Walmart Inc.: Contribution Plan for Central Florida work locations

Coverage for: Associate Only; Associate + Spouse/Partner, Associate + Children, and Associate + Family | **Plan Type**: PPO

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?	Network: $1,750 individual/ $3,500 family; Out-of-Network: Out-of-Network: $3,500 individual/ $7,000 family Charges for balance billing, healthcare this plan does not cover, services at out-of-network Walmart Care Clinic or Walmart Health, medical copayments, pharmacy copayment/coinsurance (including third party assistance), charges for preventive care from out-of-network and Nonpreferred network provider, and amounts the plan pays at 100% do not count toward the deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay. The employer contribution to the HRA is $250/individual or $500/family per year. If you have HRA funds from a prior year that rollover, the rollover combined with the new year allocation cannot exceed the in-network deductible; your rollover will be reduced by the amount exceeding the in-network deductible.
Are there services covered before you meet your deductible?	Yes. Deductible is waived for: Doctor On Demand, certain services that are included in the Centers of Excellence programs (except bariatric surgery), eligible pharmacy charges, and certain preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $6,850 individual/ $13,700 family Out-of-Network: Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization for services, health care this plan doesn't cover, out-of-network coinsurance, services at out-of-network Walmart Care Clinic or Walmart Health, amounts from third parties to assist with prescription drug purchases and amounts the plan pays at 100%.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

* 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 network provider?	Yes. See www.One.Walmart.com/ProviderGuide or call 1-866-823-3790 for a list of network providers.	This plan uses a provider network. You will pay the least if you use a Preferred Provider in the plan's network. You will pay more if you use a Nonpreferred Provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay the least for Preferred Providers)	Out-of-Network Provider (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	*Preferred:* 25% coinsurance; *Nonpreferred:* 50% coinsurance	50% coinsurance	If no Preferred Provider is available, in-network covered services will be paid at the Preferred Provider rate. *See the "Medical Plan" section of SPD. Special rules, including lower copayments, may apply to services received from an in-network 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 copayment, which is waived during the COVID-19 national emergency. Preauthorization may be required. *See the "Preauthorization" section in the SPD. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. *See the "Preventive care program" section in the SPD for covered preventive services and applicable limitations. During COVID-19 public health emergency, there is no charge for a COVID-19 test or diagnostic tests that result in COVID-19 testing at an in-network or an out-of-network provider.
	Specialist visit	*Preferred:* 25% coinsurance; *Nonpreferred:* 50% coinsurance	50% coinsurance	
	Preventive care /screening /immunization	*Preferred:* No charge, *Nonpreferred:* 50% coinsurance; deductible doesn't apply	50% coinsurance; deductible does not apply to preventive care.	
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	During the COVID-19 public health emergency, there is no charge for a COVID-19 test or diagnostic tests that result in COVID-19 testing at an in-network or an out-of-network provider.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay the least for Preferred Providers)	Out-of-Network Provider (You pay the most)	
	Imaging (CT/PET scans, MRIs)	50% coinsurance; 25% coinsurance for alternate network provider	50% coinsurance	Preauthorization may be required. *See the "Preauthorization" section in the SPD. PET scans are reimbursed as a diagnostic test. *See "Alternate provider networks" section in the SPD.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.OptumRx.com/Walmart	Generic drugs	$4 copayment (1-30 days); $8 copayment (31-60 days); $12 copayment (61-90 days)	Not covered	If you work within 5 miles of a Walmart or Sam's Club pharmacy, only drugs purchased at Walmart or Sam's Club are covered, unless an exception applies. If you work more than 5 miles from a Walmart or Sam's Club pharmacy, a 30-day supply of generic drugs purchased at a pharmacy in the OptumRx network will be covered at the same rate. If you work more than 5 miles from a Walmart or Sam's Club pharmacy, generic drugs exceeding a 30-day supply must be purchased at a Walmart or Sam's Club pharmacy or through mail-order. *See "The Pharmacy Benefit" section in the SPD for exceptions. Mail-order prescription drugs will be covered only when purchased through Walmart/Sam's Club or OptumRx mail-order pharmacy regardless of work location. 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.
	Preferred brand drugs	Greater of $50 or 25% coinsurance, deductible doesn't apply (30 days)	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	Non-Preferred brand drugs are not covered.
	Specialty drugs	Greater of $50 or 20% coinsurance, deductible doesn't apply (30 days)	Not covered	Preauthorization may be required. *See the "Preauthorization" section in the SPD. Specialty drugs are only available at a Walmart Specialty or OptumRx Specialty pharmacy. Prescriptions for specialty drugs are not covered when purchased at a non-network pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	Preauthorization may be required. *See "Preauthorization" section in SPD.
	Physician/surgeon fees	*Preferred:* 25% coinsurance *Nonpreferred:* 50% coinsurance	50% coinsurance	If no Preferred Provider is available, in-network covered services will be paid at the Preferred Provider rate. Preauthorization may be required. *See "Preauthorization" section in SPD.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay the least for Preferred Providers)	Out-of-Network Provider (You pay the most)	
If you need immediate medical attention	Emergency room care	$300 copayment, in addition to any remaining deductible	$300 copayment, in addition to any remaining deductible and 0% coinsurance for emergency services; or 50% coinsurance for non-emergency services;	If you are admitted to the hospital directly from the emergency room, the copayment is waived.
	Emergency medical transportation	25% coinsurance	25% coinsurance for emergency services; no coverage for non-emergency services	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. Non-emergency transport is not covered, except if pre-authorized.
	Urgent care	*Preferred:* 25% coinsurance *Nonpreferred:* 50% coinsurance	50% coinsurance	If no Preferred Provider is available, in-network covered services will be paid at the Preferred Provider rate.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	If no Preferred Provider is available, in-network covered services will be paid at the Preferred Provider rate. Preauthorization may be required. *See the "Preauthorization" section in SPD. 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% (deductible doesn't apply), through the Centers of Excellence (COE) Program. When not performed through the COE Program, spine and weight loss surgeries and organ and tissue transplants are not covered, even if performed by a network provider, unless an exception applies. When not performed through the COE Program, a hip or knee replacement is subject to the out-of-network deductible and there is a 50% coinsurance, even if performed by a network provider, unless an exception applies. *See the "Centers of Excellence" section in SPD.
	Physician/surgeon fees	*Preferred:* 25% coinsurance *Nonpreferred:* 50% coinsurance	50% coinsurance	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay the least for Preferred Providers)	Out-of-Network Provider (You pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	50% coinsurance	Preauthorization may be required. *See the "Preauthorization" section in the SPD. Doctor On Demand visits have a $4 copayment, which is waived during the COVID-19 national emergency.
	Inpatient services	25% coinsurance	50% coinsurance	
If you are pregnant	Office visits	Preventive Care: *Preferred:* No charge, N*onpreferred:* 50% coinsurance; deductible doesn't apply All other services: *Preferred:* 25% coinsurance; *Nonpreferred:* 50% coinsurance	50% coinsurance; deductible does not apply to preventive care	If no Preferred Provider is available, in-network covered services will be paid at the Preferred Provider rate. *See the "Medical Plan" section of SPD. Cost sharing does not apply for network preventive services. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Depending on the type of services, a copayment, coinsurance, or deductible may apply. Preauthorization may be required for stays exceeding standard length of stay for maternity.
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Preauthorization may be required. *See the "Preauthorization" section in the SPD. Home health care is limited to 100 visits per calendar year. Other limitations may apply. *See the "When limited benefits apply to the Associates' Medical Plan" section in the SPD.
	Rehabilitation services	25% coinsurance	50% coinsurance	Preauthorization may be required. *See the "Preauthorization" section in the SPD. See the "When Limited Benefits Apply to the Associates' Medical Plan" section of the SPD. Rehabilitation services are limited as follows: • Physical therapy limited to 20 visits/year. • Occupational therapy limited to 20 visits/year. • Speech therapy limited to 60 visits/year. • Certain other inpatient rehabilitation services are limited to 120 days per condition.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay the least for Preferred Providers)	Out-of-Network Provider (You pay the most)	
	Habilitation services	25% coinsurance	50% coinsurance	Preauthorization may be required. *See "Preauthorization" section in the SPD. Habilitation services are limited to Applied Behavior Analysis therapy.
	Skilled nursing care	25% coinsurance	50% coinsurance	Preauthorization may be required. *See the "Preauthorization" 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.
	Durable medical equipment	25% coinsurance	50% coinsurance	Preauthorization may be required. *See the "Preauthorization" section in the SPD. Orthopedic shoes when prescribed by a physician are limited to one pair per calendar year.
	Hospice services	25% coinsurance	50% coinsurance	Preauthorization may be required. *See the "Preauthorization" section in the SPD. Hospice services are limited to 365 days per illness.
If your child needs dental or eye care	Children's eye exam	No charge, deductible doesn't apply	50% coinsurance; deductible doesn't apply	Limited to screening that qualifies as preventive services. *See the "Preventive Care Program" section in the SPD for covered preventive services and applicable limitations.
	Children's glasses	Not covered	Not covered	Glasses are limited when a certain medical diagnosis applies or form 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 plan.

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
- Chiropractic care
- Dental care
- Glasses
- Hearing aids
- Non-preferred brand drugs
- Routine eye care
- Weight loss programs

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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) • 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, kwiijigo 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 coinsurance	25%
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:	
Cost Sharing	
Deductibles	$1,750
Copayments	$10
Coinsurance	$2,700
What isn't covered	
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 coinsurance	25%
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:	
Cost Sharing	
Deductibles	$1,750
Copayments	$100
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,670**

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

The plan's overall deductible	$1,750
Specialist coinsurance	25%
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:	
Cost Sharing	
Deductibles	$1,750
Copayments	$300
Coinsurance	$200
What isn't covered	
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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