Wal-Mart Stores, Inc.: HSA Plan

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

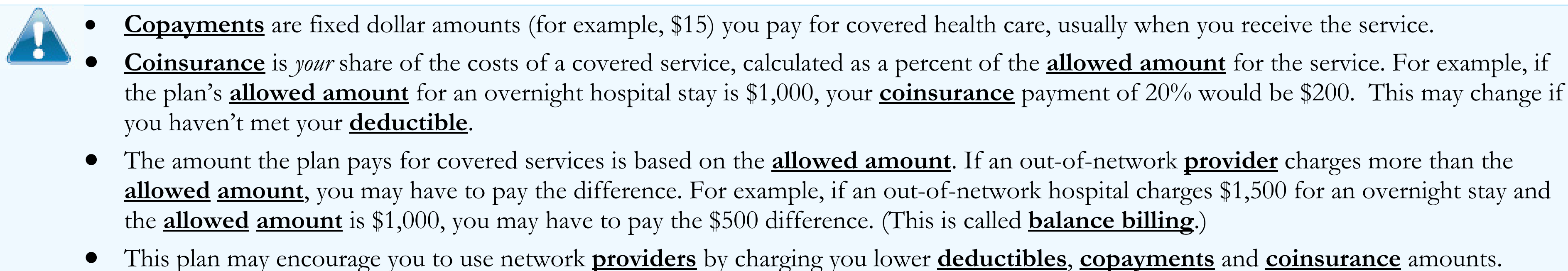
Coverage for: Associate Only, Associate + Spouse/Partner, Associate + Children and Associate + Family | **Plan Type: High-deductible**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.WalmartOne.com or by calling 1-800-421-1362.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** individual / **$6,000** family for network services, or **$6,000** individual / **$12,000** family for out-of-network services. Does not apply to certain preventive care services. Preventive care services don't count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. When using a network provider, **$6,550** individual / **$13,100** family for network services. There is no **out–of–pocket limit** for out-of-network services.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, out-of-network coinsurance, health care services this plan doesn't cover, and charges for preventive services.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers, see **www.WalmartOne.com** or call 1-800-421-1362.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the terms in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.

Questions: Call 1-800-421-1362 or visit us at **www.WalmartOne.com.** If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform/ or call 1-800-421-1362 to request a copy.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.



- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Preferred Provider	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not applicable	25% coinsurance	50% coinsurance	Coinsurance applies after deductible.
	Specialist visit	Not applicable	25% coinsurance	50% coinsurance	
	Other practitioner office visit	Not applicable	25% coinsurance	50% coinsurance	Coinsurance applies after deductible. No coverage for chiropractic or acupuncture services.
	Preventive care/ screening/immunization	Not applicable	No charge	50% coinsurance	Deductible does not apply to certain services. See the Preventive Care chart in the Medical Plan chapter of the Summary Plan Description for all covered Preventive Care services.
If you have a test	Diagnostic test (x-ray, blood work)	Not applicable	25% coinsurance	50% coinsurance	Coinsurance applies after deductible.
	Imaging (CT/PET scans, MRIs)	Not applicable	25% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	Your cost if you use a Preferred Provider	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www. WalmartOne.com. or call 1-800-887-6194.	Generic drugs	• $4 copay (up to 30-day supply) • $8 copay (31-60 day supply) • $12 copay (61-90-day supply)	• $20 copay (up to 30-day supply) • $40 copay (31-60-day supply) • $60 copay (61-90-day supply)	Not covered	You pay full price up to annual deductible, then copay rules apply. Preferred provider rates apply at a network provider if a Walmart or Sam's Club pharmacy is not located within 5 miles of your work. Prescriptions are not covered at a non-network pharmacy.
	Preferred brand drugs	Greater of $50 or 25% coinsurance of allowed cost (up to 30-day supply)	Greater of $100 or 35% coinsurance of allowed cost (up to 30-day supply)	Not covered	You pay full price up to annual deductible, then copay rules apply. Preferred provider rates apply at a network provider if a Walmart or Sam's Club pharmacy is not located within 5 miles of your work. Prescriptions are not covered at a non-network pharmacy.
	Non-preferred brand drugs	Not covered	Not covered	Not covered	——————none——————
	Specialty drugs	Greater of $50 or 20% coinsurance of allowed cost (up to 30-day supply)	Greater of $50 or 20% coinsurance of allowed cost (up to 30-day supply)	Not covered	You pay full price up to annual deductible, then copay rules apply. Specialty drugs are only available at a Walmart Specialty or ESI/Accredo Specialty pharmacy. Prescriptions are not covered at a non-network pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	25% coinsurance	50% coinsurance	Coinsurance applies after deductible. Preauthorization may apply. See the Summary Plan Description.
	Physician/surgeon fees	Not applicable	25% coinsurance	50% coinsurance	

All references to the Summary Plan Description in this document refer to the Medical chapter in the 2016 Summary Plan Description and the Summary of Material Modifications dated January 1, 2017.

Common Medical Event	Services You May Need	Your cost if you use a Preferred Provider	Network Provider	Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	Not applicable	25% coinsurance	25% coinsurance	Care that does not meet the definition of "emergency care" is paid at 50% for out-of-network services. Coinsurance applies after deductible. Non-network expenses may be considered as in network if the necessary criteria are met.
	Emergency medical transportation	Not applicable	25% coinsurance	25% coinsurance	Care that does not meet the definition of "emergency care" is paid at 50% for out-of-network services. Coinsurance applies after deductible. Non-network expenses may be considered as in network if the necessary criteria are met. Coverage is limited to the nearest hospital or 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.
	Urgent care	Not applicable	25% coinsurance	25% coinsurance	Care that does not meet the definition of "emergency care" is paid at 50% for out-of-network services. Coinsurance applies after deductible. Non-network expenses may be considered as in network if the necessary criteria are met. Coinsurance applies after deductible.

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Common Medical Event	Services You May Need	Your cost if you use a Preferred Provider	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	25% coinsurance	50% coinsurance	Coinsurance applies after deductible. Preauthorization may apply. For spine surgery, coverage is 50% if you use a network or non-network provider. For heart, spine, hip replacement or knee replacement evaluation and surgery, and breast, lung and colorectal cancer review, coverage may be 100% with no deductible if you use a Center of Excellence (COE) facility. Precertification for COE eligibility may be required. See the Summary Plan Description for details.
	Physician/surgeon fee	Not applicable	25% coinsurance	50% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not applicable	25% coinsurance	50% coinsurance	Coinsurance applies after deductible. Preauthorization may apply. See the Summary Plan Description.
	Mental/Behavioral health inpatient services	Not applicable	25% coinsurance	50% coinsurance	
	Substance use disorder outpatient services	Not applicable	25% coinsurance	50% coinsurance	
	Substance use disorder inpatient services	Not applicable	25% coinsurance	50% coinsurance	
If you are pregnant	Prenatal and postnatal care	Not applicable	25% coinsurance	50% coinsurance	Coinsurance applies after deductible.
	Delivery and all inpatient services	Not applicable	25% coinsurance	50% coinsurance	Coinsurance applies after deductible.

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Common Medical Event	Services You May Need	Your cost if you use a Preferred Provider	Network Provider	Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Not applicable	25% coinsurance	50% coinsurance	Coinsurance applies after deductible. Must be provided by a licensed nurse. Limited to 100 visits per year. Preauthorization may apply. See the Summary Plan Description.
	Rehabilitation services	Not applicable	25% coinsurance	50% coinsurance	Coinsurance applies after deductible. Limited to 120 days per condition. Preauthorization may apply. See the Summary Plan Description.
	Habilitation services	Not applicable	25% coinsurance	50% coinsurance	Coinsurance applies after deductible. Coverage is limited to ABA therapy.
	Skilled nursing care	Not applicable	25% coinsurance	50% coinsurance	Coinsurance applies after deductible. Limited to 60 calendar days per disability period. See the Summary Plan Description.
	Durable medical equipment	Not applicable	25% coinsurance	50% coinsurance	Coinsurance applies after deductible. Dr. must provide diagnosis, equipment needed and expected time of usage. Preauthorization may apply. See the Summary Plan Description.
	Hospice service	Not applicable	25% coinsurance	50% coinsurance	Coinsurance applies after deductible. Must receive from a licensed hospice agency. Limited to 365 days per illness. Preauthorization may apply. See the Summary Plan Description.
If your child needs dental or eye care	Eye exam	Not applicable	No charge	50% coinsurance	Limited to one exam per year
	Glasses	Not applicable	Not covered	Not covered	——————none——————
	Dental check-up	Not applicable	Not covered	Not covered	——————none——————

All references to the Summary Plan Description in this document refer to the Medical chapter in the 2016 Summary Plan Description and the Summary of Material Modifications dated January 1, 2017.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Chiropractic care • Dental care (Adult or child) • Glasses • Generic drugs purchased at a non-network pharmacy	• Habilitation services (except for ABA therapy) • Hearing aids • Infertility treatment • Non-preferred brand drugs • Preferred brand drugs purchased at a non-network pharmacy • Routine eye care (Adult)	• Services received through a Walmart Care Clinic except for certain primary care and certain preventive services • Specialty drugs purchased at a non-network pharmacy • Weight loss programs (except for certain weight loss surgery)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery – limited to gastric bypass surgery. • Cosmetic surgery – limited to conditions resulting from accidental injuries, tumors, diseases, congenital abnormality or as covered under the Women's Health & Cancer Rights Act.	• Long-term care – limited to 60 calendar days per disability period if admitted subsequent to an eligible acute care hospital confinement. • Non-emergency care when traveling outside the U.S. – see the Summary Plan Description.	• Private-duty nursing – limited to 100 visits per year, and must be provided by a licensed or registered nurse. • Routine foot care – limited to three (3) visits per year.

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-421-1362. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Walmart Benefits Administration, Attn: Internal Appeals, 508 SW 8th Street, Bentonville, AR 72716-3500. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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, kwiijigo holne' 1-800-421-1362.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,830
- **Patient pays** $3,710

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,000
Co-pays	$10
Coinsurance	$500
Limits or exclusions	$200
Total	**$3,710**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,720
- **Patient pays** $2,680

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,400
Co-pays	$200
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,680**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.