



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, contact the claims administrator at 1-800-421-1362 or visit www.One.Walmart.com/Benefits. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary <https://www.healthcare.gov/sbc-glossary> or call 1-800-421-1362 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|---|---|
| What is the overall deductible? | <p>In-<u>Network</u>: \$1,750 individual/ \$3,500 family Out-of-<u>Network</u>: Services are not covered</p> <p>Charges for <u>balance-billing</u>, healthcare this <u>plan</u> does not cover, services at an out-of-<u>network</u> Walmart Care Clinic or Walmart Health, medical <u>copayments</u>, pharmacy <u>copayment</u>/ <u>coinsurance</u> (including third-party assistance), and amounts the <u>plan</u> pays at 100% do not count toward the <u>deductible</u>.</p> | <p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.</p> |
| Are there services covered before you meet your deductible? | <p>Yes. <u>Deductible</u> is waived for: Doctor On Demand, certain services that are included in the Centers of Excellence programs (except bariatric surgery), eligible pharmacy charges, certain <u>preventive care</u> services, in-<u>network</u> office/telehealth visits and <u>urgent care</u>.</p> | <p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>.</p> <p>See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/</p> |
| Are there other deductibles for specific services? | <p>No.</p> | <p>You don't have to meet <u>deductibles</u> for specific services.</p> |
| What is the out-of-pocket limit for this plan? | <p>In-<u>Network</u>: \$6,850 individual/ \$13,700 family Out-of-<u>Network</u>: Services are not covered</p> | <p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p> |
| What is not included in the out-of-pocket limit? | <p><u>Premiums</u>, <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> for services, charges for health care this <u>plan</u> doesn't cover, charges for services at an out-of-<u>network</u> Walmart Care Clinic or Walmart Health, amounts from third parties to assist with <u>prescription drug purchases</u>, and amounts the <u>plan</u> pays at 100%.</p> | <p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p> |

* For more detail about limitations and exceptions, see Summary Plan Description and Summary of Material Modifications (SPD) at www.One.Walmart.com/Benefits.

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.GrandRounds.com/Walmart or call 1-800-941-1384 for a list of <u>in-network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies, unless other noted.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|---|---|
| | | <u>In-Network Provider</u> (You will pay the least) | <u>Out-of-Network Provider</u> (You will pay the most) | |
| If you visit a health care <u>provider's office or clinic</u> | Primary care visit to treat an injury or illness | \$35 <u>copayment</u> Office/telehealth visit; <u>deductible</u> doesn't apply | Not covered | Special rules, including lower <u>copayments</u> , may apply to services received from an <u>in-network</u> Walmart Care Clinic or Walmart Health. *See the "Walmart Care Clinic and Walmart Health" section of the SPD. Doctor On Demand visits have a \$4 <u>copayment</u> , which is waived during the COVID-19 national emergency. <u>Preauthorization</u> may be required. *See the " <u>Preauthorization</u> " section in the SPD. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. *See the " <u>Preventive care program</u> " section in the SPD for covered <u>preventive services</u> and applicable limitations. During COVID-19 public health emergency, there is no charge for a COVID-19 test or <u>diagnostic tests</u> that result in COVID-19 testing at an <u>in-network</u> or an <u>out-of-network provider</u> . |
| | <u>Specialist</u> visit | \$75 <u>copayment</u> Office/telehealth visit; <u>deductible</u> doesn't apply | Not covered | |
| | <u>Preventive care</u> / <u>screening</u> / <u>immunization</u> | No charge; <u>deductible</u> doesn't apply | Not covered | |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 25% <u>coinsurance</u> | Not covered | There is no charge for routine in-office <u>diagnostic tests</u> on same day as <u>network provider</u> office/telehealth visit. During the COVID-19 public health emergency, there is no charge for a COVID-19 test or <u>diagnostic tests</u> that result in COVID-19 testing at an in- <u>network</u> or an <u>out-of-network</u> provider. |
| | Imaging (CT/PET scans, MRIs) | 25% <u>coinsurance</u> | Not covered | <u>Preauthorization</u> may be required. *See the “ <u>Preauthorization</u> ” section in the SPD. |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.OptumRx.com/Walmart | Generic drugs | \$4 <u>copayment</u> (1-30 days); \$8 <u>copayment</u> (31-60 days); \$12 <u>copayment</u> (61-90 days) | Not covered | You must use a Walmart or Sam’s Club pharmacy (including through mail-order). *See “The Pharmacy Benefit” section in the SPD for exceptions. |
| | Preferred brand drugs | Greater of \$50 or 25% <u>coinsurance</u> , <u>deductible</u> doesn’t apply (30 days) | Not covered | High-cost generic drugs are not covered when a therapeutically equivalent, lower-cost generic drugs are available. Supplies of preferred brand drugs of more than 30 days must be purchased by mail-order. |
| | Non-preferred brand drugs | Not covered | Not covered | Non-Preferred brand drugs are not covered. |
| | <u>Specialty drugs</u> | Greater of \$50 or 20% <u>coinsurance</u> , <u>deductible</u> doesn’t apply (30 days) | Not covered | <u>Preauthorization</u> may be required. *See the “ <u>Preauthorization</u> ” section in the SPD. <u>Specialty drugs</u> are only available at a Walmart Specialty or OptumRx Specialty pharmacy. Prescriptions for <u>specialty drugs</u> are not covered when purchased at a non- <u>network</u> pharmacy. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 25% <u>coinsurance</u> | Not covered | <u>Preauthorization</u> may be required. *See the “ <u>Preauthorization</u> ” section in the SPD. |
| | Physician/surgeon fees | 25% <u>coinsurance</u> | Not covered | <u>Preauthorization</u> may be required. *See the “ <u>Preauthorization</u> ” section in the SPD. |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need immediate medical attention | <u>Emergency room care</u> | \$300 <u>copayment</u> , in addition to any remaining <u>deductible</u> | \$300 <u>copayment</u> , in addition to any remaining <u>deductible</u> and 0% <u>coinsurance</u> for <u>emergency services</u> ; or no coverage for non- <u>emergency services</u> | If you are admitted to the hospital directly from the emergency room, the <u>copayment</u> is waived. |
| | <u>Emergency medical transportation</u> | 25% <u>coinsurance</u> | 25% <u>coinsurance</u> for <u>emergency services</u> ; no coverage for non- <u>emergency services</u> | Coverage is limited to the nearest hospital or treatment facility capable of providing care, and only if such transportation is <u>medically necessary</u> as compared to other transportation methods of lower cost and safety. Non-emergency transport is not covered, except if pre-authorized. |
| | <u>Urgent care</u> | \$75 <u>copayment</u> /visit, <u>deductible</u> doesn't apply | Not covered | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 25% <u>coinsurance</u> | Not covered | <u>Preauthorization</u> may be required. *See the " <u>Preauthorization</u> " section in the SPD. |
| | Physician/surgeon fees | 25% <u>coinsurance</u> | Not covered | For heart surgery, dialysis/ESRD medical record review, spine, hip or knee replacement evaluation or surgery; breast, lung, blood, prostate, and colorectal cancer review; and organ and tissue transplants, coverage is 100% (<u>deductible</u> doesn't apply) through the Centers of Excellence (COE) Program. When not performed through the COE Program, these services (other than heart surgery, dialysis/ESRD medical record review and cancer medical record review) as well as weight loss surgery are not covered, even if performed by a <u>network provider</u> . *See the "Centers of Excellence" section in the SPD. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office/telehealth Visit: \$35 <u>copayment</u> /visit, <u>deductible</u> doesn't apply; other services: 25% <u>coinsurance</u> | Not covered | <u>Preauthorization</u> may be required. *See the " <u>Preauthorization</u> " section in the SPD. Doctor On Demand visits have a \$4 <u>copayment</u> , which is waived during the COVID-19 national emergency. |
| | Inpatient services | 25% <u>coinsurance</u> | Not covered | |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you are pregnant | Office visits | Preventive care: No charge; other services: \$35 copayment/visit; deductible doesn't apply | Not covered | <p><u>Cost sharing</u> does not apply for <u>preventive services</u>. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</p> <p>Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u>, or <u>deductible</u> may apply.</p> <p><u>Preauthorization</u> may be required for stays exceeding standard length of stay for maternity.</p> |
| | Childbirth/delivery professional services | 25% <u>coinsurance</u> | Not covered | |
| | Childbirth/delivery facility services | 25% <u>coinsurance</u> | Not covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 25% <u>coinsurance</u> | Not covered | <p><u>Preauthorization</u> may be required. *See the "<u>Preauthorization</u>" section in the SPD.</p> <p><u>Home health care</u> is limited to 100 visits per calendar year. Other limitations may apply. *See the "When limited benefits apply to the Associates' Medical <u>Plan</u>" section in the SPD.</p> |
| | <u>Rehabilitation services</u> | 25% <u>coinsurance</u> | Not covered | <p><u>Preauthorization</u> may be required. *See the "<u>Preauthorization</u>" section in the SPD.</p> <p><u>Rehabilitation services</u> are limited as follows:</p> <ul style="list-style-type: none"> • Physical therapy limited to 20 visits/year. • Occupational therapy limited to 20 visits/year. • Speech therapy limited to 60 visits/year. • Certain other inpatient <u>rehabilitation services</u> are limited to 120 days per condition. <p>See the "When Limited Benefits Apply to the Associates' Medical <u>Plan</u>" section of the SPD.</p> |
| | <u>Habilitation services</u> | 25% <u>coinsurance</u> | Not covered | <p><u>Preauthorization</u> may be required. *See the "<u>Preauthorization</u>" section in the SPD.</p> <p><u>Habilitation services</u> are limited to Applied Behavior Analysis therapy.</p> |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|----------------------------------|---|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | <u>Skilled nursing care</u> | 25% <u>coinsurance</u> | Not covered | <u>Preauthorization</u> may be required. *See the “ <u>Preauthorization</u> ” section in the SPD. Skilled nursing facilities are limited to 60 days per /disability period. *See the “When Limited Benefits Apply to the Associates’ Medical Plan” section in the SPD. |
| | <u>Durable medical equipment</u> | 25% <u>coinsurance</u> | Not covered | <u>Preauthorization</u> may be required. *See the “ <u>Preauthorization</u> ” section in the SPD. Orthopedic shoes when prescribed by a physician are limited to one pair per calendar year. |
| | <u>Hospice services</u> | 25% <u>coinsurance</u> | Not covered | <u>Preauthorization</u> may be required. *See the “ <u>Preauthorization</u> ” section in the SPD. <u>Hospice services</u> are limited to 365 days per illness. |
| If your child needs dental or eye care | Children's eye exam | No charge; <u>deductible</u> doesn't apply | Not covered | Limited to <u>screening</u> that qualifies as <u>preventive services</u> . *See the “ <u>Preventive Care Program</u> ” section in the SPD for covered <u>preventive services</u> and applicable limitations. |
| | Children's glasses | Not covered | Not covered | Glasses are limited when a certain medical diagnosis applies or from eye injury. See the “When Limited Benefits Apply to the Associates’ Medical Plan” section in the SPD. |
| | Children's dental check-up | Not covered | Not covered | Dental check-ups are not covered under medical benefits; however, there may be additional other coverage under a separate dental <u>plan</u> . |

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|---------------|-----------------------------|------------------------|
| • Acupuncture | • Glasses | • Routine eye care |
| • Dental care | • Hearing aids | • Weight loss programs |
| | • Non-preferred brand drugs | |

* For more detail about limitations and exceptions, see Summary Plan Description and Summary of Material Modifications (SPD) at www.One.Walmart.com/Benefits.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (gastric bypass and gastric sleeve surgery only)
- Chiropractic Care (maximum of 10 visits per calendar year)
- Cosmetic Surgery (limited to conditions that are considered reconstructive)
- Infertility treatment (limited to the diagnosis & treatment of underlying medical condition.
- Long-term care – Up to 60 days/disability period
- Non-Emergency Care when traveling Outside the U.S. (as provided by international business medical insurance policy)
- Private-duty nursing (limited to 100 visits per calendar, billed through a home health agency, and must be provided by a licensed or registered nurse)Routine eye care (limited to services and limitations that are identified under the “Preventive Care” section of the SPD)
- Routine foot care (nonsurgical foot care limited to 3 visits per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Walmart People Services, Attn: Internal Appeals, 508 SW 8th Street, Bentonville, AR 72716-3500. You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-421-1362.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-421-1362.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-421-1362.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-421-1362.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more detail about limitations and exceptions, see Summary Plan Description and Summary of Material Modifications (SPD) at www.One.Walmart.com/Benefits.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible **\$1,750**
- Specialist copayment **\$75**
- Hospital (facility) coinsurance **25%**
- Other coinsurance **25%**

This EXAMPLE event includes services like:
 Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

| | |
|--|-----------------|
| Total Example Cost | \$12,700 |
| In this example, Peg would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$1,750 |
| Copayments | \$10 |
| Coinsurance | \$2,700 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,520 |

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$1,750**
- Specialist copayment **\$75**
- Hospital (facility) coinsurance **25%**
- Other coinsurance **25%**

This EXAMPLE event includes services like:
 Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

| | |
|--|----------------|
| Total Example Cost | \$5,600 |
| In this example, Joe would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$900 |
| Copayments | \$500 |
| Coinsurance | \$800 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,220 |

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible **\$1,750**
- Specialist copayment **\$75**
- Hospital (facility) coinsurance **25%**
- Other coinsurance **25%**

This EXAMPLE event includes services like:
 Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

| | |
|--|----------------|
| Total Example Cost | \$2,800 |
| In this example, Mia would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$1,750 |
| Copayments | \$300 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,250 |

The plan would be responsible for the other costs of these EXAMPLE covered services.

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