-19 National Emergency, as defined by the U.S. Department of Labor ("DOL") unless otherwise noted, the Plan will provide additional COVID-related benefits or extensions as described below. For more information on the DOL COVID-19 National Emergency declaration, see https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/covid-19.pdf. Unless otherwise noted, these COVID-related changes apply from March 1, 2020 through the end of the COVID-19 National Emergency.

1. The period beginning March 1, 2020 and ending 60 days after the end of the COVID-19 public health emergency defined by the IRS will be disregarded when determining the deadlines for making changes to Plan elections as the result of status change events, as described in the **Eligibility and enrollment** chapter of the 2020 *Associate Benefits Book*, beginning under the subhead Status change events on page 21.
2. During the public health emergency declared by the President, the Plan will cover at 100%, without cost-sharing, a COVID-19 diagnostic test when ordered by your attending health care provider, and services and diagnostic tests that result in an order for, or administration of, a COVID-19 diagnostic test. This includes related diagnostic services and items furnished during network or non-network urgent care, emergency room, or in-person or telehealth provider visits that result in an order for or administration of a COVID-19 diagnostic test.
3. The Plan will waive the $4 copay for Doctor On Demand visits.
4. If you are enrolled in the Saver Plan, the Plan will cover telehealth visits through Doctor On Demand, even if you have not yet met your deductible. This provision will be in effect through December 31, 2021. If your telehealth visit is with a provider other than Doctor On Demand, you will still need to meet your deductible, unless the visit results in the administration of a COVID-19 diagnostic test, as described above.
5. Certain Centers of Excellence requirements may differ based on travel safety during the COVID-19 National Emergency. Additionally, for all programs, including weight loss surgery, additional funds will be provided per trip to the Centers of Excellence facility (regardless of the number of travelers), intended for purchase of personal protective equipment. For updated Plan requirements and travel guidance, contact Contigo Health (formerly Health Design Plus) for cardiac, spine, joint (hip and knee) replacement, and weight loss surgery programs, and HealthSCOPE Benefits for cancer eReview, kidney eReview and transplant programs.
6. Certain pharmacy rules, such as being able to fill prescriptions for longer periods, may differ during the COVID-19 National Emergency. These COVID-related rules may not extend through the end of the National Emergency. Contact OptumRx for current rules.
7. The deadlines to elect COBRA, provide required COBRA notifications, or pay COBRA premiums are extended, as required by law, for the period from March 1, 2020 through 60 days after the end of the COVID-19 National Emergency. Contact the Plan's COBRA administrator for more information.
8. The deadlines to file claims and appeals or to request external review are extended, as required by law, for the period from March 1, 2020 through 60 days after the end of the COVID-19 National Emergency. Contact your third-party administrator for more information.
9. Effective March 1, 2020, if you are eligible for the short-term disability plan for full-time hourly associates, you will be "disabled" if you are diagnosed with COVID-19, have exhausted all paid leave benefits under the Walmart Inc. COVID-19 Emergency Leave Policy, and are unable to perform the essential duties of your job for your normal work schedule as a result of COVID-19 or major health complications arising directly from COVID-19 (a "COVID-19 Disability"). If your disability is determined to be a COVID-19 Disability, then the initial seven-day waiting period applicable to other disabilities is waived and benefits may be paid for up to 26 weeks (instead of 25 weeks). A second occurrence of a COVID-19 Disability is treated as described in the section titled IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN in the **Short-term disability for full-time hourly associates** chapter. If you incur a COVID-19 Disability while you are disabled for another reason, or you incur a disability for another reason while you are on a COVID-19 Disability, you will be paid as though they were a single disability. If your COVID-19 diagnosis occurs during your seven-day waiting period, the remainder of the seven-day waiting period will be waived. These terms will be effective through a date announced by Walmart, which may be earlier than the end of the COVID-19 National Emergency. Benefits will end no later than 26 weeks after the earliest of your disability dates.

NOTE: These temporary terms also apply to the salaried short-term disability plan and truck-driver short-term disability plan. Those plans are not benefits covered by ERISA and are not part of the Plan.

Changes affecting multiple locations in the 2020 *Associate Benefits Book*

If you are a full-time hourly associate enrolled in the short-term disability enhanced plan or the New York short-term disability enhanced plan, you will no longer be able to drop your coverage at any time; you will be able to drop coverage only at Annual Enrollment or after a status change event. Similarly, if you are enrolled in the long-term disability plan, the long-term disability enhanced plan, the truck driver long-term disability plan, or the truck driver long-term disability enhanced plan, you will no longer be able to drop your coverage at any time; you will be able to drop coverage only at Annual Enrollment or after a status change event.	
THE FOLLOWING SECTIONS ARE AFFECTED:	**ELIGIBILITY AND ENROLLMENT** (pp. 4-37): pp. 5, 10, 21
	SHORT-TERM DISABILITY FOR FULL-TIME HOURLY ASSOCIATES (pp. 180-189): pp. 183, 188
	LONG-TERM DISABILITY (pp. 206-213): pp. 208, 213
	TRUCK DRIVER LONG-TERM DISABILITY (pp. 214-221): pp. 216, 221

Effective October 1, 2020, if you are a full-time hourly or management associate and you do not enroll in the long-term disability plan or the long-term disability enhanced plan when first eligible but later enroll during Annual Enrollment or after a status change event, you will no longer be required to complete a 12-month waiting period before your coverage is effective. However, you will be required to submit Evidence of Insurability and may be required to undergo a medical exam at your own expense before you can be approved for coverage. If approved, your coverage will be effective the first day of the following pay period after approval is received from Lincoln. If you are not approved, you will only be eligible to enroll in the long-term disability plan during the next Annual Enrollment or after a status change event.	
THE FOLLOWING SECTIONS ARE AFFECTED:	**ELIGIBILITY AND ENROLLMENT** (pp. 4-37): pp. 11, 13, 14, 17, 26, 27
	ELIGIBILITY AND ENROLLMENT FOR ASSOCIATES IN HAWAII (pp. 38-43): p. 41
	LONG-TERM DISABILITY (pp. 206-213): pp. 207, 208

Effective August 1, 2020, all references to "Health Design Plus," the third-party administrator for certain services under the Centers of Excellence program, are changed to Contigo Health.	
THE FOLLOWING SECTIONS ARE AFFECTED:	**THE MEDICAL PLAN** (pp. 44-91): pp. 66, 77, 78, 81
	CLAIMS AND APPEALS (pp. 260-279): pp. 263, 265, 267, 268

ELIGIBILITY AND ENROLLMENT

Pages 4-37 of the 2020 *Associate Benefits Book*

Page 7—60-day eligibility checks for benefits: Effective January 1, 2021, the following section is added before the section titled *Part-time hourly and temporary associates: eligibility checks for medical benefits:*

Part-time hourly and temporary associates: 60-day eligibility checks for benefits during the first 52 weeks of employment

PRE-INITIAL CHECK FOR PART-TIME ASSOCIATES DURING FIRST 52 WEEKS OF EMPLOYMENT–MEDICAL BENEFITS

If you are a part-time hourly or temporary associate (other than a part-time truck driver), your hours worked will be measured to determine whether you are eligible for benefits described in the chart on page 15 of the 2020 *Associate Benefits Book* before the end of your first 52 weeks of employment. Your hours worked per week will be measured on the 59th day following your date of hire (the 60th day of employment) and on every 60th day thereafter until you have been employed for 52 weeks (six total pre-initial checks during your first year of employment). No 60-day check will be performed after the date on which you reach the end of your initial measurement period, as described later in this chapter.

If you work an average of at least 30 hours a week during your first 60-day measurement cycle, without a break in employment of greater than 30 days, you will become eligible for benefits at the close of that measurement cycle. Specifically, your eligibility for benefits described in the chart on page 15 of the 2020 *Associate Benefits Book* will begin on the first day of the month in which your 89th day of employment occurs.

If you do not work an average of at least 30 hours a week during your first 60-day measurement cycle, but you do work an average of at least 30 hours a week during any subsequent 60-day measurement cycle, without a break in employment of greater than 30 days, you will become eligible for benefits described in the chart on page 15 of the 2020 *Associate Benefits Book* at the close of that measurement cycle. Specifically, your eligibility for benefits described in the chart on page 15 of the 2020 *Associate Benefits Book* will begin on the first day of the month in which your 89th day of employment occurs after the successful 60-day measurement cycle began.

For example, if your date of hire is April 16, 2021, your average hours worked from that day through June 14, 2021 will be measured on your 60th day of employment, June 15. If you worked an average of at least 30 hours a week over this 60-day measurement cycle, your coverage would begin July 1, 2021 (assuming you enroll in a timely manner), the first day of the month in which your 89th day of employment occurs.

If you work an average of at least 30 hours a week during any 60-day measurement cycle and are offered benefits but do not enroll, you will not be included in future 60-day measurement cycles and the next time your hours will be measured is at the end of the initial measurement period, which is described later in this chapter.

If you meet the average-hours-worked requirement, eligibility for medical coverage continues through the end of the second calendar year following the date that coverage is first offered and and eligibility for all other benefits described in the chart on page 15 of the 2020 *Associate Benefits Book* will continue as long as you remain a part-time or temporary associate. However, if you do not elect coverage when first eligible, you will only be able to elect coverage during Annual Enrollment or if a qualifying event occurs.

In the example above, if you elect medical coverage, your medical coverage (if you enroll in a timely manner) would continue through the end of 2022. For years after 2022, you would be subject to annual eligibility checks, as described later in this chapter.

IF YOU TAKE TIME OFF DURING ANY 60-DAY MEASUREMENT CYCLE

If you take any type of unpaid time off that is not an approved leave of absence, as described later in this chapter, your number of actual service hours will still be used in the calculation of your average hours for the 60-day measurement cycle (even if it is zero) in which the absence occurs.

If your absence is an approved leave (including for jury duty, Family and Medical Leave Act of 1993 [“FMLA”] leave, or military leave), your average-hours-worked calculation will be based on the number of days during the 60-day measurement cycle that you worked. For example, if you take an approved leave during five days of the 60-day measurement cycle, your average hours worked will be calculated over 55 days rather than 60.

TRANSITION RULE FOR ASSOCIATES WHO WERE EMPLOYED ON OR BEFORE NOVEMBER 2, 2020

If you were employed as a part-time hourly or temporary associate on or before November 2, 2020, there will be a one-time eligibility check of hours worked from November 2, 2020 through December 31, 2020 to determine whether you worked an average of 30 hours per week during that period. If you meet the average-hours-worked requirement, eligibility for medical coverage continues through the end of 2022 and eligibility for all other benefits described in the chart on page 15 of the 2020 *Associate Benefits Book* will continue as long as you remain a part-time or temporary associate. However, if you do not elect coverage when first eligible, you will only be able to elect coverage during Annual Enrollment or if a qualifying event occurs.

For years after 2022, you would be subject to annual eligibility checks for medical benefits, as described later in this chapter.

If you did not work an average of 30 hours a week during that period, ongoing 60-day eligibility checks will resume, based on your original hire date under the rules described above.

IF YOU LEAVE THE COMPANY AND ARE REHIRED

PART-TIME HOURLY AND TEMPORARY ASSOCIATES

If you return to employment as a part-time hourly or temporary associate within 30 days after leaving during the first 52 weeks of employment, you will be treated as if you had not left.

If you were enrolled in medical coverage before you left, you will still be enrolled in medical coverage with a break in coverage for the time coverage was not paid. The medical coverage will continue through the end of the second calendar year following date that coverage is first offered.

If you are rehired and re-enrolled in the same calendar year, your annual deductible and out-of-pocket maximum under the AMP for the calendar year in which you terminate will not reset.

If you are rehired in a different calendar year, your annual deductible and out-of-pocket maximum will reset and you will be responsible for meeting the new deductible and out-of-pocket maximum in their entirety. You will have 60 days after resuming employment to drop or otherwise change the coverage in which you were automatically re-enrolled.

If you were eligible for medical coverage before you left but did not elect coverage, you will still be eligible to enroll in medical coverage when you return (assuming you enroll in a timely manner). Your eligibility continues through the end of the second calendar year

following the date that coverage is first offered. You will be able to elect coverage during this period during Annual Enrollment or if a qualifying event occurs. If you do not enroll in a timely manner, you will not be included in future 60-day measurement cycles and the next time your hours will be measured is at the end of the initial measurement period, which is described later in this chapter.

If you were in a 60-day measurement cycle when you left and you return during that same measurement cycle, your hours will continue to be measured until the end of that measurement cycle. All hours worked during that measurement cycle will be used in the average-hours-worked calculation. For example, if you have a 10-day break in service during the 60-day measurement cycle, your average hours will be calculated using the 50 days during which you worked, rather than 60 days.

If you return to employment as a part-time hourly or temporary associate more than 30 days after leaving during your first 52 weeks of employment, you will be treated as a new hire. The 60-day measurement cycles will resume, with your date of rehire being the first day of the first 60-day measurement cycle that occurs after you are rehired. The 60-day measurement cycles will continue until the end of the initial measurement period, which is explained later in this chapter.

Page 12—"Active work" or "actively at work": Effective January 1, 2020, the two paragraphs following this subhead are replaced with the following:

For medical, dental, vision, critical illness insurance, accident insurance, AD&D and Resources for Living coverage, "active work" (or "actively at work") means you are on active status and have reported to your first day of work at the company, even if you are not at work the day coverage begins (for example, due to illness).

For company-paid life insurance, optional associate life insurance, optional dependent life insurance, and business travel accident insurance, being actively at work means you are on active status and not on a leave of absence.

For all types of disability coverage, being actively at work means you have worked hours in the immediately preceding pay period if you are an hourly associate or have earned wages if you are a member of management.

Page 15—PART-TIME HOURLY AND TEMPORARY ASSOCIATES: The following text replaces the text under the heading "Initial enrollment period": You must enroll in coverage during the 60-day period beginning with the earlier of 1) the date on which you are first notified that you have passed a 60-day eligibility check described in the new section titled Part-time hourly and temporary associates: 60-day eligibility checks for benefits during the first 52 weeks of employment, or 2) your 52-week anniversary date.

The following text replaces the text under the heading "When coverage is effective": Your coverage is effective the earlier of 1) the first day of the month in which your 89th day of employment occurs after the successful 60-day measurement cycle began, as described in the new section titled *Part-time hourly and temporary associates: 60-day eligibility checks for benefits during the first 52 weeks of employment*, or 2) the first day of the second calendar month following your 52-week anniversary date.*

Page 32—MANAGEMENT ASSOCIATES TRANSFERRING TO FULL-TIME HOURLY: The following text replaces the bullet point reading "You are eligible to enroll in the long-term disability plan," which appears in the top row of the chart (as labeled "Within 60 days of your date of hire and before you have enrolled for benefits"):

- You are eligible to enroll in the long-term disability ("LTD") plan during the 60-day period beginning on the first day of the pay period in which your transition occurs. Your coverage under the LTD plan is effective on your date of hire.
- If you do not enroll in LTD during the 60-day period following your transition, you will only be able to enroll or make changes during Annual Enrollment or after a status change event and will be required to submit Evidence of Insurability (EOI), which may include undergoing a medical exam at your own expense before you can be approved for coverage.
  - If you are within 12 months of your date of hire and are approved through EOI, your coverage will be effective on the 12-month anniversary of your date of hire.
  - If you are not within 12 months of your date of hire and are approved through EOI, your coverage will be effective the first day of the following pay period after approval is received from Lincoln.

In addition, the following text replaces the bullet point reading "You are eligible to enroll in the long-term disability plan," which appears in the bottom row of the chart (as labeled "Within 60 days of your date of hire and after you have enrolled for benefits"):

- You are eligible to enroll in the long-term disability ("LTD") plan. If you are enrolled in LTD coverage, you will maintain your benefit coverage.
- If you have not enrolled in LTD coverage, you are eligible to enroll in the LTD plan during the 60-day period beginning on the first day of the pay period in which your transition occurs. Your coverage under the LTD plan is effective on your date of hire.
- If you do not enroll in LTD coverage during the 60-day period following your transition, you will only be able to enroll or make changes during Annual Enrollment or after a status change event and will be required to submit Evidence of Insurability (EOI), which may include undergoing a medical exam at your own expense before you can be approved for coverage.
  - If you are within 12 months of your date of hire and are approved through EOI, your coverage will be effective on the 12-month anniversary of your date of hire.
  - If you are not within 12 months of your date of hire and are approved through EOI, your coverage will be effective the first day of the following pay period after approval is received from Lincoln.

Page 33—MANAGEMENT ASSOCIATES TRANSFERRING TO FULL-TIME HOURLY (CONTINUED): The following text replaces the fifth bullet point in the chart (as labeled "More than 60 days after your date of hire):

- You are eligible to enroll in the long-term disability ("LTD") plan. If you are enrolled in LTD coverage, you will maintain your benefit coverage.
- If you have not enrolled in LTD coverage, you are eligible to enroll in LTD during the 60-day period beginning on the first day of the pay period in which your transition occurs.
  - If you are within 12 months of your date of hire, your coverage will be effective on the 12-month anniversary of your date of hire.
  - If you are not within 12 months of your date of hire, your coverage will be effective as of the date of your transition.
- If you do not enroll in LTD coverage during the 60-day period following your transition, you will only be able to enroll or make changes during Annual Enrollment or after a status change event and will be required to submit Evidence of Insurability (EOI), which may include undergoing a medical exam at your own expense before you can be approved for coverage.
  - If you are within 12 months of your date of hire and are approved through EOI, your coverage will be effective on the 12 month anniversary of your date of hire.
  - If you are not within 12 months of your date of hire and are approved through EOI, your coverage will be effective the first day of the following pay period after approval is received from Lincoln.

Page 36—Qualified Medical Child Support Orders ("QMCSO"): The following text replaces the paragraph at the bottom of the first column:

When the Plan receives a QMCSO, it will apply the following rules:

- If the Plan receives a QMCSO when you are eligible but prior to you satisfying your initial waiting period for medical coverage, the order will be put into effect when your initial waiting period is satisfied.
- If you are ineligible for coverage when the Plan receives a QMCSO, the order will be rejected.
- If you are ineligible for coverage when the plan receives a QMCSO but subsequently become eligible, the Plan requires a new QMCSO before coverage for your dependent can take effect.
- If you are eligible for coverage when the Plan receives a QMCSO and you lose eligibility, and then subsequently regain eligibility, the Plan requires a new QMCSO before coverage for your dependent can take effect.
- If you are eligible for coverage when the Plan receives a QMCSO, then become ineligible and then subsequently regain eligibility, the Plan requires a new QMCSO before coverage for your dependent can take effect.
- If you are eligible for coverage and have a QMCSO in effect, then terminate, then are rehired and become eligible again, the Plan requires a new QMCSO before coverage can take effect.

When the third-party administrator enforces coverage for a court-ordered dependent, information regarding the dependent is shared only with the legal custodian. If you have questions, contact Medical Support Services at **877-930-5607**.

See also the section titled Changes Affecting Multiple Locations in the 2020 *Associate Benefits Book*, earlier in this SMM, for additional changes in the **Eligibility and enrollment** chapter.

THE MEDICAL PLAN

Pages 44-91 of the 2020 *Associate Benefits Book*

Page 46—Changes to Plan Options Available in Certain Regions: Plan terms are changed in certain medical plan options available in three geographic areas. The section titled *National plan options* is replaced with the following:

National plan options

The charts on the following pages summarize the coverage offered under the AMP coverage options.

The national plan options under the AMP are the Premier Plan, the Contribution Plan, and the Saver Plan. Under each of these national plan options, plan terms in most areas nationwide are summarized in the first chart that immediately follows, titled Walmart plans offered nationwide.

If you participate in one of the national plan options and your work location is within one of three geographic areas, as detailed below, each national plan option available to you has terms that are different from the same national plan option available to associates with work locations outside of these three areas. Different terms apply if you work in one of the following areas:

- **Central Florida (including Orlando and Tampa)**
  - Counties within this area are Brevard, Citrus, Hernando, Hillsborough, Lake, Manatee, Marion, Orange, Osceola, Pasco, Pinellas, Polk, northern Sarasota (Sarasota area only), Seminole, Sumter, and Volusia
- **Dallas/Fort Worth**
  - Counties within this area are Collin, Dallas, Denton, Ellis, Hunt, Johnson, Kaufman, Parker, Rockwall, Tarrant, and Wise (the Contribution Plan is available only in limited work locations in this area)
- **Northwest Arkansas**
  - Counties within this area are Benton, Madison, and Washington

References throughout this chapter to central Florida, Dallas/Fort Worth, or northwest Arkansas are references to these listed counties, respectively.

The terms of the Premier Plan, Contribution Plan, and Saver Plan options available in central Florida, Dallas/Fort Worth, and northwest Arkansas are summarized in the charts titled, respectively, Central Florida, Dallas/Fort Worth, and Northwest Arkansas, which follow the chart on the next page.

Page 47-49—Medical plan summary charts: Replace the charts on page 47, 48, and 49 with the following:

WALMART PLANS OFFERED NATIONWIDE

If your work location is in central Florida, Dallas/Fort Worth, or northwest Arkansas, refer to the charts on the following pages.

	Premier Plan	Contribution Plan	Saver Plan
Annual deductible (Individual/Family) • Network • Out-of-network	 $2,750/$5,500 $5,500/$11,000	 $1,750/$3,500 $3,500/$7,000	 $3,000/$6,000 $6,000/$12,000
Walmart-provided funds (Individual/Family)	N/A	$250/$500 *Maximum company contribution to HRA*	$350/$700 *Maximum company matching contribution to HSA*
Annual out-of-pocket maximum (Individual/Family) • Network • Out-of-network	 $6,850/$13,700 None	 $6,850/$13,700 None	 $6,650/$13,300 None
Eligible preventive care • Network • Non-network	 100% (no deductible) 50% (no deductible)	 100% (no deductible) 50% (no deductible)	 100% (no deductible) 50% (no deductible)
Doctor visits (provider's office or telehealth) *Including routine same-day diagnostic tests performed in doctor's office* **Primary care** • Network • Non-network **Specialist** • Network • Non-network	 100% after $35 copay 50% after deductible 100% after $75 copay 50% after deductible	 75% after deductible 50% after deductible 75% after deductible 50% after deductible	 75% after deductible 50% after deductible 75% after deductible 50% after deductible
Telehealth video visits through Doctor On Demand	100% after $4* copay	100% after $4* copay	100% after deductible and $4* copay
**The $4 Doctor On Demand copay is waived for the duration of the COVID-19 National Emergency. In addition, Saver Plan participants will not be required to first meet their annual deductible before utilizing Doctor On Demand services throughout 2021.*			
Urgent care • Network • Non-network	 100% after $75 copay 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Diagnostic tests *All nonpreventive tests ordered or performed outside a doctor's office* • Network • Non-network	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Advanced imaging MRI, CT scans • Alternate network • Network • Non-network	 75% after deductible 50% after deductible 50% after deductible	 75% after deductible 50% after deductible 50% after deductible	 75% after deductible 50% after deductible 50% after deductible
Hospitalization Inpatient & outpatient care • Network • Non-network	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Behavioral health **Inpatient & outpatient (facility)** • Network • Non-network **Outpatient (provider's office or telehealth)** • Network • Non-network	 75% after deductible 50% after deductible 100% after $35 copay 50% after deductible	 75% after deductible 50% after deductible 75% after deductible 50% after deductible	 75% after deductible 50% after deductible 75% after deductible 50% after deductible
Emergency care through emergency room visit • Network • Non-network	100% after deductible and $300 copay For information regarding non-network emergency room coverage, see later in chapter.		
Pharmacy	See **The pharmacy benefit** chapter		
Centers of Excellence	See the **Centers of Excellence** section of this chapter		
Walmart Care Clinic and Walmart Health	See the **Walmart Care Clinic and Walmart Health** section of this chapter		

CENTRAL FLORIDA

	Premier Plan	Contribution Plan	Saver Plan
Annual deductible (Individual/Family) • Network preferred & nonpreferred • Out-of-network	 $2,750/$5,500 $5,500/$11,000	 $1,750/$3,500 $3,500/$7,000	 $3,000/$6,000 $6,000/$12,000
Walmart-provided funds (Individual/Family)	N/A	$250/$500 *Maximum company contribution to HRA*	$350/$700 *Maximum company matching contribution to HSA*
Annual out-of-pocket maximum (Individual/Family) • Network preferred & nonpreferred • Out-of-network	 $6,850/$13,700 None	 $6,850/$13,700 None	 $6,650/$13,300 None
Eligible preventive care • Network preferred • Network nonpreferred & non-network	 100% (no deductible) 50% (no deductible)	 100% (no deductible) 50% (no deductible)	 100% (no deductible) 50% (no deductible)
Doctor visits (provider's office or telehealth) *Including routine same-day diagnostic tests performed in doctor's office* **Primary care** • Network preferred • Network nonpreferred & non-network **Specialist** • Network preferred • Network nonpreferred & non-network	 100% after $35 copay 50% after deductible 100% after $75 copay 50% after deductible	 75% after deductible 50% after deductible 75% after deductible 50% after deductible	 75% after deductible 50% after deductible 75% after deductible 50% after deductible
Telehealth video visits through Doctor On Demand	100% after $4* copay	100% after $4* copay	100% after deductible and $4* copay
**The $4 Doctor On Demand copay is waived for the duration of the COVID-19 National Emergency. In addition, Saver Plan participants will not be required to first meet their annual deductible before utilizing Doctor On Demand services throughout 2021.*			
Urgent care • Network preferred • Network nonpreferred & non-network	 100% after $75 copay 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Diagnostic tests *All nonpreventive tests ordered or performed outside a doctor's office* • Network • Non-network	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Advanced imaging MRI, CT scans • Alternate network • Network • Non-network	 75% after deductible 50% after deductible 50% after deductible	 75% after deductible 50% after deductible 50% after deductible	 75% after deductible 50% after deductible 50% after deductible
Hospitalization Inpatient & outpatient care • Network • Non-network	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Behavioral health **Inpatient & outpatient (facility)** • Network • Non-network **Outpatient (provider's office or telehealth)** • Network • Non-network	 75% after deductible 50% after deductible 100% after $35 copay 50% after deductible	 75% after deductible 50% after deductible 75% after deductible 50% after deductible	 75% after deductible 50% after deductible 75% after deductible 50% after deductible
Emergency care through emergency room visit • Network • Non-network	100% after deductible and $300 copay For information regarding non-network emergency room coverage, see later in chapter.		
Pharmacy	See **The pharmacy benefit** chapter		
Centers of Excellence	See the **Centers of Excellence** section of this chapter		
Walmart Care Clinic and Walmart Health	See the **Walmart Care Clinic and Walmart Health** section of this chapter		

DALLAS/FORT WORTH

The Contribution Plan is available in limited locations in the Dallas/Fort Worth area.

	Premier Plan	Contribution Plan	Saver Plan
Annual deductible (Individual/Family) • Network preferred & nonpreferred (Network benefits only)	$2,750/$5,500	$1,750/$3,500	$3,000/$6,000
Walmart-provided funds (Individual/Family)	N/A	$250/$500 *Maximum company contribution to HRA*	$350/$700 *Maximum company matching contribution to HSA*
Annual out-of-pocket maximum (Individual/Family) • Network preferred & nonpreferred (Network benefits only)	$6,850/$13,700	$6,850/$13,700	$6,650/$13,300
Eligible preventive care • Network preferred • Network nonpreferred • Non-network	100% (no deductible) 50% (no deductible) No coverage	100% (no deductible) 50% (no deductible) No coverage	100% (no deductible) 50% (no deductible) No coverage
Doctor visits (provider's office or telehealth) *Including routine same-day diagnostic tests performed in doctor's office* **Primary care** • Network preferred • Network nonpreferred • Non-network **Specialist** • Network preferred • Network nonpreferred • Non-network	 100% after $35 copay 50% after deductible No coverage 100% after $75 copay 50% after deductible No coverage	 75% after deductible 50% after deductible No coverage 75% after deductible 50% after deductible No coverage	 75% after deductible 50% after deductible No coverage 75% after deductible 50% after deductible No coverage
Telehealth video visits through Doctor On Demand	100% after $4* copay	100% after $4* copay	100% after deductible and $4* copay
**The $4 Doctor On Demand copay is waived for the duration of the COVID-19 National Emergency. In addition, Saver Plan participants will not be required to first meet their annual deductible before utilizing Doctor On Demand services throughout 2021.*			
Urgent care • Network preferred • Network nonpreferred • Non-network	100% after $75 copay 50% after deductible No coverage	75% after deductible 50% after deductible No coverage	75% after deductible 50% after deductible No coverage
Diagnostic tests *All nonpreventive tests ordered or performed outside a doctor's office* • Network • Non-network	 75% after deductible No coverage	 75% after deductible No coverage	 75% after deductible No coverage
Advanced imaging MRI, CT scans • Alternate network • Network • Non-network	 75% after deductible 50% after deductible No coverage	 75% after deductible 50% after deductible No coverage	 75% after deductible 50% after deductible No coverage
Hospitalization Inpatient & outpatient care • Network • Non-network	 75% after deductible No coverage	 75% after deductible No coverage	 75% after deductible No coverage
Behavioral health **Inpatient & outpatient (facility)** • Network • Non-network **Outpatient (provider's office or telehealth)** • Network • Non-network	 75% after deductible No coverage 100% after $35 copay No coverage	 75% after deductible No coverage 100% after $35 copay No coverage	 75% after deductible No coverage 100% after $35 copay No coverage
Emergency care through emergency room visit • Network • Non-network	100% after deductible and $300 copay For information regarding non-network emergency room coverage, see later in chapter.		
Pharmacy	See **The pharmacy benefit** chapter		
Centers of Excellence	See the **Centers of Excellence** section of this chapter		
Walmart Care Clinic and Walmart Health	See the **Walmart Care Clinic and Walmart Health** section of this chapter		

NORTHWEST ARKANSAS

	Premier Plan	Contribution Plan	Saver Plan
Annual deductible (Individual/Family) • Network (Network benefits only)	$2,750/$5,500	$1,750/$3,500	$3,000/$6,000
Walmart-provided funds (Individual/Family)	N/A	$250/$500 *Maximum company contribution to HRA*	$350/$700 *Maximum company matching contribution to HSA*
Annual out-of-pocket maximum (Individual/Family) • Network (Network benefits only)	$6,850/$13,700	$6,850/$13,700	$6,650/$13,300
Eligible preventive care • Network • Non-network	100% (no deductible) No coverage	100% (no deductible) No coverage	100% (no deductible) No coverage
Doctor visits (provider's office or telehealth) *Including routine same-day diagnostic tests performed in doctor's office* **Primary care** • Network • Non-network **Specialist** • Network • Non-network	 100% after $35 copay No coverage 100% after $75 copay No coverage	 75% after deductible No coverage 75% after deductible No coverage	 75% after deductible No coverage 75% after deductible No coverage
Telehealth video visits through Doctor On Demand	100% after $4* copay	100% after $4* copay	100% after deductible and $4* copay
**The $4 Doctor On Demand copay is waived for the duration of the COVID-19 National Emergency. In addition, Saver Plan participants will not be required to first meet their annual deductible before utilizing Doctor On Demand services throughout 2021.*			
Urgent care • Network • Non-network	100% after $75 copay No coverage	75% after deductible No coverage	75% after deductible No coverage
Diagnostic tests *All nonpreventive tests ordered or performed outside a doctor's office* • Network • Non-network	 75% after deductible No coverage	 75% after deductible No coverage	 75% after deductible No coverage
Advanced imaging MRI, CT scans • Alternate network • Network • Non-network	 75% after deductible 50% after deductible No coverage	 75% after deductible 50% after deductible No coverage	 75% after deductible 50% after deductible No coverage
Hospitalization Inpatient & outpatient care • Network • Non-network	 75% after deductible No coverage	 75% after deductible No coverage	 75% after deductible No coverage
Behavioral health **Inpatient & outpatient (facility)** • Network • Non-network **Outpatient (provider's office or telehealth)** • Network • Non-network	 75% after deductible No coverage 100% after $35 copay No coverage	 75% after deductible No coverage 75% after deductible No coverage	 75% after deductible No coverage 75% after deductible No coverage
Emergency care through emergency room visit • Network • Non-network	100% after deductible and $300 copay For information regarding non-network emergency room coverage, see later in chapter.		
Pharmacy	See **The pharmacy benefit** chapter		
Centers of Excellence	See the **Centers of Excellence** section of this chapter		
Walmart Care Clinic and Walmart Health	See the **Walmart Care Clinic and Walmart Health** section of this chapter		

Page 50-53—Changes in local plans options: Certain local plan options are discontinued.

- The following local plans are eliminated from the chart listing all plans by name on page 50:
  - Emory Local Plan
  - Mercy Oklahoma Local Plan
  - Mercy St. Louis Local Plan
  - St. Luke's Local Plan
  - Select Local Plan
- The plan names *Emory*, *Mercy Oklahoma*, *Mercy St. Louis*, and *St. Luke's* are removed from the top row in the chart on page 52.
- The entire chart on page 53, *The Select Local Plan*, is removed.

Pages 54-65—Detailed descriptions of the AMP options: The following replaces the text on pages 54-65, starting with The Walmart Premier Plan on page 54 and concluding immediately before The local plans on page 65:

The Walmart Premier Plan

PREMIER PLAN COVERAGE

If your work location is *not* in central Florida, Dallas/Fort Worth, or northwest Arkansas

This section describes coverage under the Premier Plan in all areas except specific geographic areas of central Florida, Dallas/Fort Worth, and northwest Arkansas. See *National Plan options* earlier in this chapter for the specific counties that make up these areas. Descriptions of Premier Plan coverage for each of those areas follow later in this chapter.

The Premier Plan offers you the ability to pay for doctor visits with fixed amounts, called "copayments" or "copays," as explained below under *Coinsurance, copays, and the out-of-pocket maximum.* If you were enrolled in the HRA Plan in 2019 and have a balance in the Health Reimbursement Account ("HRA") associated with that plan, you can use the remaining funds to pay for the copay required for doctor's in-person or telehealth visits (primary care or specialist), Walmart Care Clinic or Walmart Health, Doctor On Demand, or urgent care through the end of 2021, provided you remain enrolled in the Premier Plan option.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Premier Plan begins paying a portion of the cost of covered services. Copays are in addition to the annual deductible and do not count toward the deductible. The Premier Plan has a separate annual deductible for services provided by network providers and services provided by non-network providers. Amounts you pay toward the network annual deductible apply toward the out-of-network annual deductible, and vice versa.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the network annual deductible and the out-of-network annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire applicable annual deductible is met. The following expenses do not count toward the network or out-of-network annual deductible:

- Copays for in-person or telehealth doctor visits, Doctor On Demand, urgent care, Walmart Care Clinic or Walmart Health, or emergency room visits
- Pharmacy copays/coinsurance (including copay assistance from a third party)
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services that are in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP
- Charges paid 100% by the AMP, such as charges for network preventive services and certain Centers of Excellence services, and
- Charges for non-network preventive services.

Coinsurance, copayments, and the out-of-pocket maximum

For covered services subject to a copayment, you must continue to pay the copayment, even after your applicable annual deductible has been met, until you meet your annual out-of-pocket maximum. See the WALMART PLANS OFFERED NATIONWIDE chart earlier in this chapter for information about the copayment required for specific covered services.

For covered services not subject to a copayment, you will be required to share the cost of covered services with the Plan after you meet your applicable annual deductible. The WALMART PLANS OFFERED NATIONWIDE chart shows the percentage that the Plan will pay for each covered service, which varies depending on whether the services are provided by a network provider or a non-network provider. The remaining portion, which is your coinsurance, is the share that you are responsible for. If you receive covered services from a non-network provider, you are also responsible for any amount above the maximum allowable charge. After you meet your out-of-pocket maximum, no coinsurance will be required for covered services from a network provider. There is no out-of-pocket maximum for covered services from a non-network provider.

The Plan will pay all or a portion of the cost of covered preventive services before you meet your applicable deductible and with no copayment. If services are provided by a network provider, the Plan will pay 100% of the cost of covered preventive services. If services are provided by a non-network provider, the Plan will pay 50% of the cost of covered preventive services. The remaining portion, which is your coinsurance, is the share that you are responsible for. If covered preventive services are provided by a non-network provider, you are also responsible for any amount above the maximum allowable charge.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your network annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a network facility, the Plan will pay 100% after you have met your annual deductible, regardless of whether the third-party administrator determines that the visit is an "emergency." If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your out-of-network deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum for network services, the Plan pays 100% of the cost of covered services from a network provider for the rest of the calendar year. There is no annual out-of-pocket maximum for services from non-network providers—you are responsible for paying your share of these charges in full throughout the year. The amounts you pay that apply toward your network annual out-of-pocket maximum include:

- Network and out-of-network annual deductibles (including amounts paid with remaining HRA funds)
- Copays for in-person or telehealth doctor visits, Doctor On Demand, urgent care, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network, and
- Pharmacy copays/coinsurance.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for network preventive services and certain Centers of Excellence services
- Charges for non-network preventive services
- Coinsurance when using non-network providers
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP.

If you choose associate-only coverage under the Premier Plan, you will have an individual out-of-pocket maximum for network expenses of $6,850. If you add dependents to your coverage, you will have an out-of-pocket maximum for network expenses of $13,700 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,850. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the

family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible network expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum. There is no out-of-pocket maximum for out-of-network expenses.

PREMIER PLAN COVERAGE FOR WORK LOCATIONS IN CENTRAL FLORIDA

The Premier Plan offers you the ability to pay for doctor visits with fixed amounts, called "copayments" or "copays," as explained below under *Coinsurance, copays, and the out-of-pocket maximum.* If you were enrolled in the HRA Plan in 2019 and have a balance in the Health Reimbursement Account ("HRA") associated with that plan, you can use the remaining funds to pay for the copay required for in-person or telehealth doctor's visits (primary care or specialist), Walmart Care Clinic or Walmart Health, Doctor On Demand, or urgent care through the end of 2021, provided you remain enrolled in the Premier Plan option.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Premier Plan begins paying a portion of the cost of covered services. Copays are in addition to the annual deductible and do not count toward the deductible. The Premier Plan has an annual deductible for network services (preferred and nonpreferred network providers) and a separate annual deductible for non-network services. Amounts you pay toward the network annual deductible apply toward the out-of-network annual deductible, and vice versa.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire annual deductible is met.

The following expenses do not count toward the network annual deductible or to the out-of-network annual deductible:

- Copays for in-person or telehealth doctor visits, Doctor On Demand, urgent care, Walmart Care Clinic or Walmart Health, or emergency room visits
- Pharmacy copays/coinsurance (including copay assistance from a third party)
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP
- Charges paid 100% by the AMP, such as charges for preferred network preventive services and certain Centers of Excellence services, and
- Charges for nonpreferred network preventive services and non-network preventive services.

Coinsurance, copayments, and the out-of-pocket maximum

For covered services subject to a copayment, you must continue to pay the copayment, even after your applicable annual deductible has been met, until you meet your annual out-of-pocket maximum. See the CENTRAL FLORIDA chart earlier in this chapter for information about the copayment required for specific covered services.

For covered services not subject to a copayment, you will be required to share the cost of covered services with the Plan after you meet your annual deductible. The CENTRAL FLORIDA chart shows the percentage that the Plan will pay for each covered service, which varies depending on whether the services are provided by a network provider who is preferred or nonpreferred, or a non-network provider. The remaining portion, which is your coinsurance, is the share that you are responsible for until you meet your annual out-of-pocket maximum. If you receive covered services from a non-network provider, you are also responsible for any amount above the maximum allowable charge. After you meet your out-of-pocket maximum, no coinsurance will be required for covered services from a network provider. There is no out-of-pocket maximum for covered services from a non-network provider.

The Plan will pay all or a portion of the cost of covered preventive services before you meet your applicable deductible and with no copayment. If services are provided by a network preferred provider, the Plan will pay 100% of the cost of covered preventive services. If services are provided by a network nonpreferred provider or non-network provider, the Plan will pay 50% of the cost of covered preventive services. The remaining portion, which is your coinsurance, is the share that you are responsible for. If covered preventive services are provided by a non-network provider, you are also responsible for any amount above the maximum allowable charge.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a network facility, the

Plan will pay 100% after you have met your annual deductible, regardless of whether the third-party administrator determines that the visit is an "emergency." If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum for network services, the Plan pays 100% of the cost of covered services for the rest of the calendar year. There is no out-of-pocket maximum for services from non-network providers—you are responsible for paying your share of these charges in full throughout the year.

The amounts you pay that apply toward your annual out-of-pocket maximum include:

- Annual deductible (including amounts paid with remaining HRA funds)
- Copays for in-person or telehealth doctor visits, Doctor On Demand, urgent care, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider (preferred or nonpreferred) or by a non-network provider that the Plan pays as in-network, and
- Pharmacy copays/coinsurance.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for preferred network preventive services and certain Centers of Excellence services
- Charges for non-network preventive services.
- Coinsurance charges when using non-network providers.
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP.

If you choose associate-only coverage under the Premier Plan, you will have an individual out-of-pocket maximum of $6,850. If you add dependents to your coverage, you will have an out-of-pocket maximum of $13,700 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,850. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum. There is no out-of-pocket maximum for out-of-network expenses.

PREMIER PLAN COVERAGE FOR WORK LOCATIONS IN DALLAS/FORT WORTH

The Premier Plan offers you the ability to pay for doctor visits with fixed amounts, called "copayments" or "copays," as explained below under *Coinsurance, copays, and the out-of-pocket maximum.* If you were enrolled in the HRA Plan in 2019 and have a balance in the Health Reimbursement Account ("HRA") associated with that plan, you can use the remaining funds to pay for the copay required for in-person or telehealth doctor's visits (primary care or specialist), Walmart Care Clinic or Walmart Health, Doctor On Demand, or urgent care through the end of 2021, provided you remain enrolled in the Premier Plan option.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Premier Plan begins paying a portion of the cost of covered services. Copays are in addition to the annual deductible and do not count toward the deductible.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire annual deductible is met.

The following expenses do not count toward the annual deductible:

- Copays for in-person or telehealth doctor visits, Doctor On Demand, urgent care, Walmart Care Clinic or Walmart Health, or emergency room visits
- Pharmacy copays/coinsurance (including copay assistance from a third party)
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP, and
- Charges paid 100% by the AMP, such as charges for preferred network preventive services and certain Centers of Excellence services.

Coinsurance, copayments, and the out-of-pocket maximum

For covered services subject to a copayment, you must continue to pay the copayment, even after your annual deductible has been met, until you meet your annual out-of-pocket maximum. See the DALLAS/FORT WORTH chart earlier in this chapter for information about the copayment required for specific covered services.

For covered services not subject to a copayment, you will be required to share the cost of covered services with the Plan after you meet your annual deductible. The DALLAS/FORT WORTH chart shows the percentage that the Plan will pay for each covered service, which varies depending on whether the services are provided by a network provider who is preferred or nonpreferred. The remaining portion, which is your coinsurance, is the share that you are responsible for until you meet your annual out-of-pocket maximum. Care provided by a non-network provider is not covered under this plan, except in cases of emergency.

The Plan will pay all or a portion of the cost of covered preventive services provided by a network provider before you meet your network deductible and with no copayment. If the network provider is preferred, the Plan will pay 100% of the cost of covered preventive services. If the network provider is nonpreferred, the Plan will pay 50% of the cost of covered preventive services. Preventive services provided by a non-network provider are not covered under this plan.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a network facility, the Plan will pay 100% after you have met your annual deductible, regardless of whether the third-party administrator determines that the visit is an "emergency." If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum, the Plan pays 100% of the cost of covered services for the rest of the calendar year.

The amounts you pay that apply toward your annual out-of-pocket maximum include:

- Annual deductible (including amounts paid with remaining HRA funds)
- Copays for in-person or telehealth doctor visits, Doctor On Demand, urgent care, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider (preferred or nonpreferred) or by a non-network provider that the Plan pays as in-network, and
- Pharmacy copays/coinsurance.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for preferred network preventive services and certain Centers of Excellence services

- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP, including charges for services from non-network providers.

If you choose associate-only coverage under the Premier Plan, you will have an individual out-of-pocket maximum of $6,850. If you add dependents to your coverage, you will have an out-of-pocket maximum of $13,700 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,850. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum.

PREMIER PLAN COVERAGE FOR WORK LOCATIONS IN NORTHWEST ARKANSAS

The Premier Plan offers you the ability to pay for doctor visits with fixed amounts, called "copayments" or "copays," as explained below under *Coinsurance, copays, and the out-of-pocket maximum.* If you were enrolled in the HRA Plan in 2019 and have a balance in the Health Reimbursement Account ("HRA") associated with that plan, you can use the remaining funds to pay for the copay required for in-person or telehealth doctor's visits (primary care or specialist), Walmart Care Clinic or Walmart Health, Doctor On Demand, or urgent care through the end of 2021, provided you remain enrolled in the Premier Plan option.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Premier Plan begins paying a portion of the cost of covered services. Copays are in addition to the annual deductible and do not count toward the deductible.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire annual deductible is met.

The following expenses do not count toward the annual deductible:

- Copays for in-person or telehealth doctor visits, Doctor On Demand, urgent care, Walmart Care Clinic or Walmart Health, or emergency room visits
- Pharmacy copays/coinsurance (including copay assistance from a third party)
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP, and
- Charges paid 100% by the AMP, such as charges for network preventive services and certain Centers of Excellence services.

Coinsurance, copayments, and the out-of-pocket maximum

For covered services subject to a copayment, you must continue to pay the copayment, even after your annual deductible has been met, until you meet your annual out-of-pocket maximum. See the NORTHWEST ARKANSAS chart earlier in this chapter for information about the copayment required for specific covered services.

For covered services not subject to a copayment, you will be required to share the cost of covered services with the Plan after you meet your annual deductible. The NORTHWEST ARKANSAS chart shows the percentage that the Plan will pay for each covered service. The remaining portion, which is your coinsurance, is the share that you are responsible for until you meet your annual out-of-pocket maximum. Care provided by a non-network provider is not covered under this plan, except in cases of emergency.

The Plan will pay 100% of the cost of covered preventive services provided by a network provider before you meet your network deductible, and with no copayment. Preventive services provided by a non-network provider are not covered under this plan.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a network facility, the Plan will pay 100% after you have met your annual deductible, regardless of whether the third-party administrator determines that the visit is an "emergency." If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum, the Plan pays 100% of the cost of covered services for the rest of the calendar year.

The amounts you pay that apply toward your annual out-of-pocket maximum include:

- Annual deductible (including amounts paid with remaining HRA funds)
- Copays for in-person or telehealth doctor visits, Doctor On Demand, urgent care, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network, and
- Pharmacy copays/coinsurance.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for network preventive services and certain Centers of Excellence services
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP, including charges for services from non-network providers.

If you choose associate-only coverage under the Premier Plan, you will have an individual out-of-pocket maximum of $6,850. If you add dependents to your coverage, you will have an out-of-pocket maximum of $13,700 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,850. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum.

The Walmart Contribution Plan

CONTRIBUTION PLAN COVERAGE

If your work location is *not* in central Florida, Dallas/Fort Worth, or northwest Arkansas

This section describes coverage under the Contribution Plan in all areas except specified geographic areas of central Florida, Dallas/Fort Worth, and northwest Arkansas. See *National plan options* earlier in this chapter for the specific counties that make up these areas. Descriptions of Contribution Plan coverage for each of those areas follow later in this chapter.

The Contribution Plan includes a Health Reimbursement Account ("HRA"). Each year, the company allocates money to the HRA for you and any covered dependents to use toward your portion of the cost of covered services (meaning those expenses that are your responsibility), including the annual deductible. You may not contribute your own money to the HRA. The Plan automatically pays your share of eligible medical expenses (except for prescription drug expenses, which cannot be paid from the HRA) until the HRA funds are exhausted. Amounts paid by the HRA count toward your annual deductible (both network and non-network) as well as your out-of-pocket maximum.

Any balance remaining in your HRA at the end of a calendar year rolls over for use during the next year, provided you remain enrolled in the Contribution Plan. However, your HRA balance (including your allocated HRA funds for the current year) cannot exceed your network annual deductible under the Contribution Plan. Each new year's allocation of HRA funds may be used only for eligible medical expenses for services rendered within that calendar year. For example, if you enroll in the Contribution Plan and receive an allocation of HRA funds for 2021, you would be able to use those funds for eligible medical expenses for services rendered in 2021 but not for services rendered prior to 2021 (such as an expense incurred in 2020 but not processed until 2021). The HRA funds that roll over from a prior year can be used for any eligible medical expense for services rendered while enrolled in the Contribution Plan.

If you cancel your coverage, lose eligibility, or change from the Contribution Plan to a different coverage option, any funds remaining in your HRA are forfeited. If you continue coverage in the Contribution Plan through COBRA, your HRA balance remains available to you under the terms described above and the company will continue to allocate money to your HRA. See the **COBRA** chapter for more information about COBRA continuation coverage.

HRA allocations: midyear enrollments or changes

If you are hired midyear and enroll in the Contribution Plan, the company prorates your initial HRA allocation on a monthly basis; your annual deductible and out-of-pocket maximums are not prorated.

If you have a qualifying event and change your coverage level midyear, such as from associate-only to associate + dependents coverage, the company adjusts your HRA allocation, annual deductible, and annual out-of-pocket maximum accordingly.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Contribution Plan begins paying a portion of the cost of covered services. Copays are in addition to the annual deductible and do not count toward the deductible. You can meet your annual deductible with your company-provided HRA funds from the current year and any rollover HRA funds you may have from a previous year. When you have used all your company-provided HRA funds, you must use your own funds to meet the remainder of your annual deductible.

The Contribution Plan has a separate annual deductible for services provided by network providers and services provided by non-network providers. Amounts you pay toward the network annual deductible apply toward the non-network annual deductible, and vice versa.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the network annual deductible and the non-network annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire applicable annual deductible is met.

The following expenses do not count toward the network or non-network annual deductible:

- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Pharmacy copays/coinsurance (including copay assistance from a third party)
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP
- Charges paid 100% by the AMP, such as charges for network preventive services and certain Centers of Excellence services, and
- Charges for non-network preventive services.

Coinsurance, copayments, and the out-of-pocket maximum

For covered services subject to a copayment, you must continue to pay the copayment, even after your applicable annual deductible has been met, until you meet your annual out-of-pocket maximum. See the WALMART PLANS OFFERED NATIONWIDE chart earlier in this chapter for information about the copayment required for specific covered services.

For covered services not subject to a copayment, you will be required to share the cost of covered services with the Plan after you meet your applicable annual deductible. The WALMART PLANS OFFERED NATIONWIDE chart shows the percentage that the Plan will pay for each covered service, which varies depending on whether the services are provided by a network provider or a non-network provider. The remaining portion, which is your coinsurance, is the share that you are responsible for. If you receive covered services from a non-network provider, you are also responsible for any amount above the maximum allowable charge. After you meet your out-of-pocket maximum, no coinsurance will be required for covered services from a network provider. There is no out-of-pocket maximum for covered services from a non-network provider.

The Plan will pay all or a portion of the cost of covered preventive services before you meet your applicable deductible and with no copayment. If services are provided by a network provider, the Plan will pay 100% of the cost of covered preventive services. If services are

provided by a non-network provider, the Plan will pay 50% of the cost of covered preventive services. The remaining portion, which is your coinsurance, is the share that you are responsible for. If covered preventive services are provided by a non-network provider, you are also responsible for any amount above the maximum allowable charge.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your network annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a network facility, the Plan will pay 100% after you have met your annual deductible, regardless of whether the third-party administrator determines that the visit is an "emergency." If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your out-of-network deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum, the Plan pays 100% of the cost of covered services from a network provider for the rest of the calendar year. There is no annual out-of-pocket maximum for charges for services from non-network providers—you are responsible for paying your share of these charges in full throughout the year.

The amounts you pay that apply toward your network annual out-of-pocket maximum include:

- Network and out-of-network annual deductibles (including amounts paid with HRA funds)
- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network, and
- Pharmacy copays/coinsurance.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for network preventive services and certain Centers of Excellence services
- Charges for non-network preventive services
- Coinsurance when using non-network providers
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services that are in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP.

If you choose associate-only coverage under the Contribution Plan, you will have an individual out-of-pocket maximum for network expenses of $6,850. If you add dependents to your coverage, you will have an out-of-pocket maximum for network expenses of $13,700 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,850. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible network expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum. There is no out-of-pocket maximum for out-of-network expenses.

CONTRIBUTION PLAN COVERAGE FOR WORK LOCATIONS IN CENTRAL FLORIDA

The Contribution Plan includes a Health Reimbursement Account ("HRA"). Each year, the company allocates money to the HRA for you and any covered dependents to use toward your portion of the cost of covered services (meaning those expenses that are your responsibility),

including the annual deductible. You may not contribute your own money to the HRA. The Plan automatically pays your share of eligible medical expenses (except for prescription drug expenses, which cannot be paid from the HRA) until the HRA funds are exhausted. Amounts paid by the HRA count toward your annual deductible as well as your out-of-pocket maximum.

Any balance remaining in your HRA at the end of a calendar year rolls over for use during the next year, provided you remain enrolled in the Contribution Plan. However, your HRA balance (including your allocated HRA funds for the current year) cannot exceed your annual deductible under the Contribution Plan. Each new year's allocation of HRA funds may be used only for eligible medical expenses for services rendered within that calendar year. For example, if you enroll in the Contribution Plan and receive an allocation of HRA funds for 2021, you would be able to use those funds for eligible medical expenses for services rendered in 2021 but not for services rendered prior to 2021 (such as an expense incurred in 2020 but not processed until 2021). The HRA funds that roll over from a prior year can be used for any eligible medical expense for services rendered while enrolled in the Contribution Plan.

If you cancel your coverage, lose eligibility, or change from the Contribution Plan to a different coverage option, any funds remaining in your HRA are forfeited. If you enroll in the Contribution Plan through COBRA coverage, your HRA balance remains available to you under the terms described above and the company will continue to allocate money to your HRA. See the **COBRA** chapter for more information about COBRA continuation coverage.

HRA allocations: midyear enrollments or changes

If you are hired midyear and enroll in the Contribution Plan, the company prorates your initial HRA allocation on a monthly basis; your annual deductible and out-of-pocket maximums are not prorated.

If you have a qualifying event and change your coverage level midyear, such as from associate-only to associate + dependents coverage, the company adjusts your HRA allocation, annual deductible, and annual out-of-pocket maximum accordingly.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Contribution Plan begins paying a portion of the cost of covered services. Copays are in addition to the annual deductible and do not count toward the deductible. The Contribution Plan has an annual deductible for network services (preferred and nonpreferred network providers) and a separate annual deductible for non-network services. Amounts you pay toward the network annual deductible apply toward the out-of-network annual deductible, and vice versa.

You can meet your annual deductible with your company-provided HRA funds from the current year and any rollover HRA funds you may have from a previous year. When you have used all your company-provided HRA funds, you must use your own funds to meet the remainder of your annual deductible.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire annual deductible is met.

The following expenses do not count toward the network annual deductible or to the out-of-network annual deductible:

- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Pharmacy copays/coinsurance (including copay assistance from a third party)
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP
- Charges paid 100% by the AMP, such as charges for preferred network preventive services and certain Centers of Excellence services, and
- Charges for nonpreferred network preventive services and non-network preventive services.

Coinsurance, copayments, and the out-of-pocket maximum

For covered services subject to a copayment, you must continue to pay the copayment, even after your applicable annual deductible has been met, until you meet your annual out-of-pocket maximum. See the CENTRAL FLORIDA chart earlier in this chapter for information about the copayment required for specific covered services.

For covered services not subject to a copayment, you will be required to share the cost of covered services with the Plan after you meet your annual deductible. The CENTRAL FLORIDA chart shows the percentage that the Plan will pay for each covered service, which varies depending on whether the services are provided by a network provider who is preferred or nonpreferred, or a non-network provider. The remaining portion, which is your coinsurance, is the share that you are responsible for until you meet your annual out-of-pocket maximum. If you receive

covered services from a non-network provider, you are also responsible for any amount above the maximum allowable charge. After you meet your out-of-pocket maximum, no coinsurance will be required for covered services from a network provider. There is no out-of-pocket maximum for covered services from a non-network provider.

The Plan will pay all or a portion of the cost of covered preventive services before you meet your applicable deductible and with no copayment. If services are provided by a network preferred provider, the Plan will pay 100% of the cost of covered preventive services. If services are provided by a network nonpreferred provider or non-network provider, the Plan will pay 50% of the cost of covered preventive services. The remaining portion, which is your coinsurance, is the share that you are responsible for. If covered preventive services are provided by a non-network provider, you are also responsible for any amount above the maximum allowable charge.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a network facility, the Plan will pay 100% after you have met your annual deductible, regardless of whether the third-party administrator determines that the visit is an "emergency." If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum for network services, the Plan pays 100% of the cost of covered services for the rest of the calendar year. There is no out-of-pocket maximum for services from non-network providers—you are responsible for paying your share of these charges in full throughout the year.

The amounts you pay that apply toward your annual out-of-pocket maximum include:

- Annual deductible (including amounts paid with HRA funds)
- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider (preferred or nonpreferred) or by a non-network provider that the Plan pays as in-network, and
- Pharmacy copays/coinsurance.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for preferred network preventive services and certain Centers of Excellence services
- Coinsurance charges when using non-network providers
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP.

If you choose associate-only coverage under the Contribution Plan, you will have an individual out-of-pocket maximum of $6,850. If you add dependents to your coverage, you will have an out-of-pocket maximum of $13,700 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,850. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum. There is no out-of-pocket maximum for out-of-network expenses.

CONTRIBUTION PLAN COVERAGE FOR WORK LOCATIONS IN DALLAS/FORT WORTH

The Contribution Plan is available in a limited number of work locations in the Dallas/Fort Worth area. The Contribution Plan includes a Health Reimbursement Account ("HRA"). Each year, the company allocates money to the HRA for you and any covered dependents to use toward your portion of the cost of covered services (meaning those expenses that are your responsibility), including the annual deductible. You may not contribute your own money to the HRA. The Plan automatically pays your share of eligible medical expenses (except for prescription drug expenses, which cannot be paid from the HRA) until the HRA funds are exhausted. Amounts paid by the HRA count toward your annual deductible as well as your out-of-pocket maximum.

Any balance remaining in your HRA at the end of a calendar year rolls over for use during the next year, provided you remain enrolled in the Contribution Plan. However, your HRA balance (including your allocated HRA funds for the current year) cannot exceed your annual deductible under the Contribution Plan. Each new year's allocation of HRA funds may be used only for eligible medical expenses for services rendered within that calendar year. For example, if you enroll in the Contribution Plan and receive an allocation of HRA funds for 2021, you would be able to use those funds for eligible medical expenses for services rendered in 2021 but not for services rendered prior to 2021 (such as an expense incurred in 2020 but not processed until 2021). The HRA funds that roll over from a prior year can be used for any eligible medical expense for services rendered while enrolled in the Contribution Plan.

If you cancel your coverage, lose eligibility, or change from the Contribution Plan to a different coverage option, any funds remaining in your HRA are forfeited. If you enroll in the Contribution Plan through COBRA coverage, your HRA balance remains available to you under the terms described above and the company will continue to allocate money to your HRA. See the **COBRA** chapter for more information about COBRA continuation coverage.

HRA allocations: midyear enrollments or changes

If you are hired midyear and enroll in the Contribution Plan, the company prorates your initial HRA allocation on a monthly basis; your annual deductible and out-of-pocket maximums are not prorated.

If you have a qualifying event and change your coverage level midyear, such as from associate-only to associate + dependents coverage, the company adjusts your HRA allocation, annual deductible, and annual out-of-pocket maximum accordingly.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Contribution Plan begins paying a portion of the cost of covered services. Copays are in addition to the annual deductible and do not count toward the deductible. You can meet your annual deductible with your company-provided HRA funds from the current year and any rollover HRA funds you may have from a previous year. When you have used all your company-provided HRA funds, you must use your own funds to meet the remainder of your annual deductible.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire annual deductible is met.

The following expenses do not count toward the annual deductible:

- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Pharmacy copays/coinsurance (including copay assistance from a third party)
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP, and
- Charges paid 100% by the AMP, such as charges for preferred network preventive services and certain Centers of Excellence services.

Coinsurance, copayments, and the out-of-pocket maximum

For covered services subject to a copayment, you must continue to pay the copayment, even after your annual deductible has been met, until you meet your annual out-of-pocket maximum. See the DALLAS/FORT WORTH chart earlier in this chapter for information about the copayment required for specific covered services.

For covered services not subject to a copayment, you will be required to share the cost of covered services with the Plan after you meet your annual deductible. The DALLAS/FORT WORTH chart shows the percentage that the Plan will pay for each covered service, which varies

depending on whether the services are provided by a network provider who is preferred or nonpreferred. The remaining portion, which is your coinsurance, is the share that you are responsible for until you meet your annual out-of-pocket maximum. Care provided by a non-network provider is not covered under this plan, except in cases of emergency.

The Plan will pay all or a portion of the cost of covered preventive services provided by a network provider before you meet your network deductible and with no copayment. If the network provider is preferred, the Plan will pay 100% of the cost of covered preventive services. If the network provider is nonpreferred, the plan will pay 50% of the cost of covered preventive services. Preventive services provided by a non-network provider are not covered under this plan.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a network facility, the Plan will pay 100% after you have met your annual deductible, regardless of whether the third-party administrator determines that the visit is an "emergency." If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum, the Plan pays 100% of the cost of covered services for the rest of the calendar year.

The amounts you pay that apply toward your annual out-of-pocket maximum include:

- Annual deductible (including amounts paid with HRA funds)
- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider (preferred or nonpreferred) or by a non-network provider that the Plan pays as in-network, and
- Pharmacy copays/coinsurance.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for preferred network preventive services and certain Centers of Excellence services
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP, including charges for services from non-network providers.

If you choose associate-only coverage under the Contribution Plan, you will have an individual out-of-pocket maximum of $6,850. If you add dependents to your coverage, you will have an out-of-pocket maximum of $13,700 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,850. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum.

CONTRIBUTION PLAN COVERAGE FOR WORK LOCATIONS IN NORTHWEST ARKANSAS

The Contribution Plan includes a Health Reimbursement Account ("HRA"). Each year, the company allocates money to the HRA for you and any covered dependents to use toward your portion of the cost of covered services (meaning those expenses that are your responsibility), including the annual deductible. You may not contribute your own money to the HRA. The Plan automatically pays your share of eligible medical expenses (except for prescription drug expenses, which cannot be paid from the HRA) until the HRA funds are exhausted. Amounts paid by the HRA count toward your annual deductible as well as your out-of-pocket maximum.

Any balance remaining in your HRA at the end of a calendar year rolls over for use during the next year, provided you remain enrolled in the Contribution Plan. However, your HRA balance (including your allocated HRA funds for the current year) cannot exceed your annual deductible under the Contribution Plan. Each new year's allocation of HRA funds may be used only for eligible medical expenses for services rendered within that calendar year. For example, if you enroll in the Contribution Plan and receive an allocation of HRA funds for 2021, you would be able to use those funds for eligible medical expenses for services rendered in 2021 but not for services rendered prior to 2021 (such as an expense incurred in 2020 but not processed until 2021). The HRA funds that roll over from a prior year can be used for any eligible medical expense for services rendered while enrolled in the Contribution Plan.

If you cancel your coverage, lose eligibility, or change from the Contribution Plan to a different coverage option, any funds remaining in your HRA are forfeited. If you enroll in the Contribution Plan through COBRA coverage, your HRA balance remains available to you under the terms described above and the company will continue to allocate money to your HRA. See the **COBRA** chapter for more information about COBRA continuation coverage.

HRA allocations: midyear enrollments or changes

If you are hired midyear and enroll in the Contribution Plan, the company prorates your initial HRA allocation on a monthly basis; your annual deductible and out-of-pocket maximums are not prorated.

If you have a qualifying event and change your coverage level midyear, such as from associate-only to associate + dependents coverage, the company adjusts your HRA allocation, annual deductible, and annual out-of-pocket maximum accordingly.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Contribution Plan begins paying a portion of the cost of covered services. Copays are in addition to the annual deductible and do not count toward the deductible. You can meet your annual deductible with your company-provided HRA funds from the current year and any rollover HRA funds you may have from a previous year. When you have used all your company-provided HRA funds, you must use your own funds to meet the remainder of your annual deductible.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire annual deductible is met.

The following expenses do not count toward the annual deductible:

- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Pharmacy copays/coinsurance (including copay assistance from a third party)
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP, and
- Charges paid 100% by the AMP, such as charges for network preventive services and certain Centers of Excellence services.

Coinsurance, copayments, and the out-of-pocket maximum

For covered services subject to a copayment, you must continue to pay the copayment, even after your annual deductible has been met, until you meet your annual out-of-pocket maximum. See the NORTHWEST ARKANSAS chart earlier in this chapter for information about the copayment required for specific covered services.

For covered services not subject to a copayment, you will be required to share the cost of covered services with the Plan after you meet your annual deductible. The NORTHWEST ARKANSAS chart shows the percentage that the Plan will pay for each covered service. The remaining portion, which is your coinsurance, is the share that you are responsible for until you meet your annual out-of-pocket maximum. Care provided by a non-network provider is not covered under this plan, except in cases of emergency.

The Plan will pay 100% of the cost of covered preventive services provided by a network provider before you meet your network deductible, and with no copayment. Preventive services provided by a non-network provider are not covered under this plan.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a network facility, the Plan will pay 100%

after you have met your annual deductible, regardless of whether the third-party administrator determines that the visit is an "emergency." If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum, the Plan pays 100% of the cost of covered services for the rest of the calendar year.

The amounts you pay that apply toward your annual out-of-pocket maximum include:

- Annual deductible (including amounts paid with HRA funds)
- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network, and
- Pharmacy copays/coinsurance.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for network preventive services and certain Centers of Excellence services
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP, including charges for services from non-network providers.

If you choose associate-only coverage under the Contribution Plan, you will have an individual out-of-pocket maximum of $6,850. If you add dependents to your coverage, you will have an out-of-pocket maximum of $13,700 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,850. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,700, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum.

The Walmart Saver Plan

SAVER PLAN COVERAGE

If your work location is *not* in central Florida, Dallas/Fort Worth, or northwest Arkansas

This section describes coverage under the Saver Plan in all areas except specific geographic areas of central Florida, Dallas/Fort Worth, and northwest Arkansas. See *National plan options* earlier in this chapter for the specific counties that make up these areas. Descriptions of Saver Plan coverage for each of those areas follow later in this chapter.

If you enroll in the Saver Plan and contribute to a Health Savings Account ("HSA"), the company matches your payroll deductions into your HSA, dollar-for-dollar up to $350 if you have individual coverage or $700 if you have family coverage. Combined contributions to your HSA (your own and the company's) cannot exceed the 2021 annual IRS limit of $3,600 for individual coverage or $7,200 for family coverage, plus a $1,000 catch-up contribution if you are age 55 or over.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Saver Plan begins paying a portion of the cost of covered services. Copays are in addition to the annual deductible and do not count toward the deductible. The Saver Plan has a separate annual deductible for services provided by network providers and services provided by non-network providers. Amounts you pay toward the network annual deductible apply toward the out-of-network annual deductible, and vice versa.

Preventive care services, as described in the Preventive care program section later in this chapter, are covered even if you have not met the annual deductible.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the network annual deductible and the out-of-network annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire applicable annual deductible is met.

You can choose to use money in your HSA to pay expenses that are subject to the annual deductible, or you can pay them out of your own pocket and save your HSA money for future expenses.

If you enroll in the Saver Plan, you generally must pay full cost for prescriptions until you meet your network annual deductible. The exception is medications on the OptumRx list of approved preventive medications, which are not subject to the Saver Plan's network annual deductible—you can purchase these medications at the appropriate copay or coinsurance level even if you have not met the network annual deductible. In addition, certain over-the-counter drugs are available at 100% coverage if you obtain a prescription, even if you have not satisfied your deductible. See **The pharmacy benefit** chapter for details. With the exception of these charges for approved preventive medications, pharmacy charges under the Saver Plan apply toward your network annual deductible and out-of-pocket maximum.

The following expenses do not count toward the network or out-of-network annual deductible:

- Copays for preventive medications not subject to the annual deductible
- Discounts, coupons, pharmacy discount programs or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug charges paid directly to pharmacies on your behalf through discount programs/coupons)
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP
- Charges paid 100% by the AMP, such as charges for network preventive services and certain Centers of Excellence services, and
- Charges for non-network preventive services.

Coinsurance, copayments, and the out-of-pocket maximum

For covered services subject to a copayment, you must continue to pay the copayment, even after your applicable annual deductible has been met, until you meet your annual out-of-pocket maximum. See the WALMART PLANS OFFERED NATIONWIDE chart earlier in this chapter for information about the copayment required for specific covered services.

For covered services not subject to a copayment, you will be required to share the cost of covered services with the Plan after you meet your applicable annual deductible. The WALMART PLANS OFFERED NATIONWIDE chart shows the percentage that the Plan will pay for each covered service, which varies depending on whether the services are provided by a network provider or a non-network provider. The remaining portion, which is your coinsurance, is the share that you are responsible for. If you receive covered services from a non-network provider, you are also responsible for any amount above the maximum allowable charge. After you meet your out-of-pocket maximum, no coinsurance will be required for covered services from a network provider. There is no out-of-pocket maximum for covered services from a non-network provider.

The Plan will pay all or a portion of the cost of covered preventive services before you meet your applicable deductible and with no copayment. If services are provided by a network provider, the Plan will pay 100% of the cost of covered preventive services. If services are provided by a non-network provider, the Plan will pay 50% of the cost of covered preventive services. The remaining portion, which is your coinsurance, is the share that you are responsible for. If covered preventive services are provided by a non-network provider, you are also responsible for any amount above the maximum allowable charge.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your network annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a network facility, the Plan will pay 100% after you have met your annual deductible, regardless of whether the third-party administrator determines that the visit is an "emergency." If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your out-of-network deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum for network services, the Plan pays 100% of the cost of covered services from a network provider for the rest of the calendar year. There is no annual out-of-pocket maximum for services from non-network providers—you are responsible for paying your share of these charges in full throughout the year.

The amounts you pay that apply toward your network annual out-of-pocket maximum include:

- Network and out-of-network annual deductibles (including amounts paid with HSA funds)
- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network
- Pharmacy copays/coinsurance, and
- Pharmacy charges before your annual deductible is met.

Your network annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for network preventive services and certain Centers of Excellence services
- Charges for non-network preventive services
- Coinsurance when using non-network providers
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP.

If you choose associate-only coverage under the Saver Plan, you will have an individual out-of-pocket maximum for network expenses of $6,650. If you add dependents to your coverage, you will have an out-of-pocket maximum for network expenses of $13,300 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,650. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,300, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible network expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum. There is no out-of-pocket maximum for out-of-network expenses.

SAVER PLAN COVERAGE FOR WORK LOCATIONS IN CENTRAL FLORIDA

If you enroll in the Saver Plan and contribute to a Health Savings Account ("HSA"), the company matches your payroll deductions into your HSA, dollar-for-dollar up to $350 if you have individual coverage or $700 if you have family coverage. Combined contributions to your HSA (your own and the company's) cannot exceed the 2021 annual IRS limit of $3,600 for individual coverage or $7,200 for family coverage, plus a $1,000 catch-up contribution if you are age 55 or over.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Saver Plan begins paying a portion of the cost of your covered services. Copays are in addition to the annual deductible and do not count toward the deductible. The Saver Plan has an annual deductible for network services (preferred and nonpreferred network providers) and a separate annual deductible for non-network services. Amounts you pay toward the network annual deductible apply toward the out-of-network annual deductible, and vice versa.

Preventive care services, as described in the Preventive care program section later in this chapter, are covered even if you have not met the annual deductible.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire annual deductible is met.

You can choose to use money in your HSA to pay expenses that are subject to the annual deductible, or you can pay them out of your own pocket and save your HSA money for future expenses.

If you enroll in the Saver Plan, you generally must pay full cost for prescriptions until you meet your annual deductible. The exception is medications on the OptumRx list of approved preventive medications, which are not subject to the Saver Plan's annual deductible—you can purchase these medications at the appropriate copay or coinsurance level even if you have not met the annual deductible. In addition, certain over-the-counter drugs are available at 100% coverage if you obtain a prescription, even if you have not satisfied your deductible. See **The pharmacy benefit** chapter for details. With the exception of these charges for approved preventive medications, pharmacy charges under the Saver Plan apply toward your annual deductible and out-of-pocket maximum.

The following expenses do not count toward the network annual deductible or to the out-of-network annual deductible:

- Copays for preventive medications not subject to the annual deductible
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug charges paid directly to pharmacies on your behalf through discount programs/coupons)
- Amounts in excess of the Plan's maximum allowable charge that you pay to non-network providers, including amounts paid for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP
- Charges paid 100% by the AMP, such as charges for preferred network preventive services and certain Centers of Excellence services, and
- Charges for nonpreferred network preventive services and non-network preventive services.

Coinsurance, copayments, and the out-of-pocket maximum

For covered services subject to a copayment, you must continue to pay the copayment, even after your applicable annual deductible has been met, until you meet your annual out-of-pocket maximum. See the CENTRAL FLORIDA chart earlier in this chapter for information about the copayment required for specific covered services.

For covered services not subject to a copayment, you will be required to share the cost of covered services with the Plan after you meet your annual deductible. The CENTRAL FLORIDA chart shows the percentage that the Plan will pay for each covered service, which varies depending on whether the services are provided by a network provider who is preferred or nonpreferred, or a non-network provider. The remaining portion, which is your coinsurance, is the share that you are responsible for until you meet your annual out-of-pocket maximum. If you receive covered services from a non-network provider, you are also responsible for any amount above the maximum allowable charge. After you meet your out-of-pocket maximum, no coinsurance will be required for covered services from a network provider. There is no out-of-pocket maximum for covered services from a non-network provider.

The Plan will pay all or a portion of the cost of covered preventive services before you meet your applicable deductible and with no copayment. If services are provided by a network preferred provider, the Plan will pay 100% of the cost of covered preventive services. If services are provided by a network nonpreferred provider or non-network provider, the Plan will pay 50% of the cost of covered preventive services. The remaining portion, which is your coinsurance, is the share that you are responsible for. If covered preventive services are provided by a non-network provider, you are also responsible for any amount above the maximum allowable charge.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a network facility, the Plan will pay 100% after you have met your annual deductible, regardless of whether the third-party administrator determines that the visit is an "emergency." If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum for network services, the Plan pays 100% of the cost of covered services for the rest of the calendar year. There is no out-of-pocket maximum for services from non-network providers—you are responsible for paying your share of these charges in full throughout the year.

The amounts you pay that apply toward your annual out-of-pocket maximum include:

- Annual deductible (including amounts paid with HSA funds)

- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network
- Pharmacy copays/coinsurance, and
- Pharmacy charges before your annual deductible is met.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for preferred network preventive services and certain Centers of Excellence services
- Charges for non-network preventive services
- Coinsurance charges when using non-network providers
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP.

If you choose associate-only coverage under the Saver Plan, you will have an individual out-of-pocket maximum of $6,650. If you add dependents to your coverage, you will have an out-of-pocket maximum of $13,300 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,650. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,300, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum. There is no out-of-pocket maximum for out-of-network expenses.

SAVER PLAN COVERAGE FOR WORK LOCATIONS IN DALLAS/FORT WORTH

If you enroll in the Saver Plan and contribute to a Health Savings Account ("HSA"), the company matches your payroll deductions into your HSA, dollar-for-dollar up to $350 if you have individual coverage or $700 if you have family coverage. Combined contributions to your HSA (your own and the company's) cannot exceed the 2021 annual IRS limit of $3,600 for individual coverage or $7,200 for family coverage, plus a $1,000 catch-up contribution if you are age 55 or over.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Saver Plan begins paying a portion of the cost of your covered services. Copays are in addition to the annual deductible and do not count toward the deductible.

Preventive care services, as described in the Preventive care program section later in this chapter, are covered even if you have not met the annual deductible.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire annual deductible is met.

You can choose to use money in your HSA to pay expenses that are subject to the annual deductible, or you can pay them out of your own pocket and save your HSA money for future expenses.

If you enroll in the Saver Plan, you generally must pay full cost for prescriptions until you meet your annual deductible. The exception is medications on the OptumRx list of approved preventive medications, which are not subject to the Saver Plan's annual deductible — you can purchase these medications at the appropriate copay or coinsurance level even if you have not met the annual deductible. In addition, certain over-the-counter drugs are available at 100% coverage if you obtain a prescription, even if you have not satisfied your deductible. See **The pharmacy benefit** chapter for details. With the exception of these charges for approved preventive medications, pharmacy charges under the Saver Plan apply toward your annual deductible and out-of-pocket maximum.

The following expenses do not count toward the annual deductible:

- Copays for preventive medications not subject to the annual deductible

- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug charges paid directly to pharmacies on your behalf through discount programs/coupons)
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP, and
- Charges paid 100% by the AMP, such as charges for preferred network preventive services and certain Centers of Excellence services.

Coinsurance, copayments, and the out-of-pocket maximum

For covered services subject to a copayment, you must continue to pay the copayment, even after your annual deductible has been met, until you meet your annual out-of-pocket maximum. See the DALLAS/FORT WORTH chart earlier in this chapter for information about the copayment required for specific covered services.

For covered services not subject to a copayment, you will be required to share the cost of covered services with the Plan after you meet your annual deductible. The DALLAS/FORT WORTH chart shows the percentage that the Plan will pay for each covered service, which varies depending on whether the services are provided by a network provider who is preferred or nonpreferred. The remaining portion, which is your coinsurance, is the share that you are responsible for until you meet your annual out-of-pocket maximum. Care provided by a non-network provider is not covered under this plan, except in cases of emergency.

The Plan will pay all or a portion of the cost of covered preventive services provided by a network provider before you meet your network deductible and with no copayment. If the network provider is preferred, the Plan will pay 100% of the cost of covered preventive services. If the network provider is nonpreferred, the Plan will pay 50% of the cost of covered preventive services. Preventive services provided by a non-network provider are not covered under this plan.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a network facility, the Plan will pay 100% after you have met your annual deductible, regardless of whether the third-party administrator determines that the visit is an "emergency." If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum, the Plan pays 100% of the cost of covered services for the rest of the calendar year.

The amounts you pay that apply toward your annual out-of-pocket maximum include:

- Annual deductible (including amounts paid with HSA funds)
- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network
- Pharmacy copays/coinsurance, and
- Pharmacy charges before your annual deductible is met.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for preferred network preventive services and certain Centers of Excellence services
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)

- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP, including charges for services from non-network providers.

If you choose associate-only coverage under the Saver Plan, you will have an individual out-of-pocket maximum of $6,650. If you add dependents to your coverage, you will have an out-of-pocket maximum of $13,300 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,650. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,300, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum.

SAVER PLAN COVERAGE FOR WORK LOCATIONS IN NORTHWEST ARKANSAS

If you enroll in the Saver Plan and contribute to a Health Savings Account ("HSA"), the company matches your payroll deductions into your HSA, dollar-for-dollar up to $350 if you have individual coverage or $700 if you have family coverage. Combined contributions to your HSA (your own and the company's) cannot exceed the 2021 annual IRS limit of $3,600 for individual coverage or $7,200 for family coverage, plus a $1,000 catch-up contribution if you are age 55 or over.

The annual deductible

Your annual deductible is the amount you must pay each calendar year before the Saver Plan begins paying a portion of the cost of your covered services. Copays are in addition to the annual deductible and do not count toward the deductible.

Preventive care services, as described in the Preventive care program section later in this chapter, are covered even if you have not met the annual deductible.

The amount of your annual deductible is based on whether you are covering just yourself or any eligible dependents as well. If you choose coverage for any dependents as well as for yourself, the annual deductible can be met by any combination of you and your covered dependents, but no benefits are payable for any covered person until the entire annual deductible is met.

You can choose to use money in your HSA to pay expenses that are subject to the annual deductible, or you can pay them out of your own pocket and save your HSA money for future expenses.

If you enroll in the Saver Plan, you generally must pay full cost for prescriptions until you meet your annual deductible. The exception is medications on the OptumRx list of approved preventive medications, which are not subject to the Saver Plan's annual deductible — you can purchase these medications at the appropriate copay or coinsurance level even if you have not met the annual deductible. In addition, certain over-the-counter drugs are available at 100% coverage if you obtain a prescription, even if you have not satisfied your deductible. See **The pharmacy benefit** chapter for details. With the exception of these charges for approved preventive medications, pharmacy charges under the Saver Plan apply toward your annual deductible and out-of-pocket maximum.

The following expenses do not count toward the annual deductible:

- Copays for preventive medications not subject to the annual deductible
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including any prescription drug charges paid directly to pharmacies on your behalf through discount programs/coupons)
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Charges for services not covered by the AMP, and
- Charges paid 100% by the AMP, such as charges for network preventive services and certain Centers of Excellence services.

Coinsurance, copayments, and the out-of-pocket maximum

For covered services subject to a copayment, you must continue to pay the copayment, even after your annual deductible has been met, until you meet your annual out-of-pocket maximum. See the NORTHWEST ARKANSAS chart earlier in this chapter for information about the copayment required for specific covered services.

For covered services not subject to a copayment, you will be required to share the cost of covered services with the Plan after you meet your annual deductible. The NORTHWEST ARKANSAS chart shows the percentage that the Plan will pay for each covered service. The remaining portion, which is your coinsurance, is the share that you are responsible for until you meet your annual out-of-pocket maximum. Care provided by a non-network provider is not covered under this plan, except in cases of emergency.

The Plan will pay 100% of the cost of covered preventive services provided by a network provider before you meet your network deductible, and with no copayment. Preventive services provided by a non-network provider are not covered under this plan.

The emergency room copay is $300 per visit. This copay is in addition to your annual deductible and must be paid even after you have met your annual deductible. The AMP will pay only the maximum allowable charge for covered services and only covered services will apply to the annual deductible. If the third-party administrator determines that the emergency room visit is an "emergency," the AMP will pay 100% of the maximum allowable charge after you have met your annual deductible, regardless of whether the facility is a network facility. However, if it is a non-network facility, you will still be responsible for any amount over the maximum allowable charge. If the facility is a network facility, the Plan will pay 100% after you have met your annual deductible, regardless of whether the third-party administrator determines that the visit is an "emergency." If the facility is a non-network facility, and the third-party administrator determines that the emergency room visit is not an "emergency," the AMP will pay 50% of the maximum allowable charge for covered services after you have met your deductible and you will be responsible for paying the deductible, the other 50%, and any amount over the maximum allowable charge.

The $300 copay is waived if the patient is directly admitted to the hospital from an emergency room, or if the patient dies prior to hospital admission. Note that the cost-sharing details described above apply to all services provided in the emergency room (physician, facility, tests, etc.).

Generally, the emergency room visit will be considered an "emergency" if an average prudent person with a basic knowledge of health care and in the same situation would have thought that not going to the emergency room would result in their life or health being in serious jeopardy.

After you meet the annual out-of-pocket maximum, the Plan pays 100% of the cost of covered services for the rest of the calendar year.

The amounts you pay that apply toward your annual out-of-pocket maximum include:

- Annual deductible (including amounts paid with HSA funds)
- Copays for Doctor On Demand, Walmart Care Clinic or Walmart Health, or emergency room visits
- Coinsurance for services provided by a network provider or by a non-network provider that the Plan pays as in-network
- Pharmacy copays/coinsurance, and
- Pharmacy charges before your annual deductible is met.

Your annual out-of-pocket maximum may be met by any combination of covered medical services. Certain expenses, however, do not count toward the annual out-of-pocket maximum, as listed here:

- Charges paid 100% by the AMP such as charges for network preventive services and certain Centers of Excellence services
- Amounts in excess of the Plan's maximum allowable charge for services from a non-network provider that the Plan pays as in-network, including for emergency room services in excess of the Plan's maximum allowable charge
- Charges for services provided at any Walmart Care Clinic or Walmart Health that is a non-network provider (however, amounts for covered diagnostic tests performed outside the Walmart Care Clinic or Walmart Health with a network provider will count toward your deductible, subject to other exclusions in this list)
- Discounts, coupons, pharmacy discount programs, or similar arrangements provided by drug manufacturers or pharmacies to assist you in purchasing prescription drugs (including prescription drug discount/coupons provided to pharmacies when you fill a prescription), and
- Charges for services not covered by the AMP, including charges for services from non-network providers.

If you choose associate-only coverage under the Saver Plan, you will have an individual out-of-pocket maximum of $6,650. If you add dependents to your coverage, you will have an out-of-pocket maximum of $13,300 per family.

Regardless of the coverage level you choose, you and each of your covered dependents have an individual out-of-pocket maximum of $6,650. Once you or any of your covered dependents have incurred charges for covered services up to that amount, that individual's eligible expenses are paid at 100% for the rest of the calendar year. If your coverage includes dependents, you have a family out-of-pocket maximum of $13,300, which is a combination of all family members' covered expenses. Any combination of two or more family members can contribute to meet the family out-of-pocket maximum. Once you meet the total family out-of-pocket maximum, eligible expenses for your entire family are paid at 100% for the rest of the calendar year, even if each individual has not met the individual out-of-pocket maximum.

Pages 66-67—Clarification of maximum allowable charge: Clarifications are made in the MAXIMUM ALLOWABLE CHARGE section, beginning on page 66. The following new paragraph is added immediately after the first complete paragraph on page 67:

From time to time, and notwithstanding any Plan provisions that state otherwise, the AMP may enter into an agreement with a non-network provider (directly or indirectly through a third-party administrator) that sets the rate the AMP will pay for a service or supply. In these cases, the MAC will be the rate established in the agreement with the non-network provider.

In addition, the paragraph in the second column of page 67 beginning "UnitedHealthcare" is replaced with the following:

UnitedHealthcare: The MAC is 125% of Medicare's maximum allowable charge for voluntary and involuntary out-of-network services unless the provider is in UnitedHealthcare's Shared Savings Program ("SSP"). SSP provider charges are paid at a discount. In cases where a Medicare maximum allowable charge is not published by the Center for Medicare and Medicaid Services for a specific service, UnitedHealthcare uses a gap methodology to calculate the MAC.

Page 68—If your provider leaves the network: In the section titled *Your provider network*, the paragraph at the bottom of the first column (continuing to the second column) is replaced with the following:

If your provider leaves the network, your benefit is adjusted accordingly, based on the terms of the medical plan options you have elected. If you are covered under the Premier Plan, Contribution Plan, or Saver Plan and your work location is not in Dallas/Fort Worth or northwest Arkansas, services provided by a provider who has left the network are generally treated as non-network services; you may be required to pay any amount above the maximum allowable charge, or choose another provider in the network. If you are covered under a local plan, or under the Premier Plan, Contribution Plan, or Saver Plan in Dallas/Fort Worth or northwest Arkansas, no benefit is paid for services received from a non-network provider, except in cases of emergency. In that case, services provided by a provider who has left the network are not covered under the Plan except as described in the section titled WHEN NETWORK BENEFITS ARE PAID FOR OUT-OF-NETWORK EXPENSES, on page 68.

Page 70—Preventive care program: The first three paragraphs under *Preventive care program* are replaced with the following chart:

PLAN	Eligible preventive care services received from a network provider	Eligible preventive care services received from a non-network provider
National plan with work location outside of central Florida, Dallas/Fort Worth and northwest Arkansas	Covered at 100%	Covered at 50%
National plan with work location in northwest Arkansas, *or* Local plans	Covered at 100%	Not covered Out-of-pocket costs do not apply toward your out-of-pocket maximum
National plan with work location in Dallas/Fort Worth	When received from preferred provider: covered at 100% When received from nonpreferred provider: covered at 50% Out-of-pocket costs apply to out-of-pocket maximum	Not covered Out-of-pocket costs do not apply toward your out-of-pocket maximum
National plan with work location in central Florida	When received from preferred provider: covered at 100% When received from nonpreferred provider: covered at 50% Out-of-pocket costs apply to out-of-pocket maximum	Covered at 50% Out-of-pocket costs do not apply toward your out-of-pocket maximum

Pages 70-72—Preventive care program: The following service is added to the list titled COVERED PREVENTIVE SERVICES FOR ADULTS, on p. 70:

- **Preexposure prophylaxis ("PrEP")** with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.

The following items should be added to the list titled COVERED PREVENTIVE SERVICES FOR WOMEN, INCLUDING PREGNANT WOMEN, on page 71:

- Aromatase inhibitors are added to the list of "breast cancer risk-reducing prescription medications" for certain women at increased risk of breast cancer
- **Anxiety** screening in adolescent and adult women, including those who are pregnant or postpartum
- **Diabetes** screening for women with a history of gestational diabetes who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes
- **Maternal depression** screening for mothers at certain well-child visits
- **Perinatal depression** counseling interventions or referrals for pregnant and postpartum women who are at increased risk of perinatal depression
- **Urinary** incontinence screening annually, and referral for further evaluation and treatment if indicated

Page 72—Flu vaccine: The first three paragraphs under FLU VACCINE PROGRAM are replaced with the following:

An annual flu vaccination is a preventive service and covered according to the terms detailed in the table inserted on page 70 in the section titled *The preventive care program*.

Page 75—myAgileLife: The following new section is added following the section titled TELEHEALTH VIDEO VISITS THROUGH DOCTOR ON DEMAND on page 75:

MYAGILELIFE

As part of myAgileLife, associates who are covered under the AMP will have access to lower copays for certain diabetes-related medications by enrolling for the diabetes self-care program. This is a voluntary program where incentives for eligible individuals are based on participation in myAgileLife programs, not based on achieving a health status.

The program features a text messaging-based coaching curriculum designed to help participants develop behaviors that support stated health objectives and outcomes (i.e., medication adherence, diet, exercise, self-monitoring, and provider engagement/interaction as part of an effective diabetes self-management regimen to reduce A1C, improve quality of life, and avoid unnecessary healthcare utilization).

Eligible participants will include only participants who are current beneficiaries under the AMP, comply with the formulary and sourcing requirements specified by the Plan, and are active participants in the program.

Page 75—New pilot programs: The following new sections are added immediately before Walmart clinics:

DIGITAL PHYSICAL THERAPY

Physera: Participants with work locations in Alabama and Tennessee have access to a digital physical therapy program through Physera. This app-based approach offers guidance, treatment, and support from a licensed physical therapist. Whether you want to prevent an injury, recover from one, or just live without pain, Physera is available as part of your Walmart medical plan and subject to copays, deductible, and coinsurance, as otherwise applicable to physical therapy telehealth doctor's visits.

IMC (Integrated Musculoskeletal Care): Participants utilizing the Walmart Centers of Excellence program, administered by Contigo Health (formerly Health Design Plus), for spine surgery or joint (hip and knee) replacement, have access to digital physical therapy through IMC. This app-based approach is designed to help participants prior to and after surgical procedures. Services provided by IMC for spine surgery or joint (hip and knee) replacement for participants in the Centers of Excellence program will be covered at 100%. Due to federal tax law, participants in the Saver Plan must meet their annual deductible before the 100% benefit can be provided. IMC is not available outside of Centers of Excellence program participation, including when a local network exception may be granted.

AIRCARE

The Plan expects to add AiRCare care management services in 2021.

The following terms will apply only after AiRCare care management services are added to the AMP:

If you are enrolled in a plan offered by the AMP, you also have the benefit of voluntary care management services through AiRCare, in addition to the other care management resources described in section titled Helping you manage your health. The goal of all care management resources available to you under the AMP is to bring consistency to the full range of care and services provided to you as an AMP participant by looking at you as a whole individual.

AiRCare is a clinical services company offering a data-driven, comprehensive clinical approach to the treatment of emotional and behavioral health conditions. AiRCare reviews Plan data to identify participants in the AMP who could benefit from emotional and behavioral health support. AiRCare's licensed clinicians then proactively reach out to those participants to offer support and counseling, and connect participants with other Plan benefits, including behavioral health services, and, as appropriate, community resources to augment care.

The AiRCare program will be available only to participants with work locations in Arkansas. You are not required to utilize the services of AiRCare or engage with an AiRCare licensed clinician that reaches out directly to you. This care management resource is voluntary.

Page 76—Centers of Excellence: The chart at the bottom of page 76 is changed to reflect the following:

If you are enrolled in the Premier Plan, Contribution Plan, or Saver Plan and your work location is other than Dallas/Fort Worth or northwest Arkansas, as defined in the 2020 *Associate Benefits Book*, the AMP benefit for hip or knee replacement surgery not performed through the Centers of Excellence program will be 50% and you will be subject to the out-of-network deductible.

Page 77—Centers of Excellence: The following text is added to the end of the list of bullet points in the first column, following the paragraph beginning "If you believe you may be a candidate for Centers of Excellence services…":

- You acknowledge that you, your caregiver, and any visitors must abide by all rules and policies of the hotel and Centers of Excellence facility, including those that apply to onsite conduct. Failure to do so may result in loss of eligibility for benefits under the Centers of Excellence program.

Page 77—Centers of Excellence out-of-network coverage: The paragraph at the bottom of the second column, beginning "NOTE," is replaced with the following:

NOTE: Under limited circumstances, the AMP provides out-of-network coverage for certain procedures otherwise available through the Centers of Excellence program if you are enrolled in the Premier Plan, Contribution Plan, or Saver Plan and have a work location other than Dallas/Fort Worth or northwest Arkansas. In this case, you will have a 50% coinsurance and will be subject to the out-of-network deductible. If you are enrolled in the Premier Plan, Contribution Plan, or Saver Plan and your work location is in Dallas/Fort Worth or northwest Arkansas, or you are enrolled in a local plan, you have no out-of-network coverage for these procedures.

Page 78—Centers of Excellence out-of-network coverage for hip or knee replacement: The second bullet point in the first column is replaced with the following:

If you have coverage under the Premier Plan, Contribution Plan, or Saver Plan and your work location is in an area other than Dallas/Fort Worth or northwest Arkansas, and you have your procedure performed by a network provider, the AMP coinsurance is 50% and you will be subject to the out-of-network deductible before benefits are payable.

Page 78–Centers of Excellence pre-service exception request: The second paragraph in the second column is replaced with the following:

Decisions not to move forward with spine surgery or hip or knee replacement by the respective Centers of Excellence providers are not subject to review under this process if the Centers of Excellence provider decides not to treat you based on your refusal to follow the terms and conditions of the Centers of Excellence Program or determines that the procedure is not appropriate because you refuse to comply with medical restrictions or requirements, including weight loss, smoking cessation, alcohol cessation, social support, or similar factors.

Page 80—Centers of Excellence requests for organ transplants at facilities other than Mayo Clinic: The first full paragraph in the second column is replaced with the following:

Transplant denials by Mayo Clinic are not subject to review under this process if Mayo Clinic decides not to treat you based on your refusal to follow the terms and conditions of the Center of Excellence Program or determines that the transplant is not appropriate because you refuse to comply with medical restrictions or requirements, including weight loss, smoking cessation, alcohol cessation, social support, or similar factors. Transplant-related claims where treatment has already been rendered are decided under the regular medical claims and appeals procedures found in the Claims and appeals chapter.

Page 82—Male sterilization: In the second column, "male sterilization" is removed from the list of services and/or devices that are not included in the contraceptive benefit. Male sterilization is no longer excluded and is covered under the otherwise applicable Plan terms for doctor visits (not as preventive care).

Page 85—Video visits: The "video visits" paragraph in the second column on page 85 is replaced in its entirety with the following:

Telehealth visits: Except for Doctor On Demand, telehealth visits with your provider are covered under the same terms as in-person visits and are subject to the same terms, including cost sharing and coverage based on network or non-network status of the provider.

THE PHARMACY BENEFIT

Pages 92-97 of the 2020 *Associate Benefits Book*

Page 95—PHARMACY BENEFITS: The summary chart at the top of the page is replaced with the following:

<table>
<tr><th colspan="3">PHARMACY BENEFITS</th></tr>
<tr><td>Generic drugs
Up to 30-day supply
31- to 60-day supply
61- to 90-day supply
High-cost generic drugs are not covered when a therapeutically equivalent, lower-cost generic is available.</td><td>
$4 copay
$8 copay
$12 copay</td><td rowspan="4">Filling your prescriptions
• Present your plan ID card at a Walmart or Sam's Club pharmacy.
• If you are covered under the Premier Plan, Contribution Plan, or Saver Plan and your work location is more than 5 miles from a Walmart or Sam's Club pharmacy, you may also purchase drugs at an OptumRx network retail pharmacy. (Note, however, that supplies of generic drugs for greater than 30 days may be purchased only at a Walmart or Sam's Club pharmacy.)
• Prescription refills are available after 75% of your previous prescription has been used.
• See WHEN PRESCRIPTIONS CAN BE FILLED AT ANY NETWORK PHARMACY on the previous page for additional information.</td></tr>
<tr><td>Preferred brand-name drugs
Up to a 30-day supply</td><td>Greater of $50 or 25% of allowed cost</td></tr>
<tr><td>Non-preferred brand-name drugs</td><td>Not covered</td></tr>
<tr><td>Specialty drugs
Available only at Walmart Specialty Pharmacy or Optum Specialty Pharmacy</td><td>Greater of $50 or 20% of allowed cost</td></tr>
<tr><td colspan="3">Under the Saver Plan: The charges listed above apply after the Saver Plan's network annual deductible has been met, with the exception of medications that are on the OptumRx list of approved preventive medications, which are not subject to the deductible. See PREVENTIVE MEDICATIONS NOT SUBJECT TO THE SAVER PLAN'S NETWORK ANNUAL DEDUCTIBLE later in this chapter for details.</td></tr>
<tr><td colspan="3">When purchasing mail-order drugs:
• You may purchase mail-order prescriptions through a Walmart/Sam's Club mail-order pharmacy, regardless of your work location or medical plan. OptumRx home delivery pharmacy is also an option.
• Your cost for a 90-day supply is three times the cost of a 30-day supply purchased at a Walmart or Sam's Club pharmacy, as listed above.
• For brand-name drugs, supplies of more than 30 days must be purchased through mail order.</td></tr>
</table>

Page 95—HIV prevention: The following new text is added at the bottom of the page, following the section titled CONTRACEPTIVES FOR WOMEN:

HIV PREVENTION

The AMP covers preexposure prophylaxis ("PrEP") with effective antiretroviral therapy at 100%, with no deductible, when the drug is prescribed by a physician to a person at high risk of becoming infected with HIV.

HEATH SAVINGS ACCOUNT (HSA)

Pages 98-105 of the 2020 *Associate Benefits Book*

Pages 102-103—IRS contribution limits for 2021: New HSA contribution limits, set annually by the IRS, will be $3,600 for self-only (associate) coverage and $7,200 for family coverage.

- Under ANNUAL CONTRIBUTION LIMITS on page 102, the references to $3,550 (individual coverage) and $7,100 (family coverage) are changed to $3,600 and $7,200 respectively.
- In the chart titled YOUR CONTRIBUTIONS AND THE COMPANY'S CONTRIBUTIONS TO THE HSA on page 102, the references to $3,550 (associate-only coverage) and $7,100 (family coverage) are changed to $3,600 and $7,200 respectively.
- On page 103, in multiple paragraphs referencing the family contribution limit, $7,100 is changed to $7,200.

Page 104—Eligible expenses: Effective January 1, 2020, the following replaces the paragraph under the heading *Paying qualified medical expenses through your HSA*:

When you have an eligible medical expense, you can decide whether to pay out of your pocket or use the funds in your HSA. Some people use their HSA for current expenses, while others prefer to use the HSA as an account for future health care expenses. Eligible expenses include health plan deductibles and coinsurance, most medical care and services, dental and vision care, prescription drugs, and over-the-counter drugs. In addition, amounts paid for certain menstrual care products such as tampons and pads are eligible medical expenses. These expenses must not already be covered by your medical plan, and health insurance premiums generally do not qualify. Refer to IRS Publications 969 and 502 at irs.gov for information about qualified medical expenses. You can also find information about qualified medical expenses on **One.Walmart.com** and **MyHealthEquity.com**.

SHORT-TERM DISABILITY FOR HOURLY ASSOCIATES

Pages 180-189 of the 2020 *Associate Benefits Book*

Page 182—Legally mandated plans: Delete the final paragraph in the LEGALLY MANDATED PLANS chart, in the row bearing the subhead **All other states**, and replace it with the following:

Associates who work in Washington State, Washington, D.C., and Massachusetts will have the opportunity to enroll in the short-term disability enhanced plan to supplement the benefits mandated by the state or locality. The amount of the benefit under Walmart's short-term disability plans will be reduced by the amount of the mandated benefit Sedgwick estimates you are eligible to receive from the state or locality, regardless of whether you apply for that legally mandated benefit. The total benefits payable under the Walmart short-term disability plan to supplement your state or locality benefit will not exceed the level of benefits otherwise payable under the plan. You will be responsible for providing your award letter from the state or locality to Sedgwick. If Sedgwick overestimated what your mandated benefit would be, meaning that you were paid less under the Walmart short-term disability plan than you were entitled to, you will be paid the difference. If Sedgwick underestimated what your mandated benefit would be, meaning that you were paid more under the Walmart short-term disability plan than you were entitled to, you must repay any amount overpaid to you. See THE PLAN'S RIGHT TO RECOVER OVERPAYMENT and THE PLAN'S RIGHT TO SALARY/WAGE DEDUCTION in the **Claims and appeals** chapter. If you do not repay overpaid amounts in a timely manner, the company may treat the portion of such amounts that were not taxed when paid as taxable wages to you (reportable on your Form W-2) or, alternatively, deduct such amounts from your paycheck or future disability benefit payments, to the extent permitted by law.

SALARIED SHORT-TERM DISABILITY

Pages 190-197 of the 2020 *Associate Benefits Book*

Page 192—Legally mandated plans: Delete the LEGALLY MANDATED PLANS chart and replace it with the following:

LEGALLY MANDATED PLANS	
eCommerce salaried associates who work in California	Associates are eligible to participate in Walmart's salaried short-term disability plan to supplement their state benefits. The amount of the benefit under Walmart's salaried short-term disability plan will be reduced by the amount of the legally mandated benefit.

(continued on next page)

LEGALLY MANDATED PLANS	
Associates who work in Washington State, Washington, D.C., and Massachusetts	The amount of the benefit under Walmart's salaried short term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates that you are eligible to receive from the state or locality, regardless of whether you apply for that legally-mandated benefit. The total benefits payable under the Walmart short term disability plan to supplement your state or locality benefit will not exceed the level of benefits otherwise payable under the plan. You will be responsible for providing your award letter from the state or locality to Sedgwick. If Sedgwick overestimated what your mandated benefit would be, meaning that you were paid less under the Walmart short-term disability plan than you were entitled to, you will be paid the difference. If Sedgwick underestimated what your mandated benefit would be, meaning that you were paid more under the Walmart short-term disability plan than you were entitled to, you must repay any amount overpaid to you. See THE PLAN'S RIGHT TO RECOVER OVERPAYMENT and THE PLAN'S RIGHT TO SALARY/WAGE DEDUCTION in the **Claims and appeals** chapter. If you do not repay overpaid amounts in a timely manner, the company may deduct such amounts from your paycheck or future disability benefit payments, to the extent permitted by law.

CLAIMS AND APPEALS

Pages 260-279 of the 2020 *Associate Benefits Book*

The mailing address for Lincoln Financial Group is changed in two places, as shown here:

Page 276, first column:	Page 278, first column
Group Benefits Claims Lincoln Financial Group Group - Charlotte WM P.O. Box 2578 Omaha, Nebraska 68172-9688	Group Benefits Claims Appeals Unit Lincoln Financial Group Group - Charlotte WM P.O. Box 2578 Omaha, Nebraska 68172-9688

LEGAL NOTICES FOR THE ASSOCIATES' HEALTH AND WELFARE PLAN

- Medicare and Your Prescription Drug Coverage
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- Nondiscrimination Notice: Valued Plan Participant
- Availability of Summary of Health Information
- Women's Health and Cancer Rights Act

Medicare and your prescription drug coverage

Please read this notice about Medicare and your prescription drug coverage carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage under the Associates' Health and Welfare Plan (the "Plan") and your prescription drug coverage option under Medicare. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

There are important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Some of the Walmart prescription drug plans (as described later in this notice under the heading WHICH WALMART PLANS ARE CONSIDERED CREDITABLE COVERAGE?) are, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and are therefore considered creditable coverage. If you are a participant in one of these plans, you may keep your current coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
- Other Walmart plan options (as described later in this notice under the heading WHICH WALMART PLANS ARE CONSIDERED NON-CREDITABLE COVERAGE?) are, on average for all Plan participants, not expected to pay out as much as the standard Medicare prescription drug coverage will pay. If you are a participant in one of these plans, your coverage is non-creditable coverage. This is

important because for most people enrolled in these plan options, enrolling in Medicare prescription drug coverage means you will get more help with drug costs than if you had prescription drug coverage exclusively through the Plan. This is also important because it may mean that you pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

If you have non-creditable coverage under the Plan, it may affect how much you pay for Medicare D drug coverage in the future. When you become eligible for Medicare D, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offered by Medicare prescription drug coverage in your area. Read this notice carefully—it explains your options.

CREDITABLE AND NON-CREDITABLE COVERAGE

What is the meaning of the term "creditable coverage"? Creditable coverage means that your current prescription drug coverage is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Prescription drug coverage that does not satisfy this requirement is not creditable coverage.

WHICH WALMART PLANS ARE CONSIDERED CREDITABLE COVERAGE?

- Premier Plan
- Contribution Plan
- Local Plans
- HMO Plans
- eComm PPO Plan

If your coverage is creditable, you can keep your existing coverage and not pay extra if you later decide to enroll in Medicare coverage.

If you are enrolled in any of the Plans listed above, you can choose to join a Medicare prescription drug plan later without paying extra because you have existing prescription drug coverage that, on average, is as good as Medicare's coverage.

If you are enrolled in Medicare Part D, you are not eligible to enroll in any of the Plans listed above. If your dependent is enrolled in Medicare Part D and you are not, you are eligible to enroll in a Walmart medical or HMO plan, but your dependent would not be eligible for coverage.

If you drop your medical coverage with Walmart and enroll in a Medicare prescription drug plan, you and your eligible dependents will have the option of re-enrolling in the Walmart Plan during Annual Enrollment or with a valid status change event. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

WHICH WALMART PLANS ARE CONSIDERED NON-CREDITABLE COVERAGE?

The following Plan's prescription drug coverage is considered non-creditable according to Medicare guidelines:

- Saver Plan

If your coverage is non-creditable, you might want to consider enrolling in Medicare prescription drug coverage or a Walmart creditable Plan listed above because the coverage you have is, on average for all participants, not expected to pay out as much as the standard Medicare prescription drug coverage will pay.

WHEN CAN I ENROLL FOR MEDICARE PRESCRIPTION DRUG COVERAGE?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

If you have creditable prescription drug coverage and you lose it through no fault of your own, you will be eligible for a two-month Special Enrollment Period ("SEP") to join a Medicare drug plan.

If you have non-creditable prescription drug coverage and you drop coverage under the Plan, because your coverage is employer-sponsored group coverage, you will be eligible for a two-month SEP to join a Medicare drug plan. However, you may pay a higher premium (a penalty) because you did not have creditable coverage under the Plan.

WHEN WILL I PAY A HIGHER PREMIUM (A PENALTY) TO JOIN A MEDICARE DRUG PLAN?

If you have creditable coverage and drop or lose your coverage under the Plan and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join the Medicare drug plan later.

If you have non-creditable coverage, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan.

Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage,

your premium may always be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following Medicare annual enrollment period beginning in October to join.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current coverage under the Associates' Medical Plan ("AMP") will be affected. Plan guidelines restrict you from enrolling in the AMP if you are enrolled in Medicare Part D. If your dependent is enrolled in Medicare Part D and you are not, you are able to enroll in the AMP, but your dependent would not be eligible for coverage.

If you decide to join a Medicare drug plan and drop your coverage under the Walmart AMP, be aware that you and your dependents will be able to get your AMP coverage back, but only during Annual Enrollment or due to a status change event.

If you enroll in a Medicare Part D plan and decide within 60 days to switch back to a plan under the Walmart AMP, you will automatically be re-enrolled for the same coverage you had prior to the status change event. See the **Eligibility and enrollment** chapter for further details.

FOR MORE INFORMATION ABOUT MEDICARE AND YOUR PRESCRIPTION DRUG COVERAGE

- You will get this notice each year before your Medicare enrollment period.
- If we make a plan change that affects your creditable coverage, you will receive another notice.
- If you need a copy of this notice, you can request one from People Services at **800-421-1362**.

ADDITIONAL INFORMATION AVAILABLE

More detailed information about Medicare plans that offer prescription drug coverage is available through the Medicare & You handbook from Medicare. You may also be contacted directly by Medicare-approved prescription drug plans. You will get a copy of the handbook in the mail every year from Medicare. You can also get more information about Medicare prescription drug plans from these sources:

- Visit medicare.gov.
- Call your state health insurance assistance program for personalized help. (See your copy of the Medicare & You handbook for its telephone number.)
- Call 800-MEDICARE (**800-633-4227**). TTY users should call **877-486-2048**.

For people with limited income and resources, extra help paying for the Medicare prescription drug plan is available. For more information about this resource, visit the Social Security Administration online at socialsecurity.gov, or call **800-772-1213** (TTY **800-325-0778**).

REMEMBER: Keep this notice. If you enroll in one of the Medicare prescription drug plans, you may need to provide a copy of this notice when you join to show whether or not you have creditable coverage and therefore whether or not you are required to pay a higher premium (a penalty).

Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from Walmart Inc., your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial 877-KIDS NOW or insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for the Plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Walmart Inc. Plan, the Plan must allow you and your dependents to enroll in the Plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at askebsa.dol.gov or call 866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your state for more information on eligibility.

ALABAMA – Medicaid
Website: **http://myalhipp.com**
Phone: **855-692-5447**

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: **http://myakhipp.com**
Phone: **866-251-4861**
Email: **CustomerService@MyAKHIPP.com**
Eligibility:**http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**

ARKANSAS – Medicaid
Website: **http://myarhipp.com**
Phone: **855-MyARHIPP** (**855-692-7447**)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado website:
https://www.healthfirstcolorado.com
Health First Colorado Member Contact Center:
800-221-3943 State Relay 711
CHP+: **https://www.colorado.gov/pacific/hcpf/child-health-plan-plus**
CHP+ Customer Service: **800-359-1991** / **State Relay 711**

FLORIDA – Medicaid
Website: **http://flmedicaidtplrecovery.com/hipp**
Phone: **877-357-3268**

GEORGIA – Medicaid
Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: **678-564-1162** ext. **2131**

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19–64
Website: **http://www.in.gov/fssa/hip/**
Phone: **877-438-4479**
All other Medicaid
Website: **http://www.indianamedicaid.com**
Phone: **800-403-0864**

IOWA – Medicaid
Website: **http://dhs.iowa.gov/Hawki**
Phone: **800-257-8563**

KANSAS – Medicaid
Website: **http://www.kdheks.gov/hcf**
Phone: **785-296-3512**

KENTUCKY – Medicaid
Website: **http://chfs.ky.gov**
Phone: **800-635-2570**

LOUISIANA – Medicaid
Website: **http://dhh.louisiana.gov/index.cfm/subhome/1/n/331**
Phone: **888-695-2447**

MAINE – Medicaid
Website: **http://www.maine.gov/dhhs/ofi/public-assistance/index.html**
Phone: **800-442-6003**
TTY: **Maine relay 711**

MASSACHUSETTS – Medicaid and CHIP
Website: **http://www.mass.gov/eohhs/gov/departments/masshealth**
Phone: **800-862-4840**

MINNESOTA – Medicaid
Website: **http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp**
Phone: **800-657-3739**

MISSOURI – Medicaid
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**
Phone: **573-751-2005**

MONTANA – Medicaid
Website:**http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**
Phone: **800-694-3084**

NEBRASKA – Medicaid
Website: **http://www.ACCESSNebraska.ne.gov**
Phone: **855-632-7633**
Lincoln: **402-473-7000**
Omaha: **402-595-1178**

NEVADA – Medicaid
Medicaid website: **https://dhcfp.nv.gov/**
Medicaid phone: **800-992-0900**

NEW HAMPSHIRE – Medicaid
Website: **https://www.dhhs.nh.gov/oii/documents/hipp.htm**
Phone: **603-271-5218**
Toll-free for HIPP program: **800-852-3345** ext. **5218**

NEW JERSEY – Medicaid and CHIP
Medicaid website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid**
Medicaid phone: **609-631-2392**
CHIP website: **http://www.njfamilycare.org/index.html**
CHIP phone: **800-701-0710**

NEW YORK – Medicaid
Website: **https://www.health.ny.gov/health_care/medicaid/**
Phone: **800-541-2831**

NORTH CAROLINA – Medicaid
Website: **https://medicaid.ncdhhs.gov**
Phone: **919-855-4100**

NORTH DAKOTA – Medicaid
Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid**
Phone: **844-854-4825**

OKLAHOMA – Medicaid and CHIP
Website: **http://www.insureoklahoma.org**
Phone: **888-365-3742**

OREGON – Medicaid
Website: **http://healthcare.oregon.gov/Pages/index.aspx**
http://www.oregonhealthcare.gov/index-es.html
Phone: **800-699-9075**

PENNSYLVANIA – Medicaid
Website: **http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm**
Phone: **800-692-7462**

RHODE ISLAND – Medicaid and CHIP
Website: **http://www.eohhs.ri.gov**
Phone: **855-697-4347**
or **401-462-0311** (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: **https://www.scdhhs.gov**
Phone: **888-549-0820**

SOUTH DAKOTA – Medicaid
Website: **http://dss.sd.gov**
Phone: **888-828-0059**

TEXAS – Medicaid
Website: **http://gethipptexas.com**
Phone: **800-440-0493**

UTAH – Medicaid and CHIP
Medicaid website: **https://medicaid.utah.gov**
CHIP website: **http://health.utah.gov/chip**
Phone: **877-543-7669**

VERMONT– Medicaid
Website: **http://www.greenmountaincare.org**
Phone: **800-250-8427**

VIRGINIA – Medicaid and CHIP
Medicaid/CHIP website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid phone: **800-432-5924**
CHIP phone: **855-242-8282**

WASHINGTON – Medicaid
Website: **http://www.hca.wa.gov**
Phone: **800-562-3022** ext. **15473**

WEST VIRGINIA – Medicaid
Website: **http://mywvhipp.com**
Phone: **855-MyWVHIPP** (**855-699-8447**)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: **800-362-3002**

WYOMING – Medicaid
Website: **https://wyequalitycare.acs-inc.com**
Phone: **307-777-7531**

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, Menu Option 4, Ext. **61565**

A Few More Things...

Here are some important legal documents that go with it. You'll find a couple of notices that talk about your rights as a Plan participant.

You should also share these notices with any family members who are covered under your Plan. If they live in a different household, you can ask for these notices to be sent to a different address. You and your family members can also ask for a free paper copy of these notices by calling People Services at **800-421-1362**.

Valued Plan Participant

THE ASSOCIATES' HEALTH AND WELFARE PLAN (AHWP) RESPECTS THE DIGNITY OF EACH INDIVIDUAL WHO PARTICIPATES IN THE PLAN.

The AHWP does not discriminate on the basis of race, color, national origin, sex, age, or disability and strictly prohibits retaliation against any person making a complaint of discrimination. Additionally, we gladly provide our participants with language assistance, auxiliary aids, and services at no cost. We value you as our participant, and your satisfaction is important to us.

If you need such assistance or have concerns with your Plan services, please call the number on the back of your plan ID card. If you have any questions or concerns, please use one of the methods below so that we can better serve you.

For assistance, call the number on the back of your plan ID card.

عربي
خدمات الترجمة الفورية متاحة دون تكلفة. 1-800-421-1362.

မြန်မာ
စကားပြန်ဝန်ဆောင်မှုများကို အခမဲ့ ရရှိနိုင်ပါသည်။ 1-800-421-1362

汉语普通话
翻译服务免费提供。1-800-421-1362.

فارسی
خدمات مترجم بدون هیچ هزینه ای در دسترس می باشد. 1-800-421-1362

Français
Des services d'interprètes sont disponibles sans frais. 1-800-421-1362.

kreyòl ayisye
Gen Sèvis entèprèt ki disponib gratis. 1-800-421-1362.

日本人
通訳サービスは無料でご利用いただけます。1-800-421-1362.

한국어
통역 서비스를 무료로 이용하실 수 있습니다. 1-800-421-1362.

Polski Usługi tłumacza dostępne są bez żadnych kosztów. 1-800-421-1362.

To learn about or use our grievance process, contact People Services at **1-800-421-1362**.

To file a complaint of discrimination, contact the U.S. Department of Health and Human Services, Office of Civil Rights:

- **Phone**: 1-800-368-1019 or 1-800-537-7697 (TDD)
- **Website**: https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf
- **Email**: OCRComplaint@hhs.gov

Interpreter Services are available at no cost. **1-800-421-1362**.

Português (Brasil)
Serviços de interprete estão disponíveis grátis. 1-800-421-1362.

ਪੰਜਾਬੀ
ਦੋਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। 1-800-421-1362.

Română
Serviciile de interpretariat sunt disponibile gratuit. 1-800-421-1362.

Русский
Переводческие Услуги оказываются бесплатно. 1-800-421-1362.

Af-Soomaali
Adeegyada Turjumaanka waxaa lagu heli karaa kharash la'aan. 1-800-421-1362.

Español
Los servicios de interpretación están disponibles de manera gratuita. 1-800-421-1362.

Kiswahili
Huduma za tafsiri zipo bila malipo. 1-800-421-1362.

Tiếng Việt
Dịch Vụ Thông Dịch có sẵn miễn phí. 1-800-421-1362.

AVAILABILITY OF SUMMARY OF HEALTH INFORMATION

As an associate, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare options. The SBC is available on One.Walmart.com/Benefits. A paper copy is also available, free of charge, by calling 800-421-1362.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, Walmart-provided medical plans provide coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

For more information

IF YOU HAVE QUESTIONS ABOUT…	WEBSITE	PHONE
When you're eligible for benefits or how to enroll	**One.Walmart.com/Benefits**	People Services: **800-421-1362**
Medical benefits, medical claims, or care management	**One.Walmart.com/Medical**	Aetna (including Select Local Plan, Banner Local Plan, and St. Luke's Local Plan) health care advisor: **855-548-2387** BlueAdvantage Administrators of Arkansas health care advisor: **866-823-3790** UnitedHealthcare health care advisor: **888-285-9255** HealthSCOPE Benefits (includes all other Local Plans): **800-804-1272** Expanded telehealth in MN, CO, and WI: **877-385-8786**
Finding a doctor, most areas: Grand Rounds	Register at: **GrandRounds.com/Walmart** Download the app at **App Store** or **Google Play** Learn about Personal Healthcare Assistant (NC, SC only): **GrandRounds.com/Walmart**	Grand Rounds: **800-941-1384** Personal Healthcare Assistant (NC, SC only): **855-377-2200**
Finding a doctor: Central Florida, Dallas/Ft. Worth, and Northwest Arkansas, except the Mercy Arkansas Local Plan	Provider Guide: **One.Walmart.com/ProviderGuide**	BlueAdvantage Administrators of Arkansas: **866-823-3790**
Doctor On Demand	**DoctorOnDemand.com/Walmart**	**800-997-6196**
Centers of Excellence	**One.Walmart.com/COE**	People Services: **800-421-1362** or your health care advisor (see above)
Quit Tobacco	**One.Walmart.com/QuitTobacco**	Kick Buts: **855-955-1905** Craving to Quit: **866-577-7169**
Pharmacy benefits	**One.Walmart.com/Prescriptions**	OptumRx: **844-705-7493**
Health savings account (HSA)–Saver Plan	**learn.healthequity.com/walmart/hsa**	HealthEquity: **866-296-2860**
Dental plan	**One.Walmart.com/Dental**	Delta Dental: **800-462-5410**
Vision plan	**One.Walmart.com/Vision**	VSP: **866-240-8390**

IF YOU HAVE QUESTIONS ABOUT…	WEBSITE	PHONE
Resources for Living	**One.Walmart.com/RFL**	**800-825-3555**, 24/7
Accident and critical illness insurance	**One.Walmart.com/Accident** **One.Walmart.com/Critical**	Allstate Benefits: **800-514-9525**
Life, accidental death and dismemberment (AD&D), and business travel accident insurance	**One.Walmart.com/Life** **One.Walmart.com/ADD**	Prudential: **877-740-2116**
Short-term disability insurance	**One.Walmart.com/ShortTermDisability**	Sedgwick/Lincoln: **800-492-5678**
Long-term disability insurance	**One.Walmart.com/LongTermDisability**	Lincoln: **800-492-5678**
Walmart 401(k) Plan	**One.Walmart.com/401k** **Benefits.ml.com**	Bank of America Merrill Lynch: **888-968-4015**
Associate Stock Purchase Plan	**One.Walmart.com/ASPP** **ComputerShare.com/Walmart**	ComputerShare: **800-438-6278**

2020 Associate Benefits Book | Summary Plan Descriptions

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