2027 Associate Benefits Book

Summary Plan Descriptions

What's inside

Medical plan
Pharmacy benefit
Dental plan
Vision plan
Disability plans
Life insurance
Walmart 401(k) Plan
Associate Stock Purchase Plan
...and much more

Effective January 1, 2027
Walmart 401(k) Plan effective February 1, 2027
Associate Stock Purchase Plan effective April 1, 2027

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Welcome to your 2027 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.



Lots of information. So easy to find.

When you download the 2027 *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!

Contents

The Associates' Health and Welfare Plan

Eligibility, enrollment, and effective dates 4

Eligibility, enrollment, and effective dates for associates in Hawaii 78

The medical plan 86

The pharmacy benefit 138

Health savings account (HSA) 146

The dental plan 154

The vision plan 164

Associate assistance resources 170

COBRA 176

Full-time hourly short-term disability 184

Salaried short-term disability 196

Truck driver short-term disability 206

Full-time hourly and salaried long-term disability 216

Truck driver long-term disability 224

Company-paid life insurance 232

Optional associate life insurance 238

Optional dependent life insurance 244

Business travel accident insurance 250

Accident insurance 258

Accidental death and dismemberment (AD&D) insurance 266

Critical illness insurance 274

Claims and appeals 282

Legal information 316

The Walmart 401(k) Plan 330

The Associate Stock Purchase Plan (ASPP) 362

For more information 374

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: Mail Stop 3610–Benefits Total Rewards Team, Custodian of Records, 806 Excellence Drive, Bentonville, Arkansas 72716-3610.

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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 está disponible en Español. Si usted desea una copia en Español, favor de ver su Representante de Personal.

Eligibility, enrollment, and effective dates

The Associates' Health and Welfare Plan	6
Chapter overview	6
Associate eligibility	7
Part-time hourly associates and temporary associates: eligibility checks for medical benefits	10
Dependent eligibility	20
Legal documentation for dependent coverage	21
Dependents who are not eligible	21
When your dependent becomes ineligible	22
When you enroll for benefits	22
When coverage is effective	24
If you leave Walmart and are rehired	24
Effective dates for coverage under the Plan	25
Enrollment and effective dates by job classification	26
Paying for your benefits	35
Keeping your coverage payments current	38
Permitted election changes outside Annual Enrollment	41
Medical child support orders	45
When your Plan coverage ends	46
If your work location changes	47
If your job classification changes	49
Transferring from one job classification to another	50

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. See page 324 in the **Legal information** chapter for more details.

Eligibility, enrollment, and effective dates

Resources		
Find what you need	**Online**	**Other resources**
• Enroll in Walmart benefits • Notify People Services within 60 days of an election change event	**One.Walmart.com/Enroll**	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 for benefits while on a leave of absence		See the **Keeping your coverage payments current** section in this chapter for detailed information. Failure to pay amounts owed to keep coverage current will result in cancellation of coverage retroactive to the last date for which payments for coverage were made. You may pay by credit or debit card with a Visa, MasterCard, American Express, or Discover card by going to **One.Walmart.com/Enroll** and choosing "make a payment" or 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. If you are unable to pay the amount owed for coverage, the Plan will accept payments made by someone else on your behalf.

What you need to know about eligibility, enrollment, and effective dates

- If you are an hourly Hawaii associate:
  - **Medical and short-term disability and paying for coverage while on a leave of absence:** see the chapter titled **Eligibility, enrollment, and effective dates for associates in Hawaii**.
  - **Benefits other than medical and short-term disability:** see this chapter.
- Your job classification determines which benefits you are eligible to enroll in and when you are first eligible to enroll. When you are first eligible to enroll you will have an "initial enrollment period." Your enrollment communications will tell you when your initial enrollment period ends. Make sure you enroll by the deadline. See the **Enrollment and effective dates by job classification** section of this chapter for details.
- If you do not enroll during your initial enrollment period:
  - **Medical, dental, vision, short-term disability enhanced, long-term disability, critical illness, accident, or accidental death and dismemberment (AD&D):** you will not have another opportunity to enroll until Annual Enrollment or after you have an election change event.
  - **Truck driver long-term disability:**
    - You will not have another opportunity to enroll until Annual Enrollment or after you have an election change event.
    - You will be required to provide Proof of Good Health if you elect coverage at a later date.
  - **Optional life insurance benefits:** you may be required to provide Proof of Good Health for optional associate or spouse life insurance if you enroll at a later date.
- Transferring from one job classification to another may affect your eligibility for benefits, including which benefits you are eligible for, and when. Review the **If your job classification changes** section in this chapter for important details.

The Associates' Health and Welfare Plan

Walmart Inc. (Walmart) sponsors the Associates' Health and Welfare Plan (the Plan), which is a comprehensive employee benefit plan that offers medical, dental, vision, associate assistance resources, disability, life insurance, business travel accident insurance, accident insurance, accidental death and dismemberment insurance, and critical illness insurance benefits to eligible associates and their eligible family members. Eligibility for these benefits is described in this chapter, and the terms and conditions of the specific benefits offered under the Plan are described in the applicable chapters of this 2027 *Associate Benefits Book*. You are enrolled automatically 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 **Associate eligibility** section in this chapter for details about your eligibility, the **Dependent eligibility** section in this chapter for information about dependent eligibility, including which family members may be enrolled for coverage, and 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.

Eligibility for benefits and the terms and conditions of each benefit are described in the Plan document, insurance policies governing insured benefits, and this 2027 *Associate Benefits Book*. To the extent that any information provided to you through other sources, whether oral or written, including any AI-generated material or a third-party administrator's response to a request for information, conflicts with the Plan document, applicable insurance policies, or this 2027 *Associate Benefits Book*, the terms in the Plan document, applicable insurance policy, or 2027 *Associate Benefits Book* will control. In the event of any conflict between an insurance policy governing insured benefits and the Plan document or this 2027 *Associate Benefits Book*, terms of the insurance policy will control. In the event of any conflict between terms of the Plan document and this 2027 *Associate Benefits Book*, the terms of the Plan document will control. If you wish to review the Plan document, please refer to the **Legal information** chapter of this 2027 *Associate Benefits Book*, which discusses your right to review the Plan document.

If you disagree with a decision regarding your eligibility or enrollment or a decision regarding a claim for benefits, the Plan has a specific process you must follow to appeal the decision. See the **Claims and appeals** chapter for a detailed description of the appeals process. Failure to follow the Plan's claims and appeal process may adversely impact your ability to dispute a decision.

Chapter overview

This chapter contains a lot of useful information that will be important to you not just when you are first eligible for benefits, but for as long as you are employed by Walmart. In some cases, information in this chapter and other chapters in the *Associate Benefits Book* will be relevant even after you are no longer employed (e.g., if you elect COBRA continuation coverage). It contains all of the information you need about what benefits you are eligible for; when you're eligible; what dependents you can cover; when you can enroll in, or change, those benefits; when coverage is effective; how payroll deductions are handled; the impact of certain events on your benefits eligibility; and when your coverage ends.

Note: Keep in mind that the facts of your individual situation will determine the answers to your specific questions and may require the application of more than one rule in any one particular section of this chapter. It's important to review the entire chapter to fully understand your benefits rather than a single section by itself.

Depending on your situation, you might need to reference information in this chapter at different times. To help you focus on what information would be most helpful to you at any given time, here is an overview to get you pointed in the right direction:

1	**Your employment classification** Your employment classification in Walmart's payroll system has an impact on your benefits. See page 7.
2	**Becoming eligible for benefits** • Who can you cover? See page 20. • What benefits are you eligible for? See page 26. • When should you enroll? See page 26. • When is your coverage effective? See page 26.
3	**Paying for your benefits** How do you pay for benefits? See page 35. When do you have to make special arrangements to pay for your benefits? See page 38.
4	**Events that can affect your coverage** What might impact your benefits? • If you go on a leave of absence: see page 39. • A life event like a change in your family status: see page 42. • Special circumstances like a legal order or eligibility for a special enrollment period: see page 43.

Associate eligibility

Your job classification in Walmart's payroll system determines the benefits you are eligible to enroll in. When you are eligible to enroll in benefits depends on a number of factors, which may include your date of hire, average weekly hours, and whether you have transferred from one job classification to another. If your job classification is one that requires a specific number of average weekly hours to be eligible, that average will be noted in the sections that follow. Hours worked are determined on a look-back basis, as described in the sections that follow. In addition, for some benefits, you may be required to meet an eligibility waiting period or provide Proof of Good Health before benefits you enrolled in become effective.

This section discusses the general eligibility requirements applicable to a specific job classification. See the **Enrollment and effective dates by job classification** section in this chapter for a list of the benefits you are eligible for based on your job classification and any waiting period or Proof of Good Health requirements that may apply.

Note: If you experience a transfer from one job classification to another, the rules discussed in this section could be impacted by that transfer and you should review the **Transferring from one job classification to another** section later in this chapter.

Walmart's expectation is that you will provide correct and accurate information when applying for or enrolling in benefits. If you do not, you may be subject to the loss of benefits, including retroactive cancellation of coverage as permitted by law, and/or termination of employment. Additionally, some insurers of insured benefits may retain the right, up to two years after your coverage becomes effective, to reexamine statements you make during the application process. If material facts are found to have been stated inaccurately, it may impact your eligibility for the benefit.

To review Walmart's policy about intentional dishonesty, refer to the Code of Conduct, which can be found on **One.Walmart.com**. See the **Legal documentation for dependent coverage** section later in this chapter for information about documents that may be requested of you to verify dependent eligibility.

Employment classification for determining benefit options	This includes
Full-time hourly associate	• Full-time hourly associates, except full-time hourly Vision Center managers • Full-time hourly pharmacists, except California pharmacists • Full-time hourly field supply chain associates • Full-time hourly field supervisors in stores and clubs • Full-time hourly associates in Hawaii, except for medical and short-term disability benefits • Full-time hourly city driver associates
Full-time hourly Vision Center manager	• Full-time hourly Vision Center managers
Part-time hourly or temporary associate	• Part-time hourly associates, except part-time OTR truck drivers • Temporary associates
Part-time OTR truck driver	• Part-time OTR truck driver associates
Management or salaried associate	• Salaried associates • Management trainees • Full-time hourly California pharmacists • Full-time OTR truck driver associates

Full-time hourly associate eligibility

To be eligible to enroll in benefits as a full-time hourly associate, you must be classified in Walmart's payroll system as a full-time hourly associate. This includes full-time hourly pharmacists (except full-time hourly California pharmacists), full-time hourly field supply chain associates, full-time hourly city driver associates, and full-time hourly field supervisors in stores and clubs, but excludes full-time hourly Vision Center managers.

Full-time hourly California pharmacists are eligible for benefits under the same terms as management associates. If you are a full-time hourly Vision Center manager, see below.

If you are a full-time hourly associate in Hawaii, refer to the chapter titled **Eligibility, enrollment, and effective dates for associates in Hawaii** for special eligibility rules for medical and short-term disability benefits.

Full-time hourly vision center manager eligibility

To be eligible to enroll in benefits as a full-time hourly Vision Center manager, you must be classified in Walmart's payroll system as a full-time hourly Vision Center manager.

Part-time hourly associate eligibility

To be eligible to enroll in benefits as a part-time hourly associate, you must be classified in Walmart's payroll system as a part-time hourly associate. If you are a part-time over-the-road (OTR) truck driver, see the next column.

In addition to being classified in Walmart'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 associates in Hawaii are subject to different eligibility rules for medical and short-term disability benefits. Refer to the chapter titled **Eligibility, enrollment, and effective dates for associates in Hawaii** for details.

If you are a part-time hourly associate, the hours you work will be reviewed to determine your eligibility for medical benefits. If you become eligible for medical benefits during your first 52 weeks of employment, you will also become eligible for other voluntary benefits at the same time. Otherwise, you will become eligible for other voluntary benefits after you have been employed for 52 weeks, regardless of whether you are eligible for medical benefits. For more information, see the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in this chapter for details.

Temporary associate eligibility

To be eligible to enroll in benefits as a temporary associate, you must be classified in Walmart's payroll system as a temporary associate. If you are classified as a temporary associate, you are subject to the eligibility rules described in this section, regardless of whether you work on a full-time or part-time basis or whether you are in an hourly or management role.

In addition to being classified in Walmart'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 following exceptions:

- Temporary hourly associates in the field supply chain must work an average of at least 24 hours per week.
- Temporary associates in Hawaii are subject to different rules. Refer to the chapter titled **Eligibility, enrollment, and effective dates for associates in Hawaii** for details.

If you are a temporary associate, the hours you work will be reviewed to determine your eligibility for medical benefits. If you become eligible for medical benefits during your first 52 weeks of employment, you will also become eligible for other voluntary benefits at the same time. Otherwise, you will become eligible for other voluntary benefits after you have been employed for 52 weeks, regardless of whether you are eligible for medical benefits, subject to Plan terms. For more information, see the section titled **Part-time hourly associates and temporary associates: eligibility checks for medical benefits**.

Part-time OTR truck driver eligibility

To be eligible to enroll in benefits as a part-time OTR (over the road) truck driver, you must be classified in Walmart's payroll system as a part-time OTR truck driver. You do not need to work a minimum number of hours per week to be eligible to enroll in medical benefits as a part-time OTR truck driver.

Management associate eligibility (including full-time OTR truck drivers)

To be eligible to enroll in benefits as a management or salaried associate, you must be classified in Walmart's payroll system as a management associate, management trainee, full-time hourly California pharmacist, or full-time OTR truck driver.

Individuals who are not eligible

Unless stated otherwise, 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 Walmart or any participating affiliate:

- A leased employee
- A nonresident alien (except that for purposes of optional associate life insurance, optional dependent life insurance, accidental death and dismemberment insurance, and business travel accident insurance, nonresident aliens classified as full-time in the U.S. payroll system will be eligible; and nonresident aliens covered under a specific insurance policy for expatriates or third-country nationals who are employed by Walmart will be eligible for benefits described in those policies, subject to the terms of the policies)
- An independent contractor
- A consultant
- An associate residing outside the United States, except that associates covered under a specific insurance policy

for expatriates will be eligible for the benefits described in those policies, subject to the terms of the policies
- An individual who is not classified as an associate of Walmart or its participating affiliates
- An associate who is enrolled in a Medicare prescription drug plan (applicable only to eligibility for medical plan and pharmacy benefit options, including HMO options)
- An associate covered by a collective bargaining agreement, to the extent that the agreement does not provide for participation in a benefit offered under the Plan

Associates residing in Puerto Rico are not eligible for the benefits described in this 2027 *Associate Benefits Book*. Associates residing in Puerto Rico should refer to the current *Associate Benefits Book* for Puerto Rico associates for information on benefits available to them under the Plan.

Eligibility information for additional associate categories

Associates who enroll in medical benefits through an HMO option: HMO options are available for some work locations. The policies and enrollment materials for HMO options may describe different eligibility requirements and waiting periods than those described in this chapter. If there is any difference between an HMO option's eligibility terms and the eligibility terms applicable to medical coverage under the Plan as described in this chapter, eligibility terms in this chapter will control. Terms related to covered benefits under an HMO option are described in materials provided separately by that HMO insurer. Find more information about HMO coverage, including how to contact the HMO, visit **One.Walmart.com/HMO**.

In addition, some HMOs require participants to agree to arbitration terms, where permitted by law, before coverage under the HMO will become effective.

If you enroll for an HMO by online enrollment: You will complete the arbitration agreement as part of the online enrollment process.

If you enroll for an HMO by calling People Services: You may need to separately complete an arbitration agreement and submit the form to the HMO. Contact the HMO directly to learn how to submit the completed form.

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 within 60 days, you will not have medical coverage under the Associates' Medical Plan (AMP) and will not be able to enroll again until the next Annual Enrollment or until you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.

Hawaii associates: If you are a full-time hourly, part-time hourly, or temporary associate in Hawaii, special rules govern medical and short-term disability benefits eligibility and enrollment. See the chapter titled **Eligibility, enrollment, and effective dates for associates in Hawaii**. If you are a management associate in Hawaii, the eligibility and enrollment terms described in this **Eligibility, enrollment, and effective dates** chapter apply for all benefits.

Associates covered as a dependent of another associate: If you are covered as a dependent under another associate's medical, dental, and/or vision coverage, you may not select coverage under one of these benefits (e.g., dental) as an associate while continuing coverage under the other benefits as a dependent.

If you currently have medical, dental, and/or vision coverage as a dependent of another associate and you enroll in your own medical, dental, or vision coverage as an associate, you will no longer be an eligible dependent of that other associate. Enrollment as an associate will end your dependent coverage under the medical, dental, and vision plans as of the date your elections are effective.

Example 1: A mother and her child are both associates. The mother enrolled in family coverage for medical and vision and covers her child as a dependent under those coverages but has chosen not to enroll in dental coverage. When the child becomes eligible for medical, dental, and/or vision coverage as an associate, the child has two choices:
- Continue as a dependent under the mother's coverage, without dental coverage, or
- Enroll as an associate in medical, dental, and/or vision. Enrollment in any of these coverages would make the child an ineligible dependent and would remove the child from the medical and vision coverage elected by the mother as of the date the child's elections are effective

Example 2: A father, his daughter, and the daughter's husband are all associates. Currently, the father carries associate + child(ren) coverage and covers his daughter as a dependent. When the daughter's husband becomes eligible for coverage and elects to cover his wife as a dependent, she will no longer be an eligible dependent under her father's coverage, effective as of the date the husband's election is effective.

Example 3: If you are an eligible associate who is enrolled in medical, dental, and/or vision coverage as an associate and you marry another eligible associate, you may not be eligible for medical, dental, and/or vision coverage as a dependent under the other associate's coverage. Contact People Services at **800-421-1362** for more information.

If you are the dependent of another associate, you should carefully consider your options when making enrollment decisions.

Localized associates: If you have been approved by Walmart as having localized status and are in Walmart's U.S. payroll system, 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.

Your prior service with Walmart International will count for purposes of eligibility and any applicable waiting periods. In addition, if you enroll within the first 60 days of your transfer you will be considered newly eligible for purposes of showing Proof of Good Health for optional life insurance.

Obtaining a Social Security number is not required to enroll in benefits under the Plan. Any applicable waiting period is waived. You are not eligible for expatriate coverage under the Plan. If you are a localized associate in Walmart's U.S. payroll system and an eligible dependent resides outside the United States, medical claims will be processed as network claims 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. In that case, you or your enrolled dependents must file a claim for reimbursement under the Plan's claims procedures.

Associates transferring from Puerto Rico: If you transfer from a work location in Puerto Rico to a work location in the United States, your service in Puerto Rico will count for purposes of eligibility and any applicable waiting periods.

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

Note: The rules discussed below could be impacted by transferring between job classifications or terminating employment and being rehired into a different job classification. You should review the **Transferring from one job classification to another** section later in this chapter for more information if:

- You experience a transfer from one job classification to another, or
- You terminated employment when you were a part-time hourly associate and are rehired less than 13 weeks after your date of termination in a different job classification, in which case you will be treated as if you had never terminated for purposes of determining eligibility and effective dates

If you are a part-time hourly associate or temporary associate, your eligibility to enroll in medical benefits will depend on your average hours worked per week. Hours worked are determined on a look-back basis, as described in the sections below. In this section you will find descriptions of three different types of eligibility checks conducted to determine initial and ongoing eligibility for medical and other voluntary benefits for part-time hourly associates and temporary associates.

- **During your first 52 weeks of employment:** Hours are measured every 60 days during your first 52 weeks of employment to determine eligibility for medical and other voluntary benefits coverage during the first 52 weeks. See **Your 60-day eligibility checks during your first 52 weeks of employment** in this section.
- **At 52 weeks of employment:** Hours worked over your entire first 52 consecutive weeks of employment are measured one time, at the end of the 52 weeks, to determine eligibility for medical benefits. See **Your one-time eligibility check at 52 weeks of employment** in this section.
- **After one year of employment:** Hours worked during a 52-week period are measured each year to determine eligibility for medical benefits in the next calendar year. See **Your annual eligibility check** in this section.

To check your hours for the current measurement period, go to the eligibility-by-hours tool (EBH) at One.Walmart.com/EBH.

Note: The eligibility checks described in this section do not apply to part-time hourly associates and temporary associates in Hawaii. Refer to the chapter titled **Eligibility, enrollment, and effective dates for associates in Hawaii** for details.

Your 60-day eligibility checks during your first 52 weeks of employment

If you are a new part-time hourly associate or temporary associate, the number of hours you work in the first 59 days of your employment, beginning with your hire date, will be measured on your 60th day of employment to determine whether you have worked the required number of hours, which is expressed as an average number per week, during that measurement period to be eligible for medical and other voluntary benefits. See below for your required number of hours.

If you are a part-time hourly or temporary associate[1] in Walmart's system and are:	You must work this number of hours in a measurement period during your first 52 weeks of employment:
• An hourly pharmacist hired on or after Feb. 1, 2012[2] • In the field supply chain	An average of 24 hours per week
All other part-time hourly associates and temporary associates	An average of 30 hours per week

[1] Part-time hourly associates and temporary associates in Hawaii: refer to the chapter titled **Eligibility, enrollment, and effective dates for associates in Hawaii** for details.

[2] Part-time hourly pharmacists hired before Feb. 1, 2012 do not have an hours requirement.

If you work the required number of hours during your first 59 days of employment without a break in employment of more than 30 days during the measurement period, you will be eligible to enroll in medical and other voluntary benefits that are available to part-time hourly associates and temporary associates soon after the measurement period ends. If eligible, your benefits will be effective on the first day of the month in which your 89th day of employment occurs, assuming you enroll before the end of your initial enrollment period. If you work the required number of hours in this 59-day measurement period, your hours will not be measured again during your first 52 weeks of employment, even if you do not enroll in benefits during your initial enrollment period. The next time your eligibility for medical benefits will be checked is the annual eligibility check described in **Your annual eligibility check** in this section.

Example: If your date of hire is April 16, 2027, your hours worked from that day through June 13, 2027, will be measured on your 60th day of employment, which is June 14, to determine whether you have worked the required number of hours during that 59-day measurement period. If you work the required number of hours during this first measurement period and you do not have a break in employment of more than 30 days during the measurement period, you will be eligible to enroll in benefits that are available to part-time hourly associates and temporary associates. If you are eligible, your benefits will be effective on the first day of the month in which your 89th day of employment occurs, assuming you enroll before the end of your initial enrollment period. Because your 89th day of employment would be July 13, your benefits will be effective on July 1, assuming you enroll before the end of your initial enrollment period. Your hours will not be measured again during your first 52 weeks of employment, even if you do not enroll during your initial enrollment period. The next time your eligibility for medical benefits will be checked is the annual eligibility check described in **Your annual eligibility check** in this section.

If you do not work the required number of hours during your first 59 days of employment, your hours will be measured over the next 60 days of employment, with the first day of this second measurement period being your 60th day of employment. If you do work the required number of hours during this second measurement period without a break in employment of more than 30 days during the measurement period, you will be eligible to enroll in medical and other voluntary benefits that are available to part-time hourly associates and temporary associates. If you are eligible, your benefits will be effective on the first day of the month in which your 89th day of employment occurs, as measured from the first day of the applicable measurement period (in this case, the second measurement period), assuming you enroll before the end of your initial enrollment period. Your hours will not be measured again during your first 52 weeks of employment, even if you do not enroll in benefits during your initial enrollment period. The next time your eligibility for medical benefits will be checked is the annual eligibility check described in **Your annual eligibility check** in this section.

Example: If your date of hire is April 16, 2027, your hours worked from that day through June 13, 2027, will be measured on your 60th day of employment, June 14. If you do not work the required number of hours over this 59-day measurement period, the next measurement period will be the 60-day period that runs from June 14 through August 12. The hours you work over this 60-day measurement period will be measured on August 13. If you work the required number of hours during this second measurement period and you do not have a break in employment of more than 30 days during the measurement period, you will be eligible to enroll in benefits that are available to part-time hourly associates and temporary associates, which would be effective on the first day of the month that contains the 89th day of employment, counted from the first day of the second measurement period, assuming you enroll before the end of your initial enrollment period. Because the 89th day of employment, beginning with June 14, occurs on September 10, your benefits would be effective on September 1, assuming you enroll before the end of your initial enrollment period. Your hours will not be measured again during your first 52 weeks of employment, even if you do not enroll during your initial

enrollment period. The next time your eligibility for medical benefits will be checked is the annual eligibility check described in **Your annual eligibility check** in this section.

If you do not work the required number of hours during the second measurement period, these 60-day eligibility checks will continue over each subsequent 60-day measurement period, with the first day of the third measurement period being the day following the last day of your second measurement period, and so on. The 60-day eligibility checks will continue until the earlier of the date on which you are determined to have worked the required number of hours during any 60-day measurement period or the date on which you have been employed for 52 weeks. If you do not work the required number of hours in any measurement period during your first 52 weeks of employment, your hours will be checked at 52 weeks to determine whether you have worked the required hours over your entire first 52 weeks of employment. This one-time eligibility check is described in **Your one-time eligibility check at 52 weeks of employment** in this section. There will be a maximum of six 60-day eligibility checks during your first 52 weeks of employment.

If you become eligible for benefits during your first 52 weeks of employment as the result of working the required number of hours in a 60-day measurement period, your eligibility for medical benefits continues through the end of the second calendar year following the date you met your eligibility check requirements (your "medical coverage eligibility period"), assuming you remain a part-time hourly associate or temporary associate. In the examples above, your medical coverage eligibility period would continue through the end of the 2028 calendar year, which is the end of the second calendar year following the date you met your eligibility check requirements. Your eligibility for the other voluntary benefits described in the **Enrollment and effective dates by job classification** section will continue while you remain a part-time hourly associate or temporary associate, subject to applicable Plan terms. However, if you do not enroll in medical benefits when first eligible and prior to the end of the initial enrollment period, you will not be permitted to enroll in medical benefits during the remainder of your medical coverage eligibility period except during an Annual Enrollment period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section later in this chapter. Likewise, if you do not enroll in most voluntary benefits (other than optional life insurance) during your initial enrollment period, you will also not be permitted to enroll except during an Annual Enrollment period, or if you have an election change event. Once eligible for voluntary benefits, you may enroll in optional life insurance at any time. The next time your eligibility for medical benefits will be checked is the annual eligibility check described in **Your annual eligibility check** in this section.

Example: In the earlier examples, your medical benefits would continue through the end of 2028, unless you drop coverage during the 2027 Annual Enrollment period (for the 2028 calendar year) or if you have an election change event. If you do not elect medical coverage during your initial enrollment period, your eligibility for medical benefits will continue through 2028. However, you will not be permitted to change your election and enroll in medical coverage except during an Annual Enrollment period, or if you have an election change event. Your eligibility for the other voluntary benefits will continue while you remain a part-time hourly associate or temporary associate, subject to applicable Plan terms. However, if you do not enroll in most voluntary benefits during your initial enrollment period, you will also not be permitted to enroll except during an Annual Enrollment period, or if you have an election change event. Once eligible for voluntary benefits, you may enroll in optional life insurance at any time.

If you take time off during any 60-day measurement period

If you take any type of unpaid time off during any 60-day measurement period, the total number of days of unpaid time off in any 60-day measurement period will still be used to determine whether you have worked the required number of hours during that measurement period to be eligible for medical coverage (even if you work no hours on one or more days).

However, if your absence is an approved leave of absence recorded in Walmart's system as a leave of absence (including for jury duty, Family and Medical Leave Act of 1993 ["FMLA"] leave, or military leave), the number of days during the 60-day measurement period that you were on an approved leave of absence will not be considered in the measurement of your hours. The determination of whether you have met the required number of hours will be based on the number of days during the 60-day measurement period, less the number of days that you were on an approved leave of absence. For example, if you take an approved leave of absence during five days of the 60-day measurement period, your 60-day eligibility check will include 55 days rather than 60.

If you leave Walmart during your first 52 weeks of employment and are rehired

Note: If you terminated employment when you were a part-time hourly associate or temporary associate and are rehired less than 13 weeks after your date of termination in a different job classification, for purposes of determining eligibility and effective dates you will be treated as if you had never terminated, and instead, had transferred from one job

classification to another. You should review the **Transferring from one job classification to another** section later in this chapter for more information and benefits eligibility.

For purposes of the 60-day eligibility checks during your first 52 weeks of employment, if you terminate employment as a part-time hourly associate or temporary associate during that 52-week period and return to employment as a part-time hourly associate or temporary associate within 30 days after leaving, your eligibility for medical and other benefits upon being rehired will be determined in accordance with the rules in the chart below:

If you leave during your first 52 weeks of employment and are rehired within 30 days	
If you had not passed a 60-day eligibility check prior to your termination date	Rules applicable to the 60-day eligibility checks will continue to apply, based on your original hire date, as if you had not terminated. The 60-day eligibility check for each measurement period will consider only the days that you were employed during the measurement period. For example, if you have a 10-day period of termination during a 60-day measurement period, the 60-day eligibility check for that period will consider only the 50 days you were employed during the measurement period. However, if you took any time off during the period of employment, see **If you take time off during any 60-day measurement period** in this section.
If you had passed a 60-day eligibility check prior to your termination date	You will retain your previous eligibility status for medical benefits through the end of your medical coverage eligibility period. Your eligibility for the other voluntary benefits will continue while you remain a part-time hourly associate or temporary associate, subject to applicable Plan terms. • If you were enrolled in medical or other voluntary benefits when you terminated, the coverage that was in effect (or the most similar coverage offered under the Plan) on your termination date will be reinstated, with a break in coverage during the period of your absence for which payments for coverage were not made. Except as provided below, and subject to otherwise applicable Plan terms, you will not be permitted to change the reinstated coverage (other than optional life) until the next Annual Enrollment period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section in this chapter. • Except as provided below, and subject to otherwise applicable Plan terms, if you were not enrolled in medical or other voluntary benefits on your termination date, you may not enroll in those benefits (other than optional life) when you return, until the next Annual Enrollment period, or if you have an election change event. If you terminate in one calendar year after the Annual Enrollment period for the following calendar year has ended and you return before December 31 of the year in which you terminated, changes you made during Annual Enrollment (or coverage you defaulted to because you did not make any changes during Annual Enrollment) will be implemented. If you terminate in one calendar year and return to work in the following calendar year and you fall into one of the following categories, you may call People Services at **800-421-1362** to enroll in medical or other voluntary benefits within 60 days of returning to work: • You were eligible to enroll in benefits in the year you terminated but were not enrolled. • You were eligible and enrolled in benefits in the year you terminated and would like to add a dependent child (if applicable) in the year you return to work. After this 60-day period, and subject to otherwise applicable Plan terms, you will not be permitted to change your benefit elections (other than optional life) until the next Annual Enrollment, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section in this chapter.
See the **If you leave Walmart and are rehired** section in **The medical plan** chapter for information on your deductible, out-of-pocket maximum, HRA, and maximum lifetime benefit applicable to fertility benefits under the Centers of Excellence family building program, if you terminate employment and then return to work. See the **If you leave Walmart and are rehired** section in **The dental plan** chapter for information on your required minimum enrollment period, deductible, and waiting period for orthodontia assistance if you terminate employment and then return to work.	

Subject to otherwise applicable Plan terms, if you are rehired more than 30 days after leaving during your first 52 weeks of employment, you will be treated as a new associate for purposes of the 60-day check for medical and other voluntary benefits and will be subject to the 60-day eligibility checks described in **Your 60-day eligibility checks during your first 52 weeks of employment** in this section, even if you had passed a 60-day eligibility check prior to your termination date. However, if you return to employment less than 13 weeks after your termination date, see **Your one-time eligibility check at 52 weeks of employment** and **Your annual eligibility check** in this section for information about how your break in service is treated for purposes of those eligibility checks.

If you terminated employment and are rehired 13 weeks or more after your termination date, regardless of job classification, you will be treated as a new associate, subject to otherwise applicable Plan terms.

Your one-time eligibility check at 52 weeks of employment

If you are a part-time hourly or temporary associate and were not offered medical coverage during your first 52 weeks of employment because you did not work the required number of hours in any 60-day measurement period to be eligible for medical and other voluntary benefits, your eligibility for medical benefits will be checked again at 52 weeks of employment. The measurement period for the one-time check is the entire 52 consecutive weeks beginning on your date of hire and is referred to in this section as the "initial measurement period." Hours worked during the initial measurement period will be measured to determine whether you have worked the required number of hours, which is expressed as an average number per week, to be eligible for medical benefits. See below for your required number of hours.

If you are a part-time hourly or temporary associate[1] in Walmart's system and are:	You must work this number of hours during your initial measurement period:
• An hourly pharmacist hired on or after Feb. 1, 2012[2] • In the field supply chain	An average of 24 hours per week
All other part-time hourly associates and temporary associates	An average of 30 hours per week

[1] Part-time hourly associates and temporary associates in Hawaii: refer to the chapter titled **Eligibility, enrollment, and effective dates for associates in Hawaii** for details.

[2] Part-time hourly pharmacists hired before Feb. 1, 2012 do not have an hours requirement.

If you work the required number of hours during your initial measurement period without a break in employment of 13 weeks or more, you will be eligible to enroll in medical benefits. If eligible, your benefits will be effective on the first day of the second calendar month following the day prior to your one-year anniversary date, assuming you enroll before the end of your initial enrollment period. You may also be eligible for several other voluntary benefits, regardless of whether you work the required number of hours to be eligible for medical benefits, subject to applicable Plan terms. See the **Enrollment and effective dates by job classification** section later in this chapter for other benefits you may be eligible for.

Example: If your date of hire is April 16, 2026, your hours worked from that day through April 15, 2027, will be measured to determine whether you have worked the required number of hours during the initial measurement period. If you work the required number of hours during this initial measurement period and you do not have a break in employment of 13 weeks or more, you will be eligible to enroll in medical benefits. You will also be eligible to enroll in other voluntary benefits that are available to part-time hourly associates and temporary associates, subject to applicable Plan terms. In this example, all benefits you enroll in would be effective on June 1, 2027, which is the first day of the second calendar month following the day prior to your one-year anniversary date, April 15, 2027.

If you do not work the required number of hours during your initial measurement period to be eligible for medical benefits, your eligibility for medical benefits will be checked again at the annual eligibility check that follows your initial measurement period, as described in **Your annual eligibility check** in this section. If you had not worked the required number of hours at the one-time check at 52 weeks of employment in the example above, your first annual eligibility check for medical benefits would be in the fall of 2027 for 2028 medical coverage. You may still be eligible for other voluntary benefits that are available to part-time hourly associates and temporary associates, regardless of whether you work the required number of hours to be eligible for medical benefits, subject to applicable Plan terms. See the **Enrollment and effective dates by job classification** section in this chapter for other benefits you may be eligible for.

If you become eligible for benefits as a result of the one-time check at 52 weeks of employment, your eligibility for medical benefits continues through the end of the second calendar year following the date you met your eligibility check requirements, regardless of whether you actually enroll in medical coverage (your "medical coverage eligibility period"), subject to any applicable Plan terms and assuming you continue to be classified as a part-time hourly associate or temporary associate in Walmart's payroll system. For example, if you met the eligibility check requirements on April 15, 2027, the medical coverage

eligibility period would continue through the end of the 2028 calendar year. Your eligibility for the other voluntary benefits described in the **Enrollment and effective dates by job classification** section later in this chapter will continue while you remain a part-time hourly associate or temporary associate, subject to applicable Plan terms. However, if you do not enroll in medical benefits when first eligible and prior to the end of your initial enrollment period, you will not be permitted to enroll in medical benefits during the remainder of your medical coverage eligibility period except during Annual Enrollment, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section later in this chapter. Likewise, if you do not enroll in most voluntary benefits (other than optional life insurance) during your initial enrollment period, you will also not be permitted to enroll except during an Annual Enrollment period, or if you have an election change event. Once eligible for voluntary benefits, you may enroll in optional life insurance at any time. Your eligibility for medical benefits will not be checked again until the annual check that occurs in the final year of your medical coverage eligibility period, as described in **Your annual eligibility check** in this section.

If you take time off during the initial measurement period

If you take any type of unpaid time off during the initial measurement period, the total number of weeks of unpaid time off in the initial measurement period will still be used to determine whether you have worked the required number of hours during the initial measurement period to be eligible for medical benefits (even if you work no hours in one or more weeks).

However, if your absence is an approved leave of absence recorded in Walmart's system as a leave of absence (including for jury duty, Family and Medical Leave Act of 1993 ["FMLA"] leave, or military leave), the number of weeks during the initial measurement period that you were on an approved leave of absence will not be considered in the measurement of your hours. The determination of whether you have met the required number of hours will be based on the number of weeks during the initial measurement period, less the number of weeks that you were on an approved leave of absence. For example, if you take an approved leave of absence of two weeks during the 52-week initial measurement period, your average hours worked will be calculated over 50 weeks rather than 52.

If you leave Walmart and are rehired

For purposes of the one-time eligibility check at 52 weeks of employment, if you terminate employment and return to employment as a part-time hourly associate or temporary associate less than 13 weeks after your termination date, your eligibility for medical and other benefits upon being rehired will be determined in accordance with the rules in the chart below.

Note: If you terminated employment when you were a part-time hourly associate or temporary associate and are rehired less than 13 weeks after your date of termination in a different job classification, for purposes of determining eligibility and effective dates you will be treated as if you had never terminated, and instead, had transferred from one job classification to another. Review the **Transferring from one job classification to another** section later in this chapter for more information and benefits eligibility.

If you:	And are rehired less than 13 weeks after your termination date:
Terminated during your initial measurement period	You will be treated as if you had not left, for the remainder of the initial measurement period. All hours worked during the initial measurement period will be used to determine your eligibility for medical benefits as a result of the one-time eligibility check. For example, if you have a four-week break in service during the 52-week initial measurement period, your average hours will be calculated using the 48 weeks during which you were employed, rather than 52 weeks. If you took any time off during the initial measurement period, see **If you take time off during the initial measurement period** in this section.
Terminated after your initial measurement period, *and* Were eligible for medical benefits but rehired after the end of the medical coverage eligibility period, *or* Were not eligible for medical benefits when you terminated	Your eligibility for medical and other voluntary benefits will be determined as described in **Your annual eligibility check** in this section.

(Continued on the next page)

If you:	And are rehired less than 13 weeks after your termination date: (continued)
Terminated after your initial measurement period, *and* Were eligible for medical benefits when you terminated, *and* Rehired before the end of the medical coverage eligibility period	You will retain your previous eligibility status for medical benefits through the end of your medical coverage eligibility period. Your eligibility for the other voluntary benefits will continue while you remain a part-time hourly associate or temporary associate, subject to applicable Plan terms. Any coverage that was in effect (or the most similar coverage offered under the Plan) on your termination date will be reinstated, with a break in coverage during the period of your absence for which payments for coverage were not made, subject to the following terms: If you return within 30 days of your termination date: • Except as provided below, and subject to otherwise applicable Plan terms, if you were enrolled in medical or other voluntary benefits when you terminated, you will not be permitted to change the reinstated coverage (other than optional life) until the next Annual Enrollment period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section in this chapter. • Except as provided below, and subject to otherwise applicable Plan terms, if you were not enrolled in medical or other voluntary benefits on your termination date, you may not enroll in those benefits (other than optional life) when you return, until the next Annual Enrollment period, or if you have an election change event. • If you terminate in one calendar year after the Annual Enrollment period for the following calendar year has ended and you return before December 31 of the year in which you terminated, changes you made during Annual Enrollment (or coverage you defaulted to because you did not make any changes during Annual Enrollment) will be implemented. • If you terminate in one calendar year and return to work in the following calendar year and you fall into one of the following categories, you may call People Services at **800-421-1362** to enroll in medical or other voluntary benefits within 60 days of returning to work: – You were not eligible to enroll in benefits in the year you terminated but are eligible in the year you return to work – You were eligible to enroll in benefits in the year you terminated but were not enrolled – You were eligible and enrolled in benefits in the year you terminated and would like to add a dependent child (if applicable) in the year you return to work If you return after 30 days but less than 13 weeks after your termination date, you will have 60 days after returning to drop or otherwise change the reinstated coverage, subject to otherwise applicable Plan terms. After this 60-day period, and subject to otherwise applicable Plan terms, you will not be permitted to change your benefit elections (other than optional life), until the next Annual Enrollment period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section in this chapter.
See the **If you leave Walmart and are rehired** section in **The medical plan** chapter for information on your deductible, out-of-pocket maximum, HRA, and maximum lifetime benefit applicable to fertility benefits under the Centers of Excellence family building program if you terminate employment and then return to work. See the **If you leave Walmart and are rehired** section in **The dental plan** chapter for information on your required minimum enrollment period, deductible, and waiting period for orthodontia assistance if you terminate employment and then return to work.	

If you terminated employment and are rehired 13 weeks or more after your termination date, regardless of job classification, you will be treated as a new associate, subject to otherwise applicable Plan terms.

Your annual eligibility check

If you are a part-time hourly associate or temporary associate and have been employed for longer than 52 consecutive weeks, without a break in employment of 13 weeks or more, your hours will be checked annually to determine whether you have worked the required number of hours, which is expressed as an average number per week, to be eligible for medical benefits in the next calendar year. The measurement period for the annual check described in this section will be a 52-week period preceding an annually designated date in early October and is referred to as the "annual measurement period." You will be subject to the annual eligibility check each year to determine your eligibility for medical benefits in the next calendar year, provided you remain a part-time hourly associate or temporary associate. See the following page for your required number of hours.

If you were eligible for medical benefits as the result of the 60-day or one-time eligibility checks described above, your first annual eligibility check will be the annual check that occurs the year in which your medical coverage eligibility period (as defined above) ends.

If you were a full-time hourly associate or management associate who transferred to a part-time hourly associate or temporary associate job classification, your first annual eligibility check will be determined under the following rules:

- If your medical coverage was effective prior to the calendar year in which you transferred, your first annual eligibility check will be the one that occurs in the calendar year in which you transferred.

- If your medical coverage became effective in the same calendar year in which you transferred, your first annual eligibility check will be the one that occurs in the following calendar year.
- If you transferred after the annual eligibility check for the year in which you transferred, your first annual eligibility check will be the one that occurs in the following calendar year.

If you are a part-time hourly associate[1] in Walmart's system and are:	You must work this number of hours during the annual measurement period:
• An hourly pharmacist hired on or after Feb. 1, 2012[2] • In the field supply chain	An average of 24 hours per week
All other part-time hourly associates and temporary associates	An average of 30 hours per week

[1] Part-time hourly associates in Hawaii: refer to the chapter titled **Eligibility, enrollment, and effective dates for associates in Hawaii** for details.

[2] Part-time hourly pharmacists hired before Feb. 1, 2012 do not have an hours requirement.

If you work the required number of hours during your annual measurement period without a break in employment of 13 weeks or more, you will be eligible to enroll in medical benefits at Annual Enrollment. If eligible, your benefits will be effective on January 1 of the following calendar year.

If you become eligible for benefits as a result of the annual eligibility check, your eligibility for medical benefits continues through December 31 of the year in which it is effective, regardless of whether you actually enroll in medical benefits, subject to any applicable Plan terms and assuming you remain a part-time hourly associate or temporary associate. However, if you do not enroll in medical benefits during Annual Enrollment, you will not be permitted to enroll in medical benefits during the next calendar year unless you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section later in this chapter. Your eligibility for medical benefits will not be checked again until the next annual eligibility check, provided you remain a part-time hourly or temporary associate.

If you do not work the required number of hours during your annual measurement period to be eligible for medical benefits, your eligibility for medical benefits will not be checked again until the next annual eligibility check, provided you remain a part-time hourly associate or temporary associate.

If you are enrolled in medical benefits in the current calendar year but did not work the required number of hours to be eligible for medical benefits in the following 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. However, you will have the option 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 may also be eligible for other voluntary benefits, regardless of whether you work the required number of hours to be eligible for medical benefits, subject to applicable Plan terms. See the **Enrollment and effective dates by job classification** section for other benefits you may be eligible for.

If you take time off during the annual measurement period

If you take any type of unpaid time off during the annual measurement period, the total number of weeks of unpaid time off in the annual measurement period will still be used to determine whether you have worked the required number of hours during the annual measurement period to be eligible for medical benefits (even if you work no hours in one or more weeks).

If your absence is an approved leave of absence recorded in Walmart's system as a leave of absence (including for jury duty, Family and Medical Leave Act of 1993 ["FMLA"] leave, or military leave), the number of weeks during the annual measurement period that you were on an approved leave of absence will not be considered in the measurement of your hours. The determination of whether you have met the required number of hours will be based on the number of weeks during the annual measurement period, less the number of weeks that you were on an approved leave of absence. For example, if you take an approved leave of absence of two weeks during the annual measurement period, your average hours worked will be calculated over 50 weeks rather than 52.

If you leave Walmart and are rehired

For purposes of the annual eligibility check, if you terminate employment as a part-time hourly or temporary associate and are rehired as a part-time hourly associate or temporary associate less than 13 weeks after your termination date, you will be treated as if you had not left. All hours worked during an annual measurement period will be used to determine your eligibility for medical benefits for the following year. Your eligibility for medical and other voluntary benefits upon being rehired less than 13 weeks from your termination date will be determined in accordance with the rules in the chart on the following page.

Note: If you terminated employment when you were a part-time hourly associate or temporary associate and are rehired less than 13 weeks after your date of termination in a different job classification, for purposes of determining eligibility and effective dates you will be treated as if you had never terminated, and instead, had transferred from one job classification to another. Review the **Transferring from one job classification to another** section later in this chapter for more information and benefits eligibility.

If you:	And are rehired less than 13 weeks after your termination date:
Are not eligible for medical benefits in the year you are rehired but are eligible for other voluntary benefits	Your eligibility for medical benefits will not be measured again until the next annual eligibility check. You will retain your previous eligibility status for voluntary (non-medical) benefits while you remain a part-time hourly associate or temporary associate, subject to applicable Plan terms. Any coverage that was in effect (or the most similar coverage offered under the Plan) on your termination date will be reinstated, with a break in coverage during the period of your absence for which payments for coverage were not made, subject to the following terms: If you return within 30 days of your termination date: • Except as provided below, and subject to otherwise applicable Plan terms, if you were enrolled in voluntary (non-medical) benefits when you terminated, you will not be permitted to change the reinstated coverage (other than optional life) until the next Annual Enrollment period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section in this chapter. • Except as provided below, and subject to otherwise applicable Plan terms, if you were not enrolled in voluntary (non-medical) benefits on your termination date, you may not enroll in those benefits (other than optional life) when you return, until the next Annual Enrollment period, or if you have an election change event. • If you terminate in one calendar year after the Annual Enrollment period for the following calendar year has ended and you return before December 31 of the year in which you terminated, changes you made during Annual Enrollment (or coverage you defaulted to because you did not make any changes during Annual Enrollment) will be implemented. • If you terminate in one calendar year and return to work in the following calendar year and you fall into one of the following categories, you may call People Services at **800-421-1362** to enroll in voluntary (non-medical) benefits within 60 days of returning to work: – You were not eligible to enroll in benefits in the year you terminated but are eligible in the year you return to work – You were eligible to enroll in benefits in the year you terminated but were not enrolled – You were eligible and enrolled in benefits in the year you terminated and would like to add a dependent child (if applicable) in the year you return to work If you return after 30 days but less than 13 weeks after your termination date, subject to otherwise applicable Plan terms, you will have 60 days after returning to drop or otherwise change the reinstated coverage. After this 60-day period, and subject to otherwise applicable Plan terms, you will not be permitted to change your benefit elections (other than optional life), until the next Annual Enrollment period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section in this chapter.

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If you:	And are rehired less than 13 weeks after your termination date: (continued)
Are eligible for medical and other voluntary benefits in the year you are rehired	You will retain your previous eligibility status for medical benefits through the end of your medical coverage eligibility period. Your eligibility for the other voluntary benefits will continue while you remain a part-time hourly associate or temporary associate, subject to applicable Plan terms. Any coverage that was in effect (or the most similar coverage offered under the Plan) on your termination date will be reinstated, with a break in coverage during the period of your absence for which payments for coverage were not made, subject to the following terms: If you return within 30 days of your termination date: • Except as provided below, and subject to otherwise applicable Plan terms, if you were enrolled in medical or other voluntary benefits when you terminated, you will not be permitted to change the reinstated coverage (other than optional life), until the next Annual Enrollment period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section in this chapter. • Except as provided below, and subject to otherwise applicable Plan terms, if you were not enrolled in medical or other voluntary benefits on your termination date, you may not enroll in those benefits (other than optional life) when you return, until the next Annual Enrollment period, or if you have an election change event. • If you terminate in one calendar year after the Annual Enrollment period for the following calendar year has ended and you return before December 31 of the year in which you terminated, changes you made during Annual Enrollment (or coverage you defaulted to because you did not make any changes during Annual Enrollment) will be implemented. • If you terminate in one calendar year and return to work in the following calendar year and you fall into one of the following categories, you may call People Services at **800-421-1362** to enroll in medical or other voluntary benefits within 60 days of returning to work: – You were not eligible to enroll in benefits in the year you terminated but are eligible in the year you return to work – You were eligible to enroll in benefits in the year you terminated but were not enrolled – You were eligible and enrolled in benefits in the year you terminated and would like to add a dependent child (if applicable) in the year you return to work If you return after 30 days but less than 13 weeks after your termination date, subject to otherwise applicable Plan terms, you will have 60 days after returning to drop or otherwise change the reinstated coverage. After this 60-day period, and subject to otherwise applicable Plan terms, you will not be permitted to change your benefit elections (other than optional life), until the next Annual Enrollment period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section in this chapter.
See the **If you leave Walmart and are rehired** section in **The medical plan** chapter for information on your deductible, out-of-pocket maximum, HRA, and maximum lifetime benefit applicable to fertility benefits under the Centers of Excellence family building program, if you terminate employment and then return to work. See the **If you leave Walmart and are rehired** section in **The dental plan** chapter for information on your required minimum enrollment period, deductible, and waiting period for orthodontia assistance if you terminate employment and then return to work.	

If you terminated employment and are rehired 13 weeks or more after your termination date, regardless of job classification, you will be treated as a new associate, subject to otherwise applicable Plan terms.

If you have questions about the calculation of hours for the eligibility checks, call People Services at **800-421-1362**.

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. For purposes of the *Associate Benefits Book*, the term "dependent" includes your spouse/partner. If you are a part-time hourly associate or temporary associate or a part-time OTR truck driver, and you are eligible for benefits under the Plan, you may enroll only your dependent child(ren) in addition to yourself; you may not enroll your spouse/partner.

Employment classification	Eligible dependents (as defined below)
• Management (including full-time OTR truck drivers) • Full-time hourly (including full-time hourly Vision Center managers and full-time hourly city drivers)	**Can elect to cover:** • Spouse/partner • Dependent child(ren)
• Part-time hourly • Temporary • Part-time OTR truck driver	**Can elect to cover:** • Dependent child(ren) But *not* spouse/partner

Definitions: eligible dependents[1] Dependents not described in this chart are not eligible dependents.	
Spouse/partner Part-time hourly associates, temporary associates, and part-time OTR truck drivers may not cover a 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 the state where you live 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)	• Except as provided below, your dependent children through the end of the month in which the child reaches age 26.[2] Your dependent children are: – Your biological 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 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

[1] Even if your dependent otherwise falls into a category in this chart, there may be instances where that dependent is not eligible for coverage for other reasons. See the section titled **Dependents who are not eligible** later in this chapter.

[2] If a child is born on February 29, the child will be treated as attaining age 26 on March 1 of the year in which the child attains age 26.

If an individual is your eligible dependent and ceases to satisfy 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 in status. 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 termination 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 medical child support order, see **Medical child support orders** later in this chapter.

If you are enrolled for medical coverage in an HMO option, note that these options do not offer out-of-network coverage and do not offer nationwide provider networks. If you have an eligible dependent living outside your AMP option's service area, 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 whether your eligible dependent lives outside your AMP option's service area, call your health care advisor at the number on your plan ID card.

If your child is over age 26 and incapable of self-support

If your child is age 26 or older and incapable of self-support, you may enroll them in 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 financial support, and
- The child's doctor provides written medical evidence of the child's incapacity

Documentation showing that the child is physically or mentally incapable of self-support and is primarily dependent on you for financial support may be required. This could include a copy of your federal income tax return showing that you claim your child as a dependent or a determination that the child has met the requirements for Social Security disability income benefits.

If your child is age 26 or older and incapable of self-support as described above, you may enroll the child in coverage during your initial enrollment period, during any Annual Enrollment period, or if you have an election change event that would permit enrollment of a dependent child.

Medical evidence of ongoing incapacity may be required. It is your responsibility to notify the Plan if your child is over age 26 and incapable of self-support.

Dependent contact information

A dependent who is age 18 or older may provide the Plan with a mailing address that is different from yours for purposes of receiving benefits communications. Your dependent will need to contact People Services at **800-421-1362** to update their address.

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. It is your responsibility to notify the Plan, in a timely manner, of any changes in your dependent's eligibility.

Examples of valid documentation are as follows:

Spouse: Copy of marriage certificate or registration of informal marriage through county or state. If your marriage did not occur in the current calendar year, a copy of your jointly filed federal tax return from the most recent tax season, or both of your tax returns if you file separately, may also be required, on request.

Domestic partner: Copy of domestic partner affidavit (signed by you and your partner) or civil union or domestic partner registration and one of the following documents as proof of your relationship:

- Proof of shared residence via joint mortgage statement or rental agreement
- Automobile title or registration showing joint ownership of vehicle
- Joint checking, bank, or investment account statement*
- Joint credit account statement*
- Joint utility bill*
- Will and/or life insurance policy which designates the other as the primary beneficiary

* These documents must be dated within 60 days of the documentation request.

Children: Copy of the following documents, as applicable:

- **Biological child or legally adopted child:** State or county-issued birth certificate showing associate's name or signed court order.
- **Stepchild:** State or county-issued birth certificate showing parents' names and copy of marriage certificate. If your marriage did not occur in the current calendar year, a copy of your jointly filed federal tax return from the most recent tax season is also required, or both of your tax returns if you file separately.
- **Child of your partner:** State or county-issued birth certificate and proof of established partnership.
- **Foster child:** Signed letter from social service agent confirming the child has been placed under your care.
- **Child you have legal guardianship of:** Signed court order.
- **Child you are ordered by a court or agency to cover:** Signed qualified medical child support order. See **Medical child support orders** later in this chapter.
- **Child over the age of 26 who is incapable of self-support:** Medical evidence of ongoing incapacity.

Note: In certain cases you may be required to complete an affidavit as well.

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
- Not an eligible dependent as defined under **Dependent eligibility** earlier in this chapter

- Enrolled in a Medicare prescription drug plan (applicable only to eligibility for AMP options and the pharmacy benefit, including HMO options)
- On active duty in the armed forces of any country (applies only to optional life insurance or accidental death and dismemberment insurance)
- 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)

When an associate is not eligible to be covered as a dependent of another associate: An associate may not be covered under medical, dental, or vision coverage as both an associate and a dependent. If you cover a dependent who is also an associate and your dependent enrolls in medical, dental, or vision coverage as an associate, your dependent will no longer be an eligible dependent under your medical, dental or vision coverage, and your coverage will be adjusted accordingly. See the **Associates covered as a dependent of another associate** section under **Eligibility information for additional associate categories** earlier in this chapter for more information.

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 your dependent is enrolled in medical, dental, or vision coverage and you notify People Services within this time frame, the Plan will send an election notice, allowing your dependent 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. Refer to the **How payroll deductions are handled** section later in this chapter for details on how payroll deduction reconciliation related to an ineligible dependent is handled.

When you enroll for benefits

Note: Unless you are classified as a management associate or a full-time hourly Vision Center manager, you must enroll before your coverage effective date. See **When coverage is effective** and **Enrollment and effective dates by job classification** later in this chapter for details.

You must enroll for benefits during your "initial enrollment period." Your "initial enrollment period" 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, provided you have not already had an "initial enrollment period" while you were in the classification that you transfer from. 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.

Enrollment materials will be sent to the address Walmart has on file. Be sure to enroll by the enrollment deadline provided in the enrollment materials that you receive. The Plan is not permitted to make exceptions allowing individual associates to enroll after the initial enrollment period ends. If you do not enroll by the deadline, you will not be able to enroll for the following benefits until the next Annual Enrollment period, unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter:

- Medical, including HMO options (subject to the eligibility checks described in the section earlier in this chapter titled **Part-time hourly associates and temporary associates: eligibility checks for medical benefits**)
- Dental
- Vision
- Short-term disability enhanced plan
- Long-term disability (LTD) or truck driver LTD (see important exception regarding "late enrollees" on this page)
- Critical illness insurance
- Accident insurance
- Accidental death and dismemberment (AD&D)

You may add or drop optional associate life insurance and optional dependent life insurance (or add additional coverage) at any time after becoming eligible. See important exceptions regarding "Proof of Good Health" and "late enrollees" immediately below.

Proof of Good Health: Whether you must provide Proof of Good Health for optional associate life or optional dependent life insurance for your spouse/partner depends on when and how you enroll:

- **If you enroll during your initial enrollment period or due to an election change event:** Proof of Good Health is required only if you enroll for more than the guaranteed amount for yourself or your spouse/partner.
- **If you enroll in or increase coverage after your initial enrollment period for a reason other than an election change event:** Proof of Good Health is required for any coverage amount for yourself or your spouse/partner.

Proof of Good Health is not required for dependent child optional life insurance regardless of when you enroll.

For more information on coverage effective dates and approval requirements, see **Enrollment and effective dates by job classification** later in this chapter and refer to the chart that applies to your job classification. See the **Permitted election changes outside Annual Enrollment** section of this chapter for information regarding election change events.

Late enrollees: If you do not enroll in truck driver long-term disability during your initial enrollment period and then elect coverage at a later date, as permitted by the Plan, you will be considered a "late enrollee" and will also be subject to Proof of Good Health requirements before coverage is approved and effective.

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.

Choosing a coverage tier

When you enroll in the Plan, you will select your coverage tier, including any eligible dependents you will cover. If you enroll your eligible dependents in the Plan, they must have the same coverage you elect for yourself (i.e., they will be enrolled in the same medical plan option that you are enrolled in). You may change your coverage during Annual Enrollment or if you experience an election change event. See the **Permitted election changes outside Annual Enrollment** section later in this chapter.

Confirming your enrollment

Once you enroll in coverage, you can view your confirmation statement on **One.Walmart.com/Enroll**. A confirmation statement will be made available as soon as administratively feasible, generally within a day or two. Be sure to check your confirmation statement as soon as it is available. You should also check your paystub for the first pay period after your election is effective to confirm that the correct payroll deductions are being deducted.

Note: It is a good idea to keep a copy of your confirmation statement for future reference.

If you see an error on your confirmation statement or your paystub regarding the benefits you enrolled in, immediately contact People Services at **800-421-1362**. People Services can only correct internal system errors regarding enrollment elections and remove ineligible dependents from coverage.

System errors regarding enrollment can be corrected only during the Plan year in which the enrollment election was effective. An ineligible dependent can only be removed from coverage as of the event date back to a maximum of the beginning of the Plan year prior to the Plan year in which you ask for a correction.

If the Plan Administrator determines that an error did not occur or you ask for correction of an error outside the time frames described above, you may appeal that determination by following the process described in the **Appealing an enrollment or eligibility status decision** section of the **Claims and appeals** chapter of this 2027 *Associate Benefits Book*.

Refer to the **How payroll deductions are handled** section later in this chapter for details regarding how errors in payroll deductions are handled.

Your plan ID card

When you enroll in any of the medical options available under the AMP, you receive a plan ID card at your home address. Plan ID cards for dependents whose address is different from yours are sent directly to the dependent's address. Your plan ID card also serves as your pharmacy plan ID card.

If you enroll in any of the medical options under the AMP 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 plan ID card and/or your vision plan ID card.

If you enroll in an HMO option and you also enroll in the dental plan and/or the vision plan, you will receive separate plan ID cards for the dental and/or vision plan. Plan ID cards will be mailed to your home address.

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

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

When coverage is effective

See the **Enrollment and effective dates by job classification** section of this chapter for more details about coverage effective dates. While you should enroll as soon as your initial enrollment period is open, even after you enroll, you may still have to complete an applicable eligibility waiting period or actively-at-work requirements before your coverage becomes effective.

"Active work" or "actively at work"

Medical, dental, vision, critical illness, accident, accidental death and dismemberment ("AD&D"), and associate assistance resources: Provided you have enrolled and applicable payroll deductions are current, coverage will become effective even if you are not at work on the day it would otherwise become effective (for example, due to illness), if you have reported to your first day of work at Walmart. No enrollment or payroll deductions are required for associate assistance resources.

Business travel accident insurance, company-paid life, optional associate and dependent life and all types of disability: If you are on a leave of absence or suspension (paid or unpaid) on the date your coverage would otherwise become effective, coverage will be delayed until you are on active status and not on a leave of absence or suspension, provided you have enrolled and applicable payroll deductions are current. No enrollment or payroll deductions are required for business travel accident insurance, company-paid life insurance, or short-term disability basic coverage.

Automatic reenrollment

If you are currently enrolled in benefits and are eligible for those same benefits during the following calendar year, but do not make an affirmative election related to those benefits during the Annual Enrollment period, you and any dependents you cover will be automatically 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**. Call People Services at **800-421-1362** for information.

- If you do not make an affirmative election during Annual Enrollment and are enrolled automatically in coverage as described above, you will not be permitted to change this coverage except during Annual Enrollment, unless you experience an election change event.
- If you do not make an affirmative election during Annual Enrollment and are automatically reenrolled in coverage, you will be deemed to have consented to the automatic reenrollment, and your payroll deductions will be adjusted accordingly.
- If you do not make an affirmative election during Annual Enrollment and you are not enrolled in coverage, you will not be permitted to enroll in coverage until the next Annual Enrollment, unless you experience an election change event.

If you leave Walmart and are rehired

Note: If you terminated employment when you were in one job classification and are rehired less than 13 weeks after your date of termination in a different job classification, for purposes of determining eligibility and effective dates you will be treated as if you had never terminated, and instead, had transferred from one job classification to another. You should review the **Transferring from one job classification to another** section later in this chapter for more information and benefits eligibility.

If you terminate employment as a full-time hourly associate prior to meeting applicable eligibility requirements and you return to Walmart as a full-time hourly associate less than 13 weeks after your termination date, for purposes of determining eligibility and effective dates you will be treated as if you had never terminated. For example, if you are hired on January 1, terminate employment on February 15, and are rehired on March 10, your eligibility will be determined as if you had never terminated. If you had remained employed, you would have been eligible for benefits on March 1 because that would have been the first day of the month in which your 89th day of employment fell. If you are rehired on March 10, you will be eligible for benefits immediately because your effective date would have been March 1.

Management, full-time hourly, and full-time and part-time OTR truck driver associates

If you terminate employment (regardless of whether you are a management, full-time hourly, full-time hourly Vision Center manager, or full-time or part-time OTR truck driver associate) after meeting applicable eligibility requirements for benefits, and you return to Walmart in the same job classification as when you terminate, your eligibility for benefits will be determined in accordance with the rules in the chart below:

If you	
Are rehired less than 13 weeks after your termination date	You will retain your previous eligibility status for medical and other voluntary benefits as long as you remain a management, full-time hourly, full-time hourly Vision Center manager, or full-time or part-time OTR truck driver associate, subject to applicable Plan terms. Any coverage that was in effect (or the most similar coverage offered under the Plan) on your termination date will be reinstated, with a break in coverage during the period of your absence for which payments for coverage were not made, subject to the following terms: If you return within 30 days of your termination date: • Except as provided below, and subject to otherwise applicable Plan terms, if you were enrolled in medical or other voluntary benefits when you terminated, you will not be permitted to change the reinstated coverage (other than optional life), until the next Annual Enrollment period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section in this chapter. • Except as provided below, and subject to otherwise applicable Plan terms, if you were not enrolled in medical or other voluntary benefits on your termination date, you may not enroll in those benefits (other than optional life) when you return, until the next Annual Enrollment period, or if you have an election change event. • If you terminate in one calendar year after the Annual Enrollment period for the following calendar year has ended and you return before December 31 of the year in which you terminated, changes you made during Annual Enrollment (or coverage you defaulted to because you did not make any changes during Annual Enrollment) will be implemented. • If you terminate in one calendar year and return to work in the following calendar year and you fall into one of the following categories, you may call People Services at **800-421-1362** to enroll in medical or other voluntary benefits within 60 days of returning to work: – You were eligible to enroll in benefits in the year you terminated but were not enrolled – You were eligible and enrolled in benefits in the year you terminated and would like to add a dependent child (if applicable) in the year you return to work If you return after 30 days but less than 13 weeks after your termination date, subject to otherwise applicable Plan terms, you will have 60 days after returning to drop or otherwise change the reinstated coverage. After this 60-day period, and subject to otherwise applicable Plan terms, you will not be permitted to change your benefit elections (other than optional life), until the next Annual Enrollment period, or if you have an election change event, as described in the **Permitted election changes outside Annual Enrollment** section in this chapter.
See the **If you leave Walmart and are rehired** section in **The medical plan** chapter for information on your deductible, out-of-pocket maximum, HRA, and maximum lifetime benefit applicable to fertility benefits under the Centers of Excellence family building program, if you terminate employment and then return to work. See the **If you leave Walmart and are rehired** section in **The dental plan** chapter for information on your required minimum enrollment period, deductible, and waiting period for orthodontia assistance if you terminate employment and then return to work.	

If you return as a management, full-time hourly, full-time hourly Vision Center manager, or full-time or part-time OTR truck driver associate 13 weeks or more after your termination date, you will be treated as a new associate, subject to otherwise applicable Plan terms.

Part-time hourly associates and temporary associates

See the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section earlier in this chapter for information about benefits if you leave Walmart and are rehired.

Effective dates for coverage under the Plan

The following **Enrollment and effective dates by job classification** charts provide your coverage effective dates if you enroll in coverage and you are actively at work, as defined earlier, on the coverage effective date. If you are not actively at work on the date that coverage would otherwise be effective, the coverage will be effective when you are again actively at work. See **"Active work" or "actively at work"** earlier in this chapter for more information. If you terminate employment before enrolling for benefits during your initial enrollment period, you will not be eligible to enroll after your termination date. Each benefit is subject to specific terms and conditions. Please see the applicable chapter of this *Associate Benefits Book* for details.

If you are a full-time hourly associate, part-time hourly associate, or temporary associate in Hawaii, special rules govern medical and short-term disability benefits eligibility and enrollment. See the chapter titled **Eligibility, enrollment, and effective dates for associates in Hawaii**.

Enrollment and effective dates by job classification

Full-time hourly associates

Includes full-time hourly field supply chain, full-time hourly field supervisor positions in stores and clubs, full-time hourly city drivers, and full-time hourly pharmacists (except associates classified as "full-time hourly California pharmacists" in Walmart's payroll systems, who should refer to the chart for management associates); excludes full-time hourly Vision Center managers.

Note: Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.

Plan	Enrollment periods and coverage effective dates	
• Medical • HMO plans • Dental – Enrollment is for two consecutive calendar years • Vision • Critical illness insurance • Accident insurance • AD&D	**Initial enrollment period:** You must enroll in coverage between your first payday and the day *prior* to your coverage 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.	If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
• Company-paid life insurance	You are enrolled automatically on the first day of the calendar month during which your 89th day of continuous full-time employment falls and your coverage is effective on that date.	
• Associate assistance resources • Business travel accident insurance	You are enrolled automatically on your date of hire, and your coverage is effective on that date.	

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Full-time hourly associates (continued)

Includes full-time hourly field supply chain, full-time hourly field supervisor positions in stores and clubs, full-time hourly city drivers, and full-time hourly pharmacists (except associates classified as "full-time hourly California pharmacists" in Walmart's payroll systems, who should refer to the chart for management associates); excludes full-time hourly Vision Center managers.

Note: Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.

Plan	Enrollment periods and coverage effective dates
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** Your initial enrollment period starts on your first payday and ends the day *prior* to the first day of the calendar month during which your 89th day of continuous full-time employment falls. You can also enroll in, increase, or drop coverage at any time after your initial enrollment period ends. **When coverage is effective:** **If you enroll during your initial enrollment period:** • If you enroll for the guaranteed amount, coverage is effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous full-time employment falls. • If you enroll for **more than** the guaranteed amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. – If approved, coverage is effective on the later of 1) the date Prudential approves your coverage, or 2) the first day of the calendar month during which your 89th day of continuous full-time employment falls. – If any coverage above the guaranteed amount is not approved, you will be enrolled in coverage for the guaranteed amount and coverage will be effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous full-time employment falls. **If you enroll in or increase coverage after your initial enrollment period for a reason other than an election change event:** • Coverage for you and/or your spouse/partner (including an increase to previously elected coverage) is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. • If approved, coverage is effective on the date Prudential approves your coverage. **If you enroll in or increase your coverage after your initial enrollment period due to an election change event:** • If you enroll for the guaranteed amount, coverage is effective on the date you enroll. • If you enroll for **more than** the guaranteed amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. – If approved, coverage is effective on the date Prudential approves your coverage. – If any coverage above the guaranteed amount is not approved, you will be enrolled in coverage for the guaranteed amount and coverage will be effective on the date you enroll. See the **Permitted election changes outside Annual Enrollment** section of this chapter for information about election change events. You are not required to provide Proof of Good Health for children you enroll in optional dependent coverage. If your spouse/partner or dependent child is confined for medical treatment (at home or elsewhere), coverage is delayed until your spouse/partner or child has a medical release (does not apply to a newborn child). If you are required to provide Proof of Good Health, payroll deductions will not begin until your coverage is effective, as described above.

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Full-time hourly associates (continued)

Includes full-time hourly field supply chain, full-time hourly field supervisor positions in stores and clubs, full-time hourly city drivers, and full-time hourly pharmacists (except associates classified as "full-time hourly California pharmacists" in Walmart's payroll systems, who should refer to the chart for management associates); excludes full-time hourly Vision Center managers.

Note: Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.

Plan	Enrollment periods and coverage effective dates
• Short-term disability basic plan – Basic coverage (not available to associates who work in California, Hawaii, New Jersey, and Rhode Island; different coverage is available in New York) – Maternity benefits *See the* **Full-time hourly short-term disability** *chapter for general information about state benefits.*	You are enrolled automatically on the 12-month anniversary of your date of hire, and your coverage is effective on that date.
• 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) *See the* **Full-time hourly short-term disability** *chapter for general information about state benefits.*	**Initial enrollment period:** You must enroll in coverage between your first payday and the day *prior* to 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 in coverage during your initial enrollment period:** Coverage is effective on the 12-month anniversary of your date of hire. • **If you enroll in coverage after your initial enrollment period:** Coverage is effective 12 months after the date you enroll in coverage at Annual Enrollment or, in the case of an election change event, 12 months after the date of the event. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
• Long-term disability (LTD) plan (including enhanced benefits)	**Initial enrollment period:** You must enroll in coverage between your first payday and the day *prior* to 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 in coverage during your initial enrollment period:** Coverage is effective on the 12-month anniversary of your date of hire. • **If you enroll in or increase coverage after your initial enrollment period:** – If you enroll in or increase coverage following an election change event, your coverage is effective on the later of 1) the date of the event, 2) the first day of the pay period following the date you enroll, or 3) the 12-month anniversary of your date of hire. – If you enroll in or increase coverage during Annual Enrollment for the next Plan year, your coverage will be effective the later of 1) January 1 of that year, or 2) the 12-month anniversary of your date of hire. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.

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

Note: Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.

Plan	Enrollment periods and coverage effective dates	
• Medical • HMO plans • Dental – Enrollment is for two consecutive calendar years • Vision • Critical illness insurance • Accident insurance • AD&D	**Initial enrollment period:** You must enroll in coverage between your first payday and the day *prior* to your 60th day of employment, measured from your date of hire. **When coverage is effective:** Your coverage is effective on your date of hire.	If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year, unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
• Associate assistance resources • Company-paid life insurance • Business travel accident insurance	You are enrolled automatically on your date of hire and your coverage is effective on that date.	

• Optional associate life insurance
• Optional dependent life insurance
	Initial enrollment period:
	You must enroll in coverage between the date of your first payday and the day prior to 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:
	• If you enroll for the guaranteed amount, coverage is effective the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous employment falls.
	• If you enroll for **more than** the guaranteed amount, coverage for you and your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam.
	  – If approved, coverage is effective on the later of 1) the date Prudential approves your coverage, or 2) the first day of the calendar month during which your 89th day of continuous employment falls.
	  – If any coverage above the guaranteed amount is not approved, you will be enrolled in coverage for the guaranteed amount and coverage will be effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous employment falls.
	If you enroll in or increase coverage after your initial enrollment period for a reason other than an election change event:
	• Coverage for you and your spouse/partner (including an increase to previously elected coverage) is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam.
	• If approved, coverage is effective on the date Prudential approves your coverage.
	If you enroll in or increase your coverage after your initial enrollment period due to an election change event:
	• If you enroll for the guaranteed amount, coverage is effective on the date you enroll.
	• If you enroll for **more than** the guaranteed amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam.
	  – If approved, coverage is effective on the date Prudential approves your coverage.
	  – If any coverage above the guaranteed amount is not approved, you will be enrolled in coverage for the guaranteed amount and coverage will be effective on the date you enroll.
	See the **Permitted election changes outside Annual Enrollment** section of this **Eligibility, enrollment, and effective dates** chapter for information about election change events.
	You are not required to provide Proof of Good Health for children if you enroll in optional dependent coverage at any time.
	If your spouse/partner or dependent child is confined for medical treatment (at home or elsewhere), coverage is delayed until your spouse/partner or child has a medical release (does not apply to a newborn child).
	If you are required to provide Proof of Good Health, payroll deductions will not begin until your coverage is effective, as described above.	

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Full-time hourly Vision Center managers (continued)

Note: Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.

Plan	Enrollment periods and coverage effective dates
• Short-term disability basic plan – Basic coverage (not available to associates who work in California, Hawaii, New Jersey, and Rhode Island; different coverage is available in New York) – Maternity benefits *See the* **Full-time hourly short-term disability** *chapter for general information about state benefits.*	You are enrolled automatically on your date of hire, and your coverage is effective on that date.
• 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) *See the* **Full-time hourly short-term disability** *chapter for general information about state benefits.*	**Initial enrollment period:** You must enroll in coverage between your first payday and the day *prior* to the 60th day of employment, measured from your date of hire. **When coverage is effective:** • **If you enroll during your initial enrollment period:** Coverage is effective on your date of hire. • **If you enroll in coverage after your initial enrollment period:** Coverage is effective 12 months after the date you enroll in coverage at Annual Enrollment or, in the case of an election change event, 12 months after the date of the event. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
• Long-term disability (LTD) plan (including enhanced benefits)	**Initial enrollment period:** You must enroll in coverage between your first payday and the day *prior* to the 60th day following your date of hire. **When coverage is effective:** • **If you enroll in coverage during your initial enrollment period:** Coverage is effective on your date of hire. • **If you enroll in coverage after your initial enrollment period:** – If you enroll in coverage following an election change event, your coverage is effective on the later of 1) the date of the event, or 2) the first day of the pay period following the date you enroll. – If you enroll in coverage during Annual Enrollment for the next Plan year, your coverage will be effective January 1 of that year. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.

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.

Part-time hourly associates and temporary associates
Excludes part-time OTR truck drivers

Note: Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.

Plan	Enrollment periods and coverage effective dates
• Medical[1] • HMO plans • Dental – Enrollment is for two consecutive calendar years • Vision • Critical illness insurance • Accident insurance • AD&D	**Initial enrollment period:** **If you are eligible for medical and other benefits during the first 52 weeks of employment as a result of working the required number of hours in a 60-day measurement cycle:** You must enroll in coverage between the date you are first notified that you have met the eligibility requirements and the day *prior* to the 60th day following notification. See the section titled **Part-time hourly associates and temporary associates: eligibility checks for medical benefits**.[1] **If you are eligible for medical benefits as a result of the one-time eligibility check that occurs at 52 weeks of employment:** You must enroll in coverage between the date following your 52-week anniversary and the day *prior* to the 60th day following the date of your 52-week anniversary.[1] **Regardless of whether you are eligible for medical benefits as a result of the eligibility checks described above:** You are still eligible to enroll in all other benefits available to part-time hourly associates and temporary associates after 52 weeks of employment. You must enroll between the date following your 52-week anniversary and the day *prior* to the 60th day following the date of your 52-week anniversary.[1] **When coverage is effective:** **If you are eligible during the first 52 weeks of employment as a result of working the required number of hours in a 60-day measurement cycle:** Your coverage is effective on the first day of the month in which your 89th day of employment occurs, counting from the date on which the successful 60-day measurement cycle began. See the section titled **Part-time hourly associates and temporary associates: eligibility checks for medical benefits**. **If you are eligible as a result of the one-time eligibility check that occurs at 52 weeks of employment (for medical)[1] or on your 52-week anniversary (for all other benefits):** Your coverage is effective on the first day of the second calendar month following the day *prior* to your 52-week anniversary date. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
• Associate assistance resources • Business travel accident insurance	You are enrolled automatically on your date of hire, and your coverage is effective on that date.

[1] To be eligible for medical coverage, part-time hourly associates and temporary associates must work the required number of hours and pass one of the eligibility checks described under **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** earlier in this chapter. Part-time hourly pharmacists hired before February 1, 2012 are exempt from this requirement.

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Part-time hourly associates and temporary associates (continued)
Excludes part-time OTR truck drivers

Note: Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.

Plan	Enrollment periods and coverage effective dates
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** **If you are eligible during the first 52 weeks of employment as a result of working the required number of hours in a 60-day measurement cycle:** Your initial enrollment period starts the date you are first notified that you have met the eligibility requirements and ends the day *prior* to the 60th day following notification. **If you are eligible on your 52-week anniversary:** Your initial enrollment period starts the date following your 52-week anniversary and ends the day *prior* to the 60th day following the date of your 52-week anniversary. You can also enroll in, increase, or drop coverage at any time after your initial enrollment period ends. **When coverage is effective:** For purposes of determining the effective date of your optional life insurance, you will need to refer to the discussion of eligibility for medical coverage. If you become eligible for medical coverage before your first 52-week anniversary because you worked the required number of hours in a 60-day measurement period, the effective date of your medical coverage is the "applicable date" for determining the effective date for optional life insurance. If you did not become eligible for medical coverage before your 52-week anniversary and instead become eligible on your 52-week anniversary, the "applicable date" for determining the effective date for optional life insurance is the first day of the second calendar month following the day prior to your 52-week anniversary. **If you enroll during your initial enrollment period:** • If you enroll for the guaranteed amount, coverage is effective on the later of 1) the date you enroll, or 2) the "applicable date." • If you enroll for **more than** the guaranteed amount, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam. – If approved, coverage is effective on the later of 1) the date Prudential approves your coverage, or 2) the "applicable date." – If any coverage above the guaranteed amount is not approved, you will be enrolled in coverage for the guaranteed amount and coverage will be effective on the later of 1) the date you enroll, or 2) the "applicable date." **If you enroll in or increase coverage after your initial enrollment period for a reason other than an election change event:** • Coverage (including an increase to previously elected coverage) is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam. • If approved, coverage is effective on the date Prudential approves your coverage. **If you enroll in or increase your coverage after your initial enrollment period due to an election change event:** • If you enroll for the guaranteed amount, coverage is effective on the date you enroll. • If you enroll for **more than** the guaranteed amount, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam. – If approved, coverage is effective on the date Prudential approves your coverage. – If any coverage above the guaranteed amount is not approved, you will be enrolled in coverage for the guaranteed amount and coverage will be effective on the date you enroll. See the **Permitted election changes outside Annual Enrollment** section of this **Eligibility, enrollment, and effective dates** chapter for information about election change events. You are not required to provide Proof of Good Health for children if you enroll in optional dependent coverage at any time. If your dependent child is confined for medical treatment (at home or elsewhere), coverage is delayed until your child has a medical release (does not apply to a newborn child). If you are required to provide Proof of Good Health, payroll deductions will not begin until your coverage is effective, as described above.

Part-time hourly associates 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 associates and temporary 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.

Part-time OTR truck drivers

Note: Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.

Plan	Enrollment periods and coverage effective dates	
• Medical • HMO plans • Dental – Enrollment is for two consecutive calendar years • Vision • Critical illness insurance • Accident insurance • AD&D	**Initial enrollment period:** You must enroll in coverage between your first payday and your 60th day of employment, measured from your date of hire. **When coverage is effective:** Your coverage is effective the first day of the calendar month during which your 89th day of continuous employment falls.	If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
• Associate assistance resources • Business travel accident insurance	You are enrolled automatically on your date of hire and your coverage is effective on that date.	
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** Your initial enrollment period begins on your first payday and ends the day *prior* to the first day of the calendar month during which your 89th day of continuous employment falls. You can also enroll in, increase, or drop coverage at any time after your initial enrollment period ends. **When coverage is effective:** **If you enroll during your initial enrollment period:** • If you enroll for the guaranteed amount, coverage is effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. • If you enroll for **more than** the guaranteed amount, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam. – If approved, your coverage is effective on the later of 1) the date Prudential approves your coverage, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. – If any coverage above the guaranteed amount is not approved, you will be enrolled in coverage for the guaranteed amount and coverage will be effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. **If you enroll in or increase coverage after your initial enrollment period for a reason other than an election change event:** • Coverage (including an increase in previously elected coverage) is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam. • If approved, coverage is effective on the date Prudential approves your coverage. **If you enroll in or increase your coverage after your initial enrollment period due to an election change event:** • If you enroll for the guaranteed amount, coverage is effective on the date you enroll. • If you enroll for **more than** the guaranteed amount, your coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam. – If approved, coverage is effective on the date Prudential approves your coverage. – If any coverage above the guaranteed amount is not approved, you will be enrolled in coverage for the guaranteed amount and coverage will be effective on the date you enroll. See the **Permitted election changes outside Annual Enrollment** section of this **Eligibility, enrollment, and effective dates** chapter for information about election change events. You are not required to provide Proof of Good Health for children if you enroll in optional dependent coverage at any time. If your dependent child is confined for medical treatment (at home or elsewhere), coverage is delayed until your child has a medical release (does not apply to a newborn child). If you are required to provide Proof of Good Health, payroll deductions will not begin until your coverage is effective, as described above.	

Part-time OTR truck drivers are not subject to the benefits eligibility checks described earlier in this chapter.

Part-time OTR truck drivers 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 OTR truck drivers.

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.

Management associates

Includes management trainees, associates classified as "full-time hourly California pharmacists" in Walmart's payroll systems, and full-time OTR truck drivers

Note: Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.

<table>
<tr><th>Plan</th><th colspan="2">Enrollment periods and coverage effective dates</th></tr>
<tr><td>• Medical
• HMO plans
• Dental
– Enrollment is for two consecutive calendar years
• Vision
• Critical illness insurance
• Accident insurance
• AD&D</td><td>Initial enrollment period:
You must enroll in coverage between your first payday and the day prior to your 60th day of employment, measured from your date of hire.
When coverage is effective:
Your coverage is effective on your date of hire.</td><td>If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the Permitted election changes outside Annual Enrollment section of this chapter.</td></tr>
<tr><td>• Associate assistance resources
• Company-paid life insurance
• Business travel accident insurance
• Short-term disability</td><td colspan="2">You are enrolled automatically on your date of hire and your coverage is effective on that date.</td></tr>
<tr><td>• Optional associate life insurance
• Optional dependent life insurance</td><td colspan="2">Initial enrollment period:
Your initial enrollment period starts on your first payday and ends on your 60th day of employment, measured from your date of hire.
You can also enroll in, increase, or drop coverage at any time after your initial enrollment period ends.
When coverage is effective:
If you enroll during your initial enrollment period:
• If you enroll for the guaranteed amount, coverage is effective on the date you enroll.
• If you enroll for more than the guaranteed amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam.
– If approved, coverage is effective on the date Prudential approves your coverage.
– If any coverage above the guaranteed amount is not approved, you and/or your spouse/partner will be enrolled in coverage for the guaranteed amount and coverage will be effective on the date you enroll.
If you enroll in or increase coverage after your initial enrollment period for a reason other than an election change event:
• Coverage for you and/or your spouse/partner (including an increase to previously elected coverage) is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam.
• If approved, coverage is effective on the date Prudential approves your coverage.
If you enroll in or increase your coverage after your initial enrollment period due to an election change event:
• If you enroll for the guaranteed amount, coverage is effective on the date you enroll.
• If you enroll for more than the guaranteed amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam.
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See the Permitted election changes outside Annual Enrollment section of this Eligibility, enrollment, and effective dates chapter for information about election change events.
You are not required to provide Proof of Good Health for children if you enroll in optional dependent coverage at any time.
If your spouse/partner or dependent child is confined for medical treatment (at home or elsewhere), coverage is delayed until your spouse/partner or child has a medical release (does not apply to a newborn child).
If you are required to provide Proof of Good Health, payroll deductions will not begin until your coverage is effective, as described above.</td></tr>
</table>

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Management associates (continued)	
Includes management trainees, associates classified as "full-time hourly California pharmacists" in Walmart's payroll systems, and full-time OTR truck drivers **Note:** Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.	
Plan	**Enrollment periods and coverage effective dates**
• Long-term disability (LTD) plan, including enhanced benefits (for management associates other than full-time OTR truck drivers)	**Initial enrollment period:** You must enroll in coverage between your first payday and your 60th day of employment, measured from your date of hire. **When coverage is effective:** • **If you enroll in coverage during your initial enrollment period:** Coverage is effective on your date of hire. • **If you enroll in or increase coverage after your initial enrollment period:** – If you enroll in or increase coverage following an election change event, your coverage is effective on the later of 1) the date of the event, or 2) the first day of the pay period following the date you enroll. – If you enroll in or increase coverage during Annual Enrollment for the next Plan year, your coverage will be effective January 1 of that year. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the next Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
• Truck driver long-term disability (including enhanced benefits)	**Initial enrollment period:** You must enroll in coverage between your first payday and your 60th day of employment, measured from your date of hire. **When coverage is effective:** • **If you enroll in coverage during your initial enrollment period:** Coverage is effective on your date of hire. • **If you enroll in or increase coverage after your initial enrollment period:** Your coverage is subject to Lincoln's approval. You will be required to submit Proof of Good Health and may be required to undergo a medical exam at your own expense. – If you enroll in or increase coverage following an election change event and are approved, your coverage is effective on the first day of the pay period following the date your approval is received. – If you enroll in or increase coverage during Annual Enrollment for the next Plan year and are approved, your coverage will be effective the later of 1) January 1 of that year, or 2) if the approval is received on or after January 1 of that year, the first day of the pay period following the date the approval is received. – If you are not approved, you may be eligible to enroll during the next Annual Enrollment period or after an election change event but will be subject to the same Proof of Good Health requirements. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
Note: Some benefits require you to meet the definition of active work. See **"Active work" or "actively at work"** in this chapter for information.	

Paying for your benefits

Payroll deductions are required for any benefit that you choose to enroll in (e.g., medical, dental, vision, optional life, etc.) for benefit coverage to remain in effect. If your coverage changes during the year, your payroll deductions will be adjusted accordingly. Payroll deductions are not required for any benefit that you are automatically enrolled in (i.e., associate assistance resources, basic short-term disability for hourly associates, short-term disability for salaried associates, short-term disability for truck drivers, company-paid life insurance coverage, and business travel accident insurance).

For benefits that have a corresponding payroll deduction, the amount of your payroll deduction will depend on a number of factors, including the benefits you choose, the dependents you cover, and whether you are eligible for tobacco-free rates. The specific chapter for each benefit explains the factors that impact the payroll deduction amounts for that benefit, including whether you are eligible for tobacco-free rates. However, your eligibility for tobacco-free rates will depend on questions you answer during the enrollment process.

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 your covered spouse/partner do not use tobacco products, or
- You and/or your covered spouse/partner use tobacco and you and/or your covered spouse/partner agree to enroll and participate in a quit-tobacco program of your/their choice by the end of the Plan year for which you are enrolling. Alternatively, if you/they call Walmart's nicotine cessation program at **800-825-3555**, the program will work with you/them (and, if you wish, your/their doctor) to find a program that is right for you/them.

Not using tobacco products means that you and/or your covered spouse/partner have not used any type of nicotine product in the last 30 days, and you and/or your covered spouse/partner agree not to use any nicotine products in 2027. "Nicotine products" include cigarettes, cigars, pipes, snuff, chewing tobacco, and e-cigarettes or any such nicotine-delivery devices.



Important

If you are a first-time enrollee, you must actively complete an online enrollment session at **One.Walmart.com/Enroll** to receive tobacco-free rates.

You will be asked to attest to your nicotine use, the tobacco use of your covered spouse/partner, and whether you and/or your covered spouse/partner agree to enroll and participate in a quit-tobacco program to determine your eligibility for tobacco-free rates. You will be asked to make this attestation at your initial enrollment for the remainder of the calendar year and each year during Annual Enrollment for the next calendar year. Please note that your eligibility for tobacco-free rates can be established only at your initial enrollment and during Annual Enrollment. If you and/or your covered spouse/partner do not attest during initial enrollment or Annual Enrollment that you agree to enroll and participate in a nicotine cessation program, but you nonetheless become tobacco-free during the Plan year, you will not become eligible for tobacco-free rates until the following 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 apply for or enroll in benefits using correct and accurate information. If not, you may be subject to the loss of benefits and/or loss of employment."

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

For information, see **What is the nicotine cessation program?** in the **Associate assistance resources** chapter.

How payroll deductions are handled

As a general rule, payroll deductions are taken from your pay each pay period. Your payroll deductions for benefits in any pay period are paying for the coverage provided to you during that pay period.

Example: If you are paid biweekly, your payroll deductions pay for coverage for the two weeks in that pay period. Assume a pay period runs from April 1 through April 14, with the payday for that pay period being April 20. The payroll deductions taken from the pay you receive on April 20 will be for your benefits coverage from April 1 through April 14.

Example: If you are paid weekly, your payroll deductions pay for coverage for the week in that pay period. Assume a pay period runs from April 1 through April 7, with the payday for that pay period being April 13. The payroll deductions taken from the pay you receive on April 13 will be for your benefits coverage from April 1 through April 7.

Payroll deductions are not taken from your pay until your elected coverage becomes effective.

Your pay for the first pay period after your coverage effective date will generally reflect 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.

Be sure to check your paystub as soon as possible after your coverage effective date to verify that the proper deductions are being taken. You can view your paystub the Monday before payday by going to Online Paystub on **One.Walmart.com**.

If you believe the coverage or deductions are not correct on your paystub, call People Services immediately at **800-421-1362**. Requests for a review of payroll deductions are considered if submitted within one year from the date of a possible overpayment. A payroll deduction reconciliation will be completed back to the beginning of the Plan year prior to the Plan year in which you ask for a payroll deduction review. Refer to the **Confirming your enrollment** section earlier in this chapter for details on how to request correction of an enrollment error, including the time limits for doing so. In the case of an ineligible dependent, different payroll

deduction reconciliation rules may apply for company-paid life, optional associate or dependent life, business travel accident, accidental death and dismemberment (AD&D), accident, and/or critical illness insurance. In those cases, the rules are governed by the applicable insurance policy.

Taxation

Some types of coverage are paid for with pretax dollars. This means payroll deductions are taken from your biweekly pay 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. Other types of coverage are paid for with after-tax dollars, meaning payroll deductions are taken from amounts that have already been taxed.

With some exceptions discussed below, payroll deductions for the following types of coverage are taken on a pretax basis:

- Medical (except payroll deductions for partners and the children of partners under all options, which are taken on an after-tax basis, unless the partner/child is your tax dependent)
- Dental
- Vision
- Critical illness insurance
- Accident insurance
- Accidental death and dismemberment (AD&D)

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

Payroll deductions for the following types of coverage are taken on an after-tax basis:

- Medical for partners and their children, unless the partner/child is your tax dependent
- All types of disability coverage
- Optional associate and dependent life insurance

There are some instances where payroll deductions that are typically taken on a pretax basis are taken with after-tax dollars, including:

- Deductions for coverage that is effective retroactively. This may occur in instances when you are permitted to enroll after your coverage effective date (e.g., when you have experienced an election change event or you are a newly hired associate with benefits effective as of your date of hire). See the **Permitted election changes outside Annual Enrollment** section of this chapter.
- Deductions for amounts that are past due.

Tax consequences of partner benefits

What you pay for the medical coverage you enroll in for yourself and your eligible dependents represents part of the total cost of that coverage. Walmart pays the rest of the cost. Under federal law, the portion of the cost that Walmart pays for your medical coverage, and medical coverage you elect for your spouse and eligible dependent children, is not taxable income to you.

Generally, non-spouse partners and their children do not qualify as spouses or dependents under the Internal Revenue Code (or state income tax law, if applicable). If that is the case, Walmart's contribution for your partner's coverage and/or coverage for their children will be considered taxable income to you. This taxable income is often referred to as "imputed income." Imputed income is subject to applicable federal, state, local, Social Security, and Medicare taxes and withholding. As a result, imputed income is included on your paystub and Form W-2.

How your imputed income is determined

Walmart's contribution for the cost of medical coverage for associate + spouse/partner coverage or associate + family coverage minus Walmart's contribution for medical coverage for associate-only coverage is the amount of your imputed income. Here is an example of how imputed income is determined for associate + partner coverage:

Imputed income: An example	
Walmart's contribution per pay period for:	
Associate + partner coverage	$700
Associate-only coverage	-$300
The amount per pay period that is imputed income (added to your taxable wages)	$400

How imputed income appears on your paystub

If you enrolled your partner and/or your partner's children in medical coverage and have imputed income, your paystub will reflect the imputed income as a line item, with a dollar amount, in both the earnings column of your paystub and the deductions column. Imputed income may increase your taxable income and affect the amount of taxes withheld from your paycheck but does not increase your take-home pay.

If you elected medical coverage for your partner and/or their children but you are not receiving pay from Walmart, Walmart may collect your portion of the Social Security and Medicare tax liability for your imputed income directly from you.

These rules do not apply if your partner and/or their children satisfy the requirements to be considered your tax dependents under the Internal Revenue Code.

It is important to keep your dependent information and your benefits updated. Some life events may affect your taxes and other withholdings from your paycheck. See the **Permitted election changes outside Annual Enrollment** section of this chapter.

Keeping your coverage payments current

If you receive pay from Walmart (i.e., any pay processed through Walmart's payroll system), any amounts you currently owe (including past-due amounts) will be deducted from that pay to the extent permitted by law. There may be times when your pay is not sufficient to cover payments that are due. In that case, you are responsible for paying any unpaid amounts to the extent those amounts would have been paid if withheld as a payroll deduction. Payments for a pay period are due by the close of that pay period.

If you receive pay processed through Walmart's payroll system (regardless of whether it is for wages, incentive payments, paid time off, paid leave, etc.), any past-due amounts you owe will be deducted from that pay before amounts that are due for the current period. Any past-due amounts will be paid on an after-tax basis.

If any amounts for any benefit remain past due for more than 30 days, the process of canceling all of your coverage for which payments are required will begin. If your coverage is canceled, all of the coverage you elected will be canceled effective back to the date for which amounts are current. This means the cancellation of your coverage will be effective retroactively. If your coverage is canceled due to nonpayment, you will be unenrolled as if you had voluntarily dropped coverage, and:

- If you are an active associate, you will not be able to enroll again until the next Annual Enrollment period unless you experience an election change event, and provided you remain eligible. However, you may reenroll in optional life insurance at any time, provided you remain eligible. Reenrollment may require Proof of Good Health. See the **Permitted election changes outside Annual Enrollment** section of this chapter.
- If you are on a leave of absence and return to active work within one year of the first day of the leave, you will be enrolled for the same coverage that was in effect immediately prior to your leave of absence (or the most similar coverage offered under the Plan), unless you have otherwise elected other coverage as permitted by the Plan. Your coverage will be effective the first day of the pay period in which you return to active work.
- If you are on a leave of absence and return to active work after more than one year after the first day of the leave, you will be considered a new associate and will be required to meet any applicable eligibility requirements before you may enroll in coverage.

To avoid interruption or cancellation of coverage, payments can be made in advance of the due date by logging into the payment portal on **One.Walmart.com/Enroll**.

You can also call People Services at **800-421-1362** and say "make a payment." To confirm the amount owed for coverage, call People Services.

Payments made through the payment portal or by calling People Services can be made with a Visa, MasterCard, American Express, or Discover credit or debit card. Payments 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 are unable to pay the amount owed for coverage, the Plan will accept payments made by someone else on your behalf.

Payroll deductions will be taken from your final pay since those deductions pay for coverage during that pay period.

When you are on a leave

While you are on a Family and Medical Leave Act (FMLA) leave, personal leave, or military leave, you may retain most voluntary benefits you were enrolled in on the day immediately preceding the first day of the leave, provided all amounts owed for coverage are paid on a timely basis.

Coverages you can retain include medical, dental, vision, critical illness insurance, accident insurance, optional associate life, optional dependent life, and AD&D. You will also retain associate assistance resources, but no payments are required for that benefit. Coverage for these voluntary benefits is generally maintained on the same terms and conditions as if you had continued to work during the leave. Contact a member of your management team or Sedgwick, Walmart's leave administrator, for additional information about FMLA, personal, or military leave, or refer to Walmart's Leave of Absence Policy on **One.Walmart.com** for specific information. You may also contact your people lead or human resources representative for your area if you have questions about the FMLA, personal, or military leave policy. Decisions about leaves of absence are made by Walmart, not the Plan.

You also have the option to drop coverage when you go on a leave of absence. See the **Permitted election changes outside Annual Enrollment** section later in this chapter for more information, including the time period in which you may elect to drop coverage.

If you drop your coverage during your FMLA, personal, or military leave and return to work, you may reenroll in your prior coverage. See the **Permitted election changes outside Annual Enrollment** section later in this chapter for more information, including the time period in which you may elect to reenroll in coverage.

Paying for coverage when on an unpaid leave or when amounts owed are past due

It is your responsibility to make sure amounts owed for coverage are paid on time, so your benefits coverage remains active. When amounts owed for coverage are past due, regardless of the reason, you must make arrangements to keep them current, or risk cancellation of your coverage. As discussed above, if any amounts owed for any benefit remain past due for more than 30 days, all coverage you elected will be canceled effective back to the date for which payments for coverage are current.

When you are on a leave of absence, you may receive pay from which some or all of the amount you currently owe for coverage is deducted through payroll deductions. However, pay you receive may not be sufficient to pay all amounts currently owed for coverage, and there may be amounts that remain owed. When you are on any leave of absence, for any reason, it is your responsibility to make sure that all amounts owed for coverage are paid on time, so your benefits coverage remains active.

Paying for coverage when on paid leave

As discussed above, if you receive pay from Walmart (i.e., any pay processed through Walmart's payroll system), any amounts you currently owe for coverage (including past-due amounts) will be deducted from that pay to the extent permitted by law. This includes pay for wages, short-term disability benefits, and other paid leave processed through Walmart's payroll system, incentive payments, paid time off, etc. You must make arrangements to pay any amounts still owed for coverage after payroll deductions, or risk cancellation of coverage.

If you are receiving payments from any other source (such as long-term disability benefits paid by Lincoln or short-term disability benefits that are not processed through Walmart's payroll system), no payroll deductions will be taken from those payments. See the **Paying for coverage when receiving disability benefits** section later in this chapter for additional information.

Disability payroll deductions when on paid leave

If you have enrolled in any disability coverage, coverage may continue for a limited period of time if you are on a leave of absence or temporary layoff. To the extent you are required to pay for disability coverage, you will continue to owe amounts for coverage for as long as the coverage continues. For information about the time period that disability coverage continues in this circumstance, refer to the **If you are on a leave of absence or experience a temporary layoff** section of the **Full-time hourly short-term disability** chapter, the **Salaried short-term disability** chapter, the **Truck driver short-term disability** chapter, the **Full-time hourly and salaried long-term disability** chapter, or the **Truck driver long-term disability** chapter, as appropriate.

If you have elected disability coverage for which payroll deductions are required (i.e., short-term disability enhanced plan for full-time hourly or any long-term disability coverage), it's important to understand when payroll deductions for that disability coverage will be taken from pay processed through Walmart's payroll system. One of the factors that determine the disability payroll deductions you owe is the type of pay that you receive. Whether payroll deductions for disability coverage will be taken from pay processed through Walmart's payroll system depends on the type of pay it is. Not every type of pay you receive will be eligible pay for purposes of calculating disability benefits, so not every type of pay you receive will have a corresponding deduction for disability coverage. For example, in some cases, if you are disabled and receiving short-term disability benefits processed through Walmart's payroll system because you have been determined to be disabled under a short-term disability plan, no payroll deduction for disability coverage will be withheld from those disability benefit payments. On the other hand, payroll deductions for disability coverage will be taken from your non-disability pay.

There may be times when you see disability payroll deductions taken from pay that would otherwise not be subject to disability payroll deductions. For example, if you are disabled and receiving disability benefits processed through Walmart's payroll system when amounts (including amounts for disability coverage) from a prior payroll period remain past due, those past-due amounts may be deducted from the disability benefits, notwithstanding the fact that no current disability payroll deductions are otherwise due with respect to those current disability benefits.

Paying for coverage when receiving disability benefits

Disability benefits are processed differently, depending on the plan you are enrolled in and the state in which you work. The chart below and on the following page is intended to help you understand how payroll deductions are handled when you are receiving disability payments and other pay under a Walmart paid leave program.

When you are on any leave of absence for any reason, it is your responsibility to make sure that all amounts owed for coverage are paid on time so your benefits coverage remains active. If you are unable to pay the amounts owed for coverage, the Plan will accept payments made by someone else on your behalf.

To maintain coverage under these benefits	
• Medical • Dental • Vision • Critical illness insurance • Accident insurance	• Optional associate life • Optional dependent life • AD&D • Short-term disability • Long-term disability
While you are receiving...	
Short-term disability benefits under the full-time hourly short-term disability plan (except for associates who work in California, Hawaii, New Jersey, New York, or Rhode Island)	Short-term disability benefits are processed through Walmart's payroll system. You may also receive pay for paid time off, incentives, etc., which is also processed through Walmart's payroll system. • Any past-due amounts owed for coverage (including past-due amounts for disability coverage) will be deducted from short-term disability payments and other pay you receive. This means that if you owe any past-due amounts for disability coverage, those past-due amounts will be deducted from short-term disability benefits. No current disability payroll deductions will be taken from short-term disability benefits. • Any other benefit amounts (non-disability) owed for the current pay period will be deducted from short-term disability payments and other pay you receive through Walmart's payroll system (from paid time off, incentives, etc.). • You must make arrangements to pay any amounts still owed after payroll deductions or risk cancellation of your coverage.
Short-term disability benefits under the full-time hourly short-term disability plan (associates who work inCalifornia, Hawaii, New Jersey, New York, or Rhode Island)	Short-term disability benefits are not processed through Walmart's payroll system.[1] However, you may receive pay for paid time off, incentives, etc., which is processed through Walmart's payroll system. • No current short-term or long-term disability payroll deductions will be deducted from short-term disability benefits. Any past-due amounts owed for coverage (including past-due amounts for short-term or long-term disability coverage) will be deducted from short-term disability payments and other pay you receive through Walmart's payroll system. • Any other benefit (non-disability) amounts owed for the current pay period will be deducted from other pay you receive through Walmart's payroll system (from paid time off, incentives, etc.). • You must make arrangements to pay any amounts still owed after payroll deductions or risk cancellation of your coverage. [1] In some states, your maternity benefit may be supplemented by payments processed through Walmart's payroll system. In that case, any past-due amounts and current (non-disability) amounts owed for coverage would be deducted from those payments.
Long-term disability benefits under the: • Full-time hourly and salaried long-term disability plan • Truck driver long-term disability plan	Long-term disability benefits are not processed through Walmart's payroll system. However, you may receive pay for paid time off, incentives, etc., which is processed through Walmart's payroll system. • No current short-term or long-term disability payroll deductions will be taken from long-term disability benefits. Any past-due amounts (including past-due amounts for short-term or long-term disability coverage) will be deducted from other pay you receive through Walmart's payroll system. • Any other benefit (non-disability) amounts owed for the current pay period will be deducted from other pay you receive through Walmart's payroll system (from paid time off, incentives, etc.). • You must make arrangements to pay any amounts still owed for coverage after payroll deductions or risk cancellation of your coverage.

(Continued on the next page)

While you are receiving... (continued)	
Short-term disability benefits under the salaried short-term disability plan or truck driver short-term disability plan	Short-term disability benefits are processed through Walmart's payroll system. You may also receive pay for paid time off, incentives, etc., which is also processed through Walmart's payroll system. You do not have payroll deductions for short-term disability coverage under these plans. • Any past-due amounts owed for coverage (including past-due amounts for disability coverage) will be deducted from short-term disability payments and other pay you receive. This means that if you owe any past-due amounts for disability coverage, those past-due amounts will be deducted from short-term disability benefits. No current disability payroll deductions will be taken from short-term disability benefits. • Any amounts owed for other (non-disability) benefits for the current pay period will be deducted from short-term disability payments and other pay you receive through Walmart's payroll system (from paid time off, incentives, etc.). • You must make arrangements to pay any amounts still owed for coverage after payroll deductions or risk cancellation of your coverage.
Paid leave (non-disability) under a company paid leave program	Paid leave is processed through Walmart's payroll system. You may also receive pay (e.g., incentives), etc., which is also processed through Walmart's payroll system. • Any past-due benefit amounts owed for coverage will be deducted from any payments you receive. • Any amounts owed for the current pay period will be deducted from any payments you receive. • You must make arrangements to pay any amounts still owed for coverage after payroll deductions or risk cancellation of your coverage.

Permitted election changes outside Annual Enrollment

Certain benefits can be changed at any time during the year, but others can be changed only during Annual Enrollment, unless you experience an election change event, as follows:

- The medical plan options (including HMO options), dental, vision, AD&D, critical illness insurance, accident insurance, short-term disability enhanced, New York short-term disability enhanced, long-term disability, and truck driver long-term disability can be changed only during Annual Enrollment unless you experience an election change event.
- Optional associate life insurance and optional dependent life insurance can be added or dropped at any time and may be subject to Proof of Good Health requirements. See the **Optional associate life insurance** and **Optional dependent life insurance** chapters for details.

Federal tax law generally requires that your pretax benefit choices remain in effect for the entire calendar year for which the choice was made, except in the case of life events or certain other events described in federal regulations. In this *Associate Benefits Book*, we use the term "election change events" to mean the full range of circumstances described in federal regulations that allow you to change your pretax elections. 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 to both your pretax and after-tax benefit choices if you experience an election change event. An election change event, for purposes of this *Associate Benefits Book*, is a life event or other event listed in federal regulations that allows you to make changes to your coverage outside of annual or initial enrollment. Any change you make in response to a life event must be directly related to the impact of the event on your benefits and affect your eligibility. In other words, there must be a logical relationship between the life event and the change you request, and the life event that occurs must also make an individual eligible or ineligible for coverage. This is referred to in federal regulations as "the consistency rule." For example, if you (the associate) and your spouse divorce, your spouse loses eligibility for benefits under the Plan on the date of the divorce, so you may drop coverage for your spouse. However, you may not change coverage for dependent children who remain eligible because their eligibility was not affected by the divorce.

When you experience an election change event (including a life event or the loss or gain of other coverage as described in this section), any changes to your coverage must be made within 60 days from the date of the event.

Election change events include life events, gain of coverage, loss of coverage, change in cost, legal order, and Medicare or Medicaid entitlement.



The term "election change event" is used frequently in this *Associate Benefits Book* to refer to a life event or other event listed in federal regulations that allows you to make changes to your coverage outside of annual or initial enrollment. You may have seen these events referred to in other benefits-related literature as *status change events*, *family status changes*, or *qualifying events*. Detailed information about election change events can be found on this page.

Life events

- 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
  - Legal separation
- Events that change your domestic partnership status:
  - Commencement of domestic partnership
  - Termination of domestic partnership
  - 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
  - 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 or legal guardianship of a dependent
  - Loss of legal custody or legal guardianship 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
  - 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
  - Gain or loss of coverage due to a change in employment impacting your eligibility
  - A change in work location that affects your medical coverage. If the change affects your medical options (such as if a new HMO option 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 coverage is affected and do not submit a request, you will automatically be enrolled in a predetermined plan.

Gain of coverage

- Gain of coverage under any other employer plan.
- 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 coverage) 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 medical coverage (including an HMO option). For purposes of this election change event, the change must be requested within 60 calendar days of the date that the reduction in hours is reflected in Walmart's systems of record.
- Additions/improvements of a benefit option under this Plan. The Plan determines what, if any, election changes you may make in response to the addition or improvement of a benefit option. You will be informed if an election change opportunity is available.
- Eligibility under Medicare, Medicaid, TRICARE, or a state children's health insurance plan. (If you or your eligible dependents gain coverage under any other governmental plan, you cannot drop medical coverage (including an HMO option), accident insurance, or critical illness insurance coverage except during Annual Enrollment.)
- If you are eligible for a Special Enrollment Period to enroll in a qualified health plan through a Health Insurance Marketplace, or you seek to enroll in a qualified health plan through a Marketplace during the Marketplace's annual enrollment, as described in **Changes in your coverage following an election change event**, you can drop medical coverage (including an HMO option) 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 medical coverage (including an HMO option).

Loss of coverage

- Loss of coverage under any other employer plan.
- Reduction of coverage under this Plan.
- Significant loss of coverage, such as if an HMO plan in your area discontinues service. The Plan determines when a significant loss of coverage has occurred. You will be informed if an election change opportunity is available.
- 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 medical coverage (including an HMO option), 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, although loss of coverage under a Health Insurance Marketplace plan may result in a HIPAA special enrollment right if you originally declined coverage under the AMP because you had coverage through a Health Insurance Marketplace plan.)

- 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 amounts owed for coverage 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
  - Employer contributions toward other coverage have terminated

Change in cost

If the cost of coverage under this Plan or another plan changes significantly, you may be able to change your election accordingly. The Plan determines when a significant change in cost has occurred and what election changes you may make in response. You will be informed if an election change opportunity is available.

Legal order

If an order resulting from a divorce, legal separation, annulment, or change in legal custody (including a medical child support order—see **Medical child support orders** 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.

Medicare or Medicaid entitlement

If you or your eligible dependents are enrolled in medical coverage (including an HMO option), 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. 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 an election change event

When you experience an election 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 life event, each person must individually meet any applicable benefit waiting period (for example, for weight loss surgery) and will be subject to applicable Plan limitations. If you change medical plans due to an election change event, your annual deductible (if applicable) and out-of-pocket maximum will be reset (see "Note" below), and you will be responsible for meeting the new deductible (if applicable) and out-of-pocket maximum in their entirety. If you change from the Contribution HRA Plan to another plan, your HRA balance under the Contribution HRA 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, if you are covered as an associate and move to coverage as a dependent during the Plan year, or if you are covered as a dependent of one associate and become covered as the dependent of another associate during the Plan year:

- You will not receive credit under the AMP for expenses incurred prior to the date of the change (see "Note" below). 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 (if applicable) and out-of-pocket maximum under the AMP for expenses incurred as a covered dependent. You will also receive credit toward any applicable waiting periods.
- Your maximum annual benefit under the dental plan will not reset.

Note: If you or an eligible dependent:

- Were enrolled in the Associates' Medical Plan (AMP) and had accrued amounts toward, or had reached, the maximum lifetime benefit applicable to fertility benefits under the Centers of Excellence family building program, no portion of the maximum lifetime benefit will reset for any reason.
- Were enrolled in the dental plan and had accrued amounts toward, or had reached, the maximum lifetime benefit applicable to orthodontia benefits under the dental plan, no portion of the maximum lifetime benefit will reset for any reason.

The Plan reserves the right to request additional necessary documentation to show proof of an election 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 (some of which are also life events) 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). Such coverage will be effective upon the date you enroll in the Plan.
- 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. Such coverage will be effective the date of the event.
- 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 election change events or contact People Services at **800-421-1362**.

How to change your elections due to an election change event

You can make changes online within 60 days of the event on **One.Walmart.com/Enroll** for the following election change events:

- 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 or legal guardianship
- 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
- Termination of legal relationship with a person other than a spouse or domestic partner

For all other types of election change events, call People Services at **800-421-1362**.

If your election 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 to your coverage as a dependent, so long as the charges are submitted within 60 days of the birth and you add your newborn to your coverage on **One.Walmart.com/Enroll** or by calling People Services at **800-421-1362** within 180 days of the birth.

If you are adding 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 election change event, the individual will not be added to your coverage as a dependent.

If your short-term or long-term disability coverage ends because you are on a leave of absence or temporary layoff that exceeds 90 days, you may not elect to reenroll in short-term or long-term disability coverage until you return from the leave or layoff, even if you experience an election change event while on the leave of absence or temporary layoff. See the **Full-time hourly short-term disability** chapter, the **Salaried short-term disability** chapter, the **Truck driver short-term disability** chapter, the **Full-time hourly and salaried long-term disability** chapter and the **Truck driver long-term disability** chapter of this *Associate Benefits Book*, as applicable, for more information about your long-term disability coverage if your leave of absence or temporary layoff exceeds 90 days.

If you add coverage as a result of an election change event, that coverage will be effective on the date of the event. If you drop coverage as the result of an election change event, that coverage will continue through the date of the event. If any change is the result of being on an 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 (including enhanced benefits), or truck driver long-term disability (including enhanced benefits); see the **Enrollment and effective dates by job classification** charts in this chapter for information about effective dates.

If your election change results in an increase in your coverage costs, such as if you change from associate-only coverage to associate + dependent coverage, the increased

payroll deductions will be taken from your pay after you notify People Services of your election 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 election change event, you cannot add or drop coverage until the next Annual Enrollment period or until you experience a different election change event. However, as described earlier in this **Permitted election changes outside Annual Enrollment** section, any change you make in connection with an election change event must be directly related to the impact of the event on your benefits. Also, if the election 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 election 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.

Medical child support orders

If you are eligible for coverage under the Plan, you may be required to provide coverage for your child pursuant to a properly completed National Medical Support Notice (NMSN) or a Qualified Medical Child Support Order (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 qualified court order or enforcement agency notice meeting the qualifications of a QMCSO. An NMSN is a standardized medical support notice that is used by state child support enforcement agencies to require children to be enrolled in an employer's group plan. A properly completed NMSN is considered a QMCSO and must be honored by all employers' group health plans. As used in this section, the term QMCSO also means an approved NMSN.

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 and the child(ren) identified in the QMCSO will be enrolled in the default Premier PPO Plan with associate + child(ren) coverage, 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 Personalized Wellbeing Copay Plan is offered, the default plan is the Premier PPO Plan.

When you are enrolled in the default plan you will be enrolled at the tobacco rate. If you are tobacco-free, you should call People Services at **800-421-1362** within 60 days of the date on the letter from Medical Support Services to request a change in tobacco status and switch to the lower tobacco-free rate. Please see the information regarding tobacco rates in the **Paying for your benefits** section of this chapter for additional information on how to obtain tobacco-free rates, including the availability of a reasonable alternative standard to obtain those rates.

If you were enrolled in 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 the Personalized Wellbeing Copay Plan, your coverage will change to the Premier PPO 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 People Services at **800-421-1362** to select an alternative medical plan.

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 your satisfying your initial waiting period for medical coverage, the order will be put into effect when your initial waiting period is satisfied, subject to applicable Plan terms.
- 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, then become ineligible and subsequently regain eligibility, the Plan requires a new QMCSO before coverage for your dependent can take effect. This requirement will apply in the following situations:
  - If you become ineligible due to non-payment of amounts owed for coverage
  - If you become ineligible as a result of a change in your employment status

- 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**.

Dropping or changing QMCSO coverage

You may drop the court-ordered QMCSO coverage for the child(ren) identified in the QMCSO if the following applies:

- The QMCSO is terminated by a court or administrative agency order—you must request your change within 60 days (such as when the QMCSO is no longer appropriate).

  Examples:

  - You have no medical coverage prior to a court issuing a QMCSO, which requires you to cover yourself and a child. Pursuant to the QMCSO, you are enrolled in medical coverage under the Plan for yourself and your child. Due to a change in circumstances, the QMCSO is terminated prospectively. The day after the QMCSO is terminated, you request to drop coverage for yourself and your child. The Plan permits you to drop the coverage for your child who was the subject of the QMCSO as of the date the QMCSO is terminated. However, you may drop your associate coverage only during Annual Enrollment, unless another election change event occurs.
  - You are enrolled in medical coverage at the time a QMCSO is issued for your child. Pursuant to the terms of the QMCSO, you and your child are enrolled in medical coverage. Due to a change in circumstances, the QMCSO is terminated prospectively. The day after the QMCSO is terminated, you request to drop coverage for yourself and your child. The Plan permits you to drop the coverage for your child who was the subject of the QMCSO as of the date the QMCSO is terminated. However, you may drop your associate coverage only during Annual Enrollment, unless another election change event occurs.
- The QMCSO is rescinded by a court or administrative agency order (such as if an agency determines the order is invalid).

  Example:

  - You have no medical coverage prior to a court issuing a QMCSO, which requires you to cover yourself and a child. Pursuant to the QMCSO, you are enrolled in medical coverage under the Plan for yourself and your child. Six months later, the court determines that it had issued the QMCSO in error and issues a "rescind order" that retroactively withdraws the QMCSO. The Plan allows you to return to "no coverage" effective as of the first date of your and your child's enrollment and refunds any amounts you paid for coverage. You will be required to pay the cost of benefits the Plan paid on behalf of you and your child during the period for which coverage is rescinded and payroll deductions refunded. Call the third-party administrator number on your Plan ID card for more information about this process.
- A child who is the subject of the court order reaches the age of emancipation in the state issuing the court order. Contact your state child support enforcement agency for details.

If the QMCSO is terminated by court or administrative agency order, the enforcement of the order will end on the date specified in the order or the first day of the pay period in which the Plan receives the order, whichever is later. Although the order automatically ends, coverage for the child will not. You will receive a termination notification letter from Medical Support Services that your order has terminated, and you will have 60 days from your notification date to call People Services to drop the child's coverage.

Coverage for the child will not be terminated unless Medical Support Services has received satisfactory written evidence that:

- The QMCSO is no longer in effect, or
- The child is or will be enrolled in comparable coverage which will take effect no later than the effective date of the child's loss of coverage under the Plan.

When a QMCSO terminates, you may not drop your own coverage or coverage for any other dependent unless there is a change in status for you or your other dependents, or during Annual Enrollment. However, you may change your medical plan option by calling People Services as long as you request the change within 60 days of the termination notification letter. For dental coverage, you may not drop associate-level coverage during the Annual Enrollment period or due to an election change event unless you have been covered for two consecutive calendar years.

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 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
- On the last day of coverage for which payments for coverage were made, if you fail to pay the amount owed for coverage within 30 days of the date your payment 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
- When you voluntarily drop coverage

If your job classification changes, see the appropriate chart in the Transferring from one job classification to another section in this chapter for information on any impact to your coverage.

If you voluntarily drop coverage after an election change event or at Annual Enrollment:

- **After an election change event:**
  - If you drop coverage using online enrollment, coverage for all benefits except long-term disability and short-term disability will continue through the date of the event. Coverage for long-term disability and short-term disability will continue through the date of the online enrollment session.
  - If you drop coverage by calling People Services, coverage for all benefits continues through the day of the event.

  See **Permitted election changes outside Annual Enrollment** in this chapter for information.
- **At Annual Enrollment:** coverage continues through December 31 of the current year that contains the Annual Enrollment period.

If your work location changes

If your work location changes, your medical options may change. If that occurs, you will be notified of your new options.

If your work location changes to Puerto Rico, additional options may change. Refer to the current *Associate Benefits Book* for Puerto Rico associates for information on benefits available to associates residing in Puerto Rico. All of your service with Walmart will count in determining your eligibility for benefits available to associates residing in Puerto Rico.

Some states and localities provide legally mandated short-term disability benefits. If you are a full-time hourly associate working in one of those states or localities, variations in laws and administrative procedures may affect your ability to participate in the Walmart full-time hourly short-term disability plan, as well as the amount of any disability benefit. See the **Full-time hourly short-term disability** chapter for more information. If you are a salaried associate or full-time OTR truck driver associate working in one of those states or localities, variations in laws and administrative procedures may affect the amount of any disability benefit. Refer to the **Salaried short-term disability** chapter and the **Truck driver short-term disability** chapter for details.

The following chart describes the effect on your eligibility for the full-time hourly short-term disability benefit when you transfer from a work location in a state with legally mandated benefits to a state without legally mandated benefits, and vice versa.

Interstate transfers

If you transfer from a work location in a state or locality with mandated short-term disability benefits to a work location in a state without mandated short-term disability benefits, you will automatically be enrolled in the short-term disability enhanced plan, because it is the plan most like your prior state- or locally mandated benefit.

Original work location	New work location	Benefits
All locations ***except*** California, Hawaii, New Jersey, or Rhode Island	All locations ***except*** California, Hawaii, New Jersey, or Rhode Island	No change in short-term disability plan enrollment
California, Hawaii, New Jersey, or Rhode Island	All locations ***except*** California, Hawaii, New Jersey, or Rhode Island	You will automatically be enrolled in the short-term disability enhanced benefit because it is the plan most like your prior state benefit. Coverage is effective the later of 1) the first day of the pay period in which your transfer occurs, or 2) the 12-month anniversary of your date of hire. If you would like to change from the short-term disability enhanced plan to the short-term disability basic plan, you must contact People Services to request the change within 60 days from the date of the transfer. If you do not request the change during that time period you will not be able to change until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
California, Hawaii, New Jersey, or Rhode Island	California, Hawaii, New Jersey, or Rhode Island	You will not be eligible for the Walmart short-term disability basic or enhanced plans because you may be eligible for disability benefits through the state.

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Interstate transfers (continued)

If you transfer from a work location in a state or locality with mandated short-term disability benefits to a work location in a state without mandated short-term disability benefits, you will automatically be enrolled in the short-term disability enhanced plan, because it is the plan most like your prior state- or locally mandated benefit.

Original work location	New work location	Benefits
All locations ***except*** California, Hawaii, New Jersey, or Rhode Island	California, Hawaii, New Jersey, or Rhode Island	You will not be eligible for the Walmart short-term disability basic or enhanced plans because you may be eligible for disability benefits through the state. Your Walmart short-term disability benefit will end on the last day of the pay period in which your transfer occurs.
New York	All locations ***except*** California, Hawaii, New Jersey, or Rhode Island	You will automatically be enrolled in the short-term disability enhanced benefit if you were enrolled in the New York short-term disability enhanced plan prior to your transfer. If you were enrolled in the New York short-term disability basic plan prior to your transfer, there will be no change in short-term disability plan enrollment. Coverage is effective the later of 1) the first day of the pay period in which your transfer occurs, or 2) the 12-month anniversary of your date of hire. If you would like to change from the short-term disability enhanced plan to the short-term disability basic plan, you must contact People Services to request the change within 60 days from the date of the transfer. If you do not request the change during that time period you will not be able to change until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
All locations ***except*** California, Hawaii, New Jersey, or Rhode Island	New York	You will automatically be enrolled in the New York short-term disability enhanced benefit if you were enrolled in the short-term disability enhanced plan prior to your transfer. If you were enrolled in the short-term disability basic plan prior to your transfer, there will be no change in short-term disability plan enrollment. Coverage is effective the later of 1) the first day of the pay period in which your transfer occurs, or 2) the 12-month anniversary of your date of hire. If you would like to change from the short-term disability enhanced plan to the short-term disability basic plan, you must contact People Services to request the change within 60 days from the date of the transfer. If you do not request the change during that time period you will not be able to change until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
Puerto Rico	All locations ***except*** California, Hawaii, New Jersey, or Rhode Island	You will automatically be enrolled in the short-term disability basic plan. Coverage will be effective the later of 1) the first day of the pay period in which your transfer occurs, or 2) the 12-month anniversary of your original date of hire. If you would like to change from the short-term disability basic plan to the short-term disability enhanced plan, you must contact People Services to request the change within 60 days from the date of the transfer. If you do not request the change during that time period, you will not be able to change until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of this chapter.
Puerto Rico	California, Hawaii, New Jersey, or Rhode Island	You will not be eligible for the Walmart short-term disability basic or enhanced plans because you may be eligible for disability benefits through the state.

If your job classification changes

Transitioning from one job classification to another may affect your eligibility for certain benefits. The charts on the following pages discuss the changes that will occur as a result of the change in classification. If you don't enroll in some voluntary benefits when you are first eligible, but enroll at a later date, there may be additional requirements. For more information, see **Enrollment and effective dates by job classification** earlier in this chapter and refer to the chart that applies to your new job classification.

If your job classification changes from management or full-time hourly associate to part-time hourly associate, temporary associate or part-time OTR 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 you or 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.

Except as otherwise provided in one of the charts in the following **Transferring from one job classification to another** section of this chapter, eligibility changes are effective when the transfer occurs (i.e., when it is entered in Walmart's systems of record).

As explained earlier in this chapter, part-time hourly associates and temporary associates must work an average of at least 30 hours per week to be eligible to enroll in medical benefits. Limited exceptions to this rule apply. See the section titled **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** earlier in this chapter for more information on these exceptions.

After 52 weeks from the date of hire, hours for part-time hourly associates and temporary associates are measured annually during a 52-week period ending in October each year to determine eligibility for medical benefits for the next calendar year.

If your job classification changes to part-time hourly associate or temporary associate **within 52 weeks from your date of hire**:

- Your eligibility for medical benefits continues through your 52-week anniversary and to the following December 31st.
- Depending on your 52-week anniversary date, your first eligibility check for medical benefits will occur in October of either the same calendar year or the following calendar year.
  - **Example:** You are hired as a full-time hourly associate on March 20, 2027, and your job classification changes to part-time hourly associate on July 11, 2027, during your first 52 weeks of employment. Your eligibility for medical benefits continues through December 31, 2028. Your first eligibility check will occur in October 2028 for medical eligibility for 2029.
  - **Example:** You are hired as a full-time hourly associate on April 17, 2026, and your job classification changes to part-time hourly associate on March 21, 2027, during your first 52 weeks of employment. Your eligibility for medical benefits continues through December 31, 2027. Your first eligibility check will occur in October 2027 for medical eligibility for 2028.

If your job classification changes to part-time hourly or temporary associate **after 52 weeks from date of hire:**

- If you transfer before the annual eligibility check has occurred, your eligibility for medical benefits continues through December 31 of the year of the transfer, and your first eligibility check will occur in October of that year.
- If you transfer after the annual eligibility check has occurred, your eligibility for medical benefits continues through December 31 of the following year, and your first eligibility check will be the one that occurs in the following calendar year.
  - **Example:** You are hired as a full-time hourly associate on March 21, 2026, and your job classification changes to part-time hourly associate on April 20, 2027, after your first 52 weeks of employment. Your eligibility for medical benefits continues through December 31, 2027. Your first eligibility check will occur in October 2027 for medical eligibility for 2028.
  - **Example:** You are hired as a full-time hourly associate on July 21, 2026, and your job classification changes to part-time hourly associate on November 20, 2027, after your first 52 weeks of employment and after the annual eligibility check for 2028 benefits. Your eligibility for medical benefits continues through December 31, 2028. Your first eligibility check will occur in October 2028 for medical eligibility for 2029.

For additional information, see **Your annual eligibility check**, which can be found earlier in this chapter in the section titled **Part-time hourly associates and temporary associates: eligibility checks for medical benefits**.

Transferring from one job classification to another

Part-time hourly associate or temporary associate transferring to part-time OTR truck driver	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Part-time OTR truck drivers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a part-time hourly associate or temporary associate, and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your part-time hourly associate or temporary associate classification until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Medical Dental Vision Accident insurance Critical illness insurance AD&D	As a part-time OTR truck driver, you are eligible for medical, dental, vision, AD&D, critical illness and accident insurance coverage and may cover your eligible dependent children. You are not eligible for spouse/partner coverage. **If you were eligible for coverage** on the date of your transfer, you may not make changes as a result of your transfer because you already had the opportunity to enroll yourself and your eligible dependent children in coverage as a part-time hourly associate or temporary associate. **If you were not eligible for coverage** on the date of your transfer, you may enroll in associate-only or associate + child(ren) coverage. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective the later of 1) the date you enroll or 2) the first day of the month in which your 89th day of continuous employment falls. • If you enroll by calling People Services, coverage is effective the later of: – The first day of the month in which your 89th day of continuous employment falls, or – Your choice of either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive payroll deductions back to that effective date will be taken from your pay on an after-tax basis.
Optional associate life insurance Optional dependent (child) life insurance	As a part-time OTR truck driver, you are eligible for optional associate life insurance coverage and optional dependent life insurance coverage for your eligible dependent children. Proof of Good Health requirements may apply to you, but they do not apply to your children. You are not eligible for optional dependent life insurance coverage for your spouse/partner. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** **If you were eligible for coverage on the date of your transfer,** you may elect or change optional associate and dependent life insurance coverage at any time. But see the **Part-time OTR truck drivers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply if you change coverage for yourself or your child after your initial enrollment period. **If you were not eligible for coverage on the date of your transfer:** • If you enroll for the guaranteed amount for yourself, or any amount for your child, coverage is effective the later of 1) the date you enroll, or 2) the first day of the month in which your 89th day of continuous employment falls. • If you enroll for more than the guaranteed amount for yourself, coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, coverage above the guaranteed amount is effective the later of 1) the date Prudential approves your coverage, or 2) the first day of the month in which your 89th day of continuous employment falls. If any coverage above the guaranteed amount is not approved, you will be enrolled in the guaranteed amount and coverage will be effective as if you had enrolled for only the guaranteed amount when you were first eligible.

Part-time hourly associate or temporary associate transferring to full-time hourly associate (continued)

- Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs.
- If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event.
- See the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period.
- Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.
- If you became eligible as a part-time hourly associate or temporary associate, and the initial enrollment period is still open as of the date of your transfer:
  - Your initial enrollment period remains unchanged.
  - You may make any election permitted under your part-time hourly associate or temporary associate classification until your initial enrollment period ends.
- After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs.
- All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.

Medical Dental Vision Accident insurance Critical illness insurance AD&D	As a full-time hourly associate, you are eligible for medical, dental, vision, accident, critical illness, and AD&D insurance coverage and may cover your eligible dependent children and spouse/partner. **If you were eligible for coverage** on the date of your transfer, you may not enroll in associate-only or associate + child(ren) coverage as a result of your transfer because you already had the opportunity to enroll yourself and your children in coverage as a part-time hourly associate or temporary associate. However, you may enroll in associate + spouse/partner or associate + family coverage to add your spouse/partner. **If you were not eligible for coverage** on the date of your transfer, you may enroll in any coverage level. If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows: If you were eligible for coverage on the date of your transfer: • If you enroll online, coverage is effective the date you enroll. • If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive payroll deductions back to that effective date will be taken from your pay on an after-tax basis. **If you were not eligible for coverage on the date of your transfer:** • If you enroll online, coverage is effective the later of 1) the date you enroll, or 2) the first day of the month in which your 89th day of continuous employment falls. • If you enroll by calling People Services, coverage is effective the later of: – The first day of the month in which your 89th day of continuous employment falls, or – Your choice of either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive payroll deductions back to that effective date will be taken from your pay on an after-tax basis.
Company-paid life insurance	As a full-time hourly associate, you are automatically enrolled in company-paid life insurance coverage, effective the later of 1) the first day of the pay period in which your transfer occurs, or 2) the first day of the month in which your 89th day of continuous employment falls.
Optional associate life insurance Optional dependent life insurance	As a full-time hourly associate, you are eligible for optional associate life insurance coverage. You may also cover your eligible dependent children and spouse/partner under optional dependent life insurance coverage. Proof of Good Health requirements may apply to you and your spouse/partner, but they do not apply to your children. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** **If you were eligible for coverage** on the date of your transfer, you can elect or change optional associate and dependent life insurance coverage at any time. But see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply if you change coverage for yourself or your child after your initial enrollment period. **If you were not eligible for coverage** on the date of your transfer, you may enroll in optional associate life insurance coverage for yourself and optional dependent life insurance coverage for your child and spouse/partner. You and your spouse/partner may be subject to Proof of Good Health requirements. • If you enroll for the guaranteed amount for yourself or your spouse/partner, or any amount for your child, coverage is effective the later of 1) the date you enroll or 2) the first day of the month in which your 89th day of continuous employment falls. • If you enroll for more than the guaranteed amount for yourself or your spouse/partner, coverage is subject to Prudential's approval. You will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, coverage above the guaranteed amount is effective the later of 1) the date Prudential approves your or your spouse's/partner's coverage, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. If any coverage above the guaranteed amount is not approved, you or your spouse/partner will be enrolled in the guaranteed amount and coverage will be effective as if you had enrolled yourself or your spouse/partner for only the guaranteed amount when you were first eligible.

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Part-time hourly associate or temporary associate transferring to full-time hourly associate (continued)	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a part-time hourly associate or temporary associate, and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your part-time hourly associate or temporary associate classification until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Short-term disability	As a full-time hourly associate, you are eligible for short-term disability coverage. You are automatically enrolled for the basic and maternity coverage under the **full-time hourly short-term disability basic plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York will be enrolled in the **New York short-term disability basic plan**. Coverage is effective the later of: 1) the first day of the pay period in which your transfer occurs, or 2) the 12-month anniversary of your date of hire. You may enroll in the **full-time hourly short-term disability enhanced plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in **New York may enroll in the New York short-term disability enhanced plan**. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective the later of 1) the date you enroll, or 2) the 12-month anniversary of your date of hire. • If you enroll by calling People Services, coverage is effective the later of: – The 12-month anniversary of your date of hire, or – Your choice of either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs.
Long-term disability	As a full-time hourly associate, you are eligible for long-term disability coverage under the **full-time hourly and salaried long-term disability plan**. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective the later of 1) the first day of the pay period in which your transfer occurs, or 2) the 12-month anniversary of your date of hire. • If you enroll by calling People Services, coverage is effective the later of: – The 12-month anniversary of your date of hire or – Your choice of either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs.

Part-time hourly associate or temporary associate transferring to full-time hourly Vision Center manager

- Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs.
- If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event.
- See the **Full-time hourly Vision Center managers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period.
- Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.
- If you became eligible as a part-time hourly associate or temporary associate, and the initial enrollment period is still open as of the date of your transfer:
  - Your initial enrollment period remains unchanged.
  - You may make any election permitted under your part-time hourly associate or temporary associate classification until your initial enrollment period ends.
- After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs.
- All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.

Medical Dental Vision Accident insurance Critical illness insurance AD&D	As a full-time hourly Vision Center manager, you are eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children and spouse/partner. **If you were eligible for coverage** on the date of your transfer, you may not enroll in associate-only or associate + children coverage as a result of your transfer because you already had the opportunity to enroll yourself and your children in coverage as a part-time hourly associate or temporary associate. However, you may enroll in associate + spouse/partner or associate + family coverage to add your spouse/partner to coverage. **If you were not eligible for coverage** on the date of your transfer, you may enroll in any coverage level. If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows: • If you enroll online, coverage is effective the date you enroll. • If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive payroll deductions back to that effective date will be taken from your pay on an after-tax basis.
Company-paid life insurance	As a full-time hourly Vision Center manager, you are automatically enrolled in company-paid life insurance coverage, effective the first day of the pay period in which your transfer occurs.
Optional associate life insurance Optional dependent (child) life insurance	As a full-time hourly Vision Center manager, you are eligible for optional associate life insurance coverage. You may also cover your eligible dependent children and spouse/partner under optional dependent life insurance coverage. Proof of Good Health requirements may apply to you and your spouse/partner, but they do not apply to your children. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** **If you were eligible for coverage** on the date of your transfer, you may enroll or make changes at any time. But see the **Full-time hourly Vision Center managers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply if you change coverage for yourself or your child after your initial enrollment period. **If you were not eligible for coverage** on the date of your transfer, you may enroll in optional associate life insurance coverage for yourself and optional dependent life insurance coverage for your child and spouse/partner. You and your spouse/partner may be subject to Proof of Good Health requirements. • If you enroll for the guaranteed amount for yourself or your spouse/partner, or any amount for your child, coverage is effective the date you enroll. • If you enroll for more than the guaranteed amount for yourself or your spouse/partner, coverage is subject to Prudential's approval. You or your spouse/partner will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, coverage above the guaranteed amount is effective the date Prudential approves your or your spouse/partner coverage. If any coverage above the guaranteed amount is not approved, you or your spouse/partner will be enrolled in the guaranteed amount and coverage will be effective as if you had enrolled yourself or your spouse/partner for only the guaranteed amount when you were first eligible.

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Part-time hourly associate or temporary associate transferring to full-time hourly Vision Center manager (continued)	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Full-time hourly Vision Center managers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a part-time hourly associate or temporary associate, and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your part-time hourly associate or temporary associate classification until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Short-term disability	As a full-time hourly Vision Center manager, you are eligible for short-term disability coverage. You are automatically enrolled for the basic and maternity coverage under the **full-time hourly short-term disability basic plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York will be enrolled in the **New York short-term disability basic plan**. Coverage is effective the first day of the pay period in which your transfer occurs. You may enroll in the **full-time hourly short-term disability enhanced plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York may enroll in the **New York short-term disability enhanced plan**. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective the first day of the pay period in which your transfer occurs. • If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs.
Long-term disability	As a full-time hourly Vision Center manager, you are eligible for long-term disability coverage under the **full-time hourly and salaried long-term disability plan**. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective the first day of the pay period in which your transfer occurs. • If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs.

Part-time hourly associate or temporary associate transferring to management associate (including full-time OTR truck driver)

- Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs.
- If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event.
- See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period.
- Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.
- If you became eligible as a part-time hourly associate or temporary associate, and the initial enrollment period is still open as of the date of your transfer:
  - Your initial enrollment period remains unchanged.
  - You may make any election permitted under your part-time hourly associate or temporary associate classification until your initial enrollment period ends.
- After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs.
- All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.

Medical Dental Vision Accident insurance Critical illness insurance AD&D	As a management associate, you are eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children and spouse/partner. Additionally, the maximum coverage amount for AD&D insurance coverage increases to $1,000,000. **If you were eligible for coverage** on the date of your transfer, you may not enroll in associate-only or associate + child(ren) coverage as a result of your transfer because you already had the opportunity to enroll yourself and your children in coverage as a part-time hourly associate or temporary associate. However, you may enroll in associate + spouse/partner or associate + family coverage to add your spouse/partner. **If you were not eligible for coverage** on the date of your transfer, you may enroll in any coverage level. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective the date you enroll. • If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive payroll deductions back to that effective date will be taken from your pay on an after-tax basis.
Company-paid life insurance	As a management associate, you are automatically enrolled in company-paid life insurance coverage, effective the first day of the pay period in which your transfer occurs.
Optional associate life insurance Optional dependent (child) life insurance	As a management associate, you remain eligible for optional associate life insurance coverage but the maximum coverage amount increases to $1,000,000. Proof of Good Health requirements apply if you increase your coverage. As a management associate, you may cover your eligible dependent children and spouse/partner under optional dependent life insurance coverage. Proof of Good Health requirements may apply to your spouse/partner, but they do not apply to your children. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** **If you were eligible for coverage** on the date of your transfer, you can elect or change optional associate and dependent life insurance coverage at any time. But see the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply if you change coverage for yourself (including increasing the coverage amount) or your child after your initial enrollment period. **If you were not eligible for coverage** on the date of your transfer, you may enroll in optional associate life insurance coverage for yourself and optional dependent life insurance coverage for your eligible dependent children and spouse/partner. You and your spouse/partner may be subject to Proof of Good Health requirements. • If you enroll for the guaranteed amount for yourself or your spouse/partner, or any amount for your child, coverage is effective the date you enroll. • If you enroll for more than the guaranteed amount for yourself or your spouse/partner, coverage is subject to Prudential's approval. You or your spouse/partner will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, coverage above the guaranteed amount is effective the date Prudential approves your or your spouse/partner coverage. If any coverage above the guaranteed amount is not approved, you or your spouse/partner will be enrolled in the guaranteed amount and coverage will be effective as if you had enrolled yourself or your spouse/partner for only the guaranteed amount when you were first eligible.

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Part-time hourly associate or temporary associate transferring to management associate (including full-time OTR truck driver) (continued)	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a part-time hourly associate or temporary associate, and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your part-time hourly associate or temporary associate classification until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Short-term disability	***Management associate (non–truck driver):*** You are automatically enrolled for the basic and maternity coverage under the **salaried short-term disability plan**. Coverage is effective on the first day of the pay period in which your transfer occurs. ***Management associate (full-time OTR truck driver):*** You are automatically enrolled for the basic and maternity coverage under the **truck driver short-term disability plan**. Coverage is effective on the first day of the pay period in which your transfer occurs.
Long-term disability	***Management associate (non–truck driver):*** You are eligible for long-term disability coverage under the **full-time hourly and salaried long-term disability plan**. ***Management associate (full-time OTR truck driver):*** You are eligible for long-term disability coverage under the **truck driver long-term disability plan**. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective the first day of the pay period in which your transfer occurs. • If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs.

Part-time OTR truck driver transferring to part-time hourly associate or temporary associate	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Part-time hourly associates and temporary associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a part-time OTR truck driver, and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your part-time OTR truck driver classification until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Medical Dental Vision Accident insurance Critical illness insurance AD&D	As a part-time hourly associate or temporary associate transferring from a part-time OTR truck driver classification, you will be eligible for medical, dental, vision, AD&D, critical illness and accident coverage and may cover your eligible dependent children. However, see the **If your job classification changes** section and the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in this chapter for important information about the period of time that you will remain eligible for medical benefits and future eligibility checks for medical benefits. You may not make changes to your coverage as a result of your transfer because you already had the opportunity to enroll as a part-time OTR truck driver.
Optional associate life insurance Optional dependent (child) life insurance	As a part-time hourly associate or temporary associate, you remain eligible for optional associate life insurance and optional dependent life insurance coverage for your eligible dependent children.

Part-time OTR truck driver transferring to full-time hourly associate	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a part-time OTR truck driver, and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your part-time OTR truck driver classification until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Medical Dental Vision Accident insurance Critical illness insurance AD&D	As a full-time hourly associate, you are eligible for medical, dental, vision, AD&D, critical illness and accident insurance coverage and may cover your eligible dependent children and spouse/partner. You may not enroll in associate-only or associate + child(ren) coverage as a result of the transfer because as a part-time OTR truck driver, you already had the opportunity to enroll yourself and your children. However, you may enroll in associate + spouse/partner or associate + family coverage to add your spouse/partner as a result of your transfer. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective the later of 1) the date you enroll, or 2) the first day of the month in which your 89th day of continuous employment falls. • If you enroll by calling People Services, coverage is effective the later of: – The first day of the month in which your 89th day of continuous employment falls, or – Your choice of either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive payroll deductions back to that effective date will be taken from your pay on an after-tax basis.
Company-paid life insurance	As a full-time hourly associate, you are automatically enrolled in company-paid life insurance coverage, effective the later of 1) the first day of the pay period in which your transfer occurs, or 2) the first day of the month in which your 89th day of continuous employment falls.
Optional associate life insurance Optional dependent life insurance	As a full-time hourly associate, you remain eligible for optional associate life insurance and optional dependent life insurance coverage for your eligible children. You may also cover your spouse/partner under dependent life insurance coverage. Proof of Good Health requirements may apply. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll in dependent life insurance coverage for your spouse/partner, they may be subject to Proof of Good Health requirements: – If you enroll for the guaranteed amount for your spouse/partner, coverage is effective the later of 1) the date you enroll or 2) the first day of the month in which your 89th day of continuous employment falls. – If you enroll for more than the guaranteed amount for your spouse/partner, coverage is subject to Prudential's approval. Your spouse/partner will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, coverage above the guaranteed amount is effective the later of 1) the date Prudential approves your spouse/partner coverage, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. If any coverage above the guaranteed amount is not approved, your spouse/partner will be enrolled in the guaranteed amount and coverage will be effective as if you had enrolled your spouse/partner for only the guaranteed amount when you were first eligible.

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Part-time OTR truck driver transferring to full-time hourly associate (continued)	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a part-time OTR truck driver, and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your part-time OTR truck driver classification until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Short-term disability	As a full-time hourly associate, you are eligible for short-term disability coverage. You are automatically enrolled in the basic and maternity benefits under the **full-time hourly short-term disability basic plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York will be enrolled in the **New York short-term disability basic plan**. Coverage is effective on the later of: 1) the first day of the pay period in which your transfer occurs, or 2) the 12-month anniversary of your date of hire. You may enroll in the **full-time hourly short-term disability enhanced plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York may enroll in the **New York short-term disability enhanced plan**. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective the later of 1) the date you enroll or 2) the 12-month anniversary of your date of hire. • If you enroll by calling People Services, coverage is effective the later of: – The 12-month anniversary of your date of hire, or – Your choice of either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs.
Long-term disability	As a full-time hourly associate, you are eligible for long-term disability coverage under the **full-time hourly and salaried long-term disability plan**. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective the later of 1) the first day of the pay period in which your transfer occurs or 2) the 12-month anniversary of your date of hire. • If you enroll by calling People Services, coverage is effective the later of: – The 12-month anniversary of your date of hire, or – Your choice of either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs. If the effective date is any date other than the date you enroll, any retroactive payroll deductions back to that effective date will be taken from your pay.

Part-time OTR truck driver transferring to full-time hourly Vision Center manager

- Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs.
- If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event.
- See the **Full-time hourly Vision Center managers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period.
- Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.
- If you became eligible as a part-time OTR truck driver, and the initial enrollment period is still open as of the date of your transfer:
  - Your initial enrollment period remains unchanged.
  - You may make any election permitted under your part-time OTR truck driver classification until your initial enrollment period ends.
- After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs.
- All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.

Medical Dental Vision Accident insurance Critical illness insurance AD&D	As a full-time hourly Vision Center manager, you are eligible for medical, dental, vision, AD&D, critical illness and accident insurance coverage and may cover your eligible dependent children and spouse/partner. You may not enroll in associate-only or associate + child(ren) coverage as a result of the transfer because you already had the opportunity to enroll yourself and your children in coverage as a part-time OTR truck driver. However, you may enroll in associate + spouse/partner or associate + family coverage to add your spouse/partner to coverage. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective on the date you enroll. • If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive payroll deductions back to that effective date will be taken from your pay on an after-tax basis.
Company-paid life insurance	As a full-time hourly Vision Center manager, you are automatically enrolled in company-paid life insurance coverage, effective the first day of the pay period in which your transfer occurs.
Optional associate life insurance Optional dependent life insurance	As a full-time hourly Vision Center manager, you remain eligible for optional associate life insurance and optional dependent life insurance for your eligible dependent children. You may also cover your spouse/partner under dependent life insurance coverage. Proof of Good Health requirements may apply. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll in dependent life insurance coverage for your spouse/partner, they may be subject to Proof of Good Health requirements: – If you enroll for the guaranteed amount for your spouse/partner, or any amount for your child, coverage is effective the date you enroll. – If you enroll for more than the guaranteed amount for your spouse/partner, coverage is subject to Prudential's approval. Your spouse/partner will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, coverage above the guaranteed amount is effective the date Prudential approves your spouse/partner coverage. If any coverage above the guaranteed amount is not approved, your spouse/partner will be enrolled in the guaranteed amount and coverage will be effective as if you had enrolled your spouse/partner for only the guaranteed amount when you were first eligible.
Short-term disability	As a full-time hourly Vision Center manager, you are eligible for short-term disability coverage. You are automatically enrolled in the basic and maternity benefits under the **full-time hourly short-term disability basic plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York will be enrolled in the **New York short-term disability basic plan**. Coverage is effective the first day of the pay period in which your transfer occurs. You may enroll in the **full-time hourly short-term disability enhanced plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York may enroll in the **New York short-term disability enhanced plan**. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective the first day of the pay period in which your transfer occurs. • If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs.
Long-term disability	As a full-time hourly Vision Center manager, you are eligible for long-term disability coverage under the **full-time hourly and salaried long-term disability plan**. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective the first day of the pay period in which your transfer occurs. • If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs.

Part-time OTR truck driver transferring to management associate (including full-time OTR truck driver)	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a part-time OTR truck driver, and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your part-time OTR truck driver classification until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Medical Dental Vision Accident insurance Critical illness insurance AD&D	As a management associate, you are eligible for medical, dental, vision, accident, critical illness, and AD&D insurance coverage and may cover your eligible dependent children and spouse/partner. Additionally, the maximum coverage amount for AD&D insurance coverage increases to $1,000,000. You may not enroll in associate-only or associate + child(ren) coverage as a result of your transfer because as a part-time OTR truck driver, you already had the opportunity to enroll yourself and your children. However, you may enroll in associate + spouse/partner or associate + family coverage to add your spouse/partner. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective the date you enroll. • If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs. If you choose an effective date other than the date you enroll, any retroactive payroll deductions back to that effective date will be taken from your pay on an after-tax basis.
Company-paid life insurance	As a management associate, you are automatically enrolled in company-paid life insurance coverage, effective the first day of the pay period in which your transfer occurs.
Optional associate life insurance Optional dependent life insurance	As a management associate, you remain eligible for optional associate life insurance coverage but the maximum coverage amount increases to $1,000,000. Proof of Good Health requirements apply if you increase your coverage. You also remain eligible for optional dependent life insurance for your eligible dependent children. As a management associate, you may cover your spouse/partner under optional dependent life insurance coverage. Proof of Good Health requirements may apply. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll in dependent life insurance coverage for your spouse/partner, they may be subject to Proof of Good Health requirements: – If you enroll for the guaranteed amount for your spouse/partner, coverage is effective the date you enroll. – If you enroll for more than the guaranteed amount for your spouse/partner, coverage is subject to Prudential's approval. Your spouse/partner will be required to provide Proof of Good Health and may be required to undergo a medical exam. If approved, coverage above the guaranteed amount is effective the date Prudential approves your spouse/partner coverage. If any coverage above the guaranteed amount is not approved, your spouse/partner will be enrolled in the guaranteed amount and coverage will be effective as if you had enrolled your spouse/partner for only the guaranteed amount when you were first eligible. • See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply if you change coverage for yourself (including increasing the coverage amount) after your initial enrollment period.
Short-term disability	***Management associate (non–truck driver):*** You are automatically enrolled in the basic and maternity benefits under the **salaried short-term disability plan**. Coverage is effective the first day of the pay period in which your transfer occurs. ***Management associate (full-time OTR truck driver):*** You are automatically enrolled in the basic and maternity benefits under the **truck driver short-term disability plan**. Coverage is effective the first day of the pay period in which your transfer occurs.
Long-term disability	***Management associate (non–truck driver):*** You are eligible for long-term disability coverage under the **full-time hourly and salaried long-term disability plan**. ***Management associate (full-time OTR truck driver):*** You are eligible for long-term disability coverage under the **truck driver long-term disability plan**. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you enroll online, coverage is effective on the first day of the pay period in which your transfer occurs. • If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs.

Full-time hourly associate transferring to part-time hourly associate or temporary associate

- Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs.
- If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event.
- See the **Part-time hourly associates and temporary associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period.
- Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.
- If you became eligible as a full-time hourly associate, and the initial enrollment period is still open as of the date of your transfer:
  - Your initial enrollment period remains unchanged.
  - You may make any election permitted under your full-time hourly associate classification until your initial enrollment period ends.
- After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs.
- All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.

Medical Dental Vision Accident insurance Critical illness insurance AD&D	As a part-time hourly associate or temporary associate transferring from a full-time hourly associate classification, you will be eligible for medical, dental, vision, AD&D, critical illness and accident insurance coverage and may cover your eligible dependent children. However, see the **If your job classification changes** section and the **Your annual eligibility check** in the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in this chapter for important information about the period of time that you will remain eligible for medical benefits and future eligibility checks for medical benefits. As a part-time hourly associate or temporary associate, you are not eligible for spouse/partner coverage. If you were enrolled in coverage on the date of your transfer and covered your spouse/partner, your coverage is automatically adjusted to associate-only or associate + child(ren) coverage (depending on whether you cover your eligible dependent children), effective as of the first day of the pay period beginning after the date your transfer occurs. Your spouse/partner may be eligible for continuation coverage. See the **COBRA** chapter of this 2027 *Associate Benefits Book*. You may not make changes to your coverage as a result of your transfer because you already had the opportunity to enroll yourself and your eligible dependent children in coverage as a full-time hourly associate.
Company-paid life insurance	As a part-time hourly associate or temporary associate, you are not eligible for company-paid life insurance coverage. Your coverage will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your company-paid life insurance coverage to an individual policy. See the **Company-paid life insurance** chapter of this 2027 *Associate Benefits Book* for information on how to request conversion to an individual policy.
Optional associate life insurance Optional dependent life insurance	As a part-time hourly associate or temporary associate, you remain eligible for optional associate and optional dependent life insurance coverage for your eligible dependent children. As a part-time hourly associate or temporary associate, you are not eligible for spouse/partner coverage. If you have enrolled your spouse/partner in dependent life insurance coverage, it will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your spouse/partner dependent life insurance coverage to an individual policy. See the **Optional dependent life insurance** chapter of this 2027 *Associate Benefits Book* for information on how to request conversion to an individual policy.
Short-term disability	As a part-time hourly associate or temporary associate, you are not eligible for short-term disability coverage. Your prior full-time hourly short-term disability coverage will remain in effect through the last day of the pay period in which your transfer occurs and will not be effective after that date.
Long-term disability	As a part-time hourly associate or temporary associate, you are not eligible for long-term disability coverage. If you were enrolled in long-term disability insurance coverage on the date of your transfer, your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date.

Full-time hourly associate transferring to part-time OTR truck driver	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Part-time OTR truck drivers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a full-time hourly associate, and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your full-time hourly associate classification until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Medical Dental Vision Accident insurance Critical illness insurance AD&D	As a part-time OTR truck driver transferring from the full-time hourly associate classification, you will remain eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children. As a part-time OTR truck driver, you are not eligible for spouse/partner coverage. If you were enrolled in coverage on the date of your transfer and covered your spouse/partner, your coverage is automatically adjusted to associate-only or associate + child(ren) coverage (depending on whether you cover your eligible dependent children), effective as of the first day of the pay period following the date of your transfer. Your spouse/partner may be eligible for continuation coverage. See the **COBRA** chapter of this 2027 *Associate Benefits Book*. You may not make changes to your coverage as a result of your transfer because you already had the opportunity to enroll yourself and your eligible dependent children in coverage as a full-time hourly associate.
Company-paid life insurance	As a part-time OTR truck driver, you are not eligible for company-paid life insurance coverage. Your coverage will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your company-paid life insurance to an individual policy. See the **Company-paid life insurance** chapter of this 2027 *Associate Benefits Book* for information.
Optional associate life insurance Optional dependent life insurance	As a part-time OTR truck driver, you remain eligible for optional associate life insurance and dependent life insurance for your eligible children. As a part-time OTR truck driver, you are not eligible for spouse/partner coverage. If you have enrolled your spouse/partner in dependent life insurance coverage, it will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your spouse/partner dependent life insurance coverage to an individual policy. See the **Optional dependent life insurance** chapter of this 2027 *Associate Benefits Book* for information on how to request conversion to an individual policy.
Short-term disability	As a part-time OTR truck driver, you are not eligible for short-term disability coverage. Your prior full-time hourly short-term disability coverage will remain in effect through the last day of the pay period in which your transfer occurs and will not be effective after that date.
Long-term disability	As a part-time OTR truck driver, you are not eligible for long-term disability coverage. If you were enrolled in long-term disability insurance coverage on the date of your transfer, your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date.

Full-time hourly associate transferring to full-time hourly Vision Center manager

- Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs.
- If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event.
- See the **Full-time hourly Vision Center managers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period.
- Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.
- If you became eligible as a full-time hourly associate, and the initial enrollment period is still open as of the date of your transfer:
  - Your initial enrollment period remains unchanged.
  - You may make any election permitted under your full-time hourly associate classification until your initial enrollment period ends.
- After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs.
- All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.

Your benefits will not change as a result of the transfer. No changes are permitted as a result of the transfer other than changes to optional associate and dependent life insurance, which can be made at any time.

The amount of your company-paid life insurance will be updated to reflect your new salary, up to a maximum of $50,000. If the amount of your company-paid life insurance increases, the change will be effective as of the first day of the pay period in which your transfer occurs. If the amount of your company-paid life insurance decreases, the change will be effective as of the first day of the pay period beginning after the date of your transfer.

Full-time hourly associate transferring to management associate (including full-time OTR truck driver)

- Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs.
- If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event.
- See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period.
- Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.
- If you became eligible as a full-time hourly associate, and the initial enrollment period is still open as of the date of your transfer:
  - Your initial enrollment period remains unchanged.
  - You may make any election permitted under your full-time hourly associate classification until your initial enrollment period ends.
- After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs.
- All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.

Medical Dental Vision Accident insurance Critical illness insurance AD&D Company-paid life insurance	As a management associate, you remain eligible for medical, dental, vision, AD&D, critical illness and accident insurance coverage and may cover your eligible dependent children and spouse/partner. Additionally, the maximum coverage amount for AD&D insurance coverage increases to $1,000,000. No changes are permitted as a result of the transfer other than changes to AD&D insurance coverage for increased coverage amounts. The amount of your company-paid life insurance will be updated to reflect your new salary, up to a maximum of $50,000. If the amount of your company-paid life insurance increases, the change will be effective as of the first day of the pay period in which your transfer occurs. If the amount of your company-paid life insurance decreases, the change will be effective as of the first day of the pay period beginning after the date of your transfer.
Optional associate life insurance Optional dependent life insurance	As a management associate, you remain eligible for optional associate life insurance coverage but the maximum coverage amount increases to $1,000,000. Proof of Good Health requirements apply if you increase your coverage. You also remain eligible for optional dependent life insurance for your spouse/partner and eligible dependent children.

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Full-time hourly associate transferring to management associate (including full-time OTR truck driver) (continued)	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a full-time hourly associate, and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your full-time hourly associate classification until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Short-term disability	***Management associate (non–truck driver):*** You are eligible for short-term disability coverage. You are automatically enrolled in the basic and maternity benefits under the **salaried short-term disability plan**. Coverage is effective the first day of the pay period in which your transfer occurs. Your coverage under the **full-time hourly short-term disability plan** will continue through the day immediately preceding the first day of the pay period in which your transfer occurs. ***Management associate (full-time OTR truck driver):*** You are eligible for short-term disability coverage. You are automatically enrolled in the basic and maternity benefits under the **truck driver short-term disability plan**, effective the first day of the pay period in which your transfer occurs. Your coverage under the **full-time hourly short-term disability plan** will continue through the day immediately preceding the first day of the pay period in which your transfer occurs.
Long-term disability	***Management associate (non–truck driver):*** You remain eligible for long-term disability insurance coverage under the **full-time hourly and salaried long-term disability plan**. Your coverage will not change as a result of the transfer and no changes are permitted as a result of the transfer. ***Management associate (full-time OTR truck driver):*** You are eligible for long-term disability insurance coverage under the **truck driver long-term disability plan**. If you were enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer, your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs. You are automatically enrolled in the same level of coverage (50% or 60%) in the **truck driver long-term disability plan** at the five-year-duration option, effective the first day of the pay period in which your transfer occurs. ***This may result in increased payroll deductions from your pay.*** If you were not enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer, you may enroll in the **truck driver long-term disability plan**. Proof of Good Health requirements apply. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you were automatically enrolled in the **truck driver long-term disability** plan because you were enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer: – If you drop your enrollment in the **truck driver long-term disability plan** or decrease your coverage, the change is effective the day after the online enrollment session. If you make your change by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs. – If you do not make changes to the coverage level (50% or 60%) that you were automatically enrolled in, but you change to the full-duration option, you will not be subject to Proof of Good Health requirements. Coverage will be effective the first day of the pay period in which the transfer occurs. – If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level but remain in the five-year duration option, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received. If the increase in coverage is not approved, you will remain enrolled at the 50% level and coverage will be effective the first day of the pay period in which your transfer occurs. – If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level and change to the full-duration option, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, the increase in coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received. If the increase in coverage is not approved, you will remain enrolled at the 50% level and coverage will be effective the first day of the pay period in which your transfer occurs. However, the change to the full-duration option is not subject to Proof of Good Health requirements and will be effective the first day of the pay period in which the transfer occurs. • If you were not enrolled in the **full-time hourly and salaried long-term disability plan** on the date of your transfer, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received.

Full-time hourly Vision Center manager transferring to part-time hourly associate or temporary associate

- Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs.
- If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event.
- See the **Part-time hourly associates and temporary associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period.
- Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.
- If you became eligible as a full-time hourly Vision Center manager, and the initial enrollment period is still open as of the date of your transfer:
  - Your initial enrollment period remains unchanged.
  - You may make any election permitted under your full-time hourly Vision Center manager classification until your initial enrollment period ends.
- After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs.
- All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.

Medical Dental Vision Accident insurance Critical illness insurance AD&D	As a part-time hourly associate or temporary associate transferring from a full-time hourly Vision Center manager classification, you will be eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children. However, see the **If your job classification changes** section and the **Your annual eligibility check** in the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in this chapter for important information about the period of time that you will remain eligible for medical benefits and future eligibility checks for medical benefits. As a part-time hourly associate or temporary associate, you are not eligible for spouse/partner coverage. If you were enrolled in coverage on the date of your transfer and covered your spouse/partner, your coverage is automatically adjusted to associate-only or associate + child(ren) coverage (depending on whether you cover your eligible dependent children), effective as of the first day of the pay period beginning after your transfer occurs. Your spouse/partner may be eligible for continuation coverage. See the **COBRA** chapter of this 2027 *Associate Benefits Book*. You may not make changes to your coverage as a result of the transfer because you already had the opportunity to enroll yourself and your eligible dependent children in coverage as a full-time hourly associate.
Company-paid life insurance	As a part-time hourly associate or temporary associate, you are not eligible for company-paid life insurance coverage. Your coverage will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your company-paid life insurance coverage to an individual policy. See the **Company-paid life insurance** chapter of this 2027 *Associate Benefits Book* for information on requesting conversion to an individual policy.
Optional associate life insurance Optional dependent life insurance	As a part-time hourly associate or temporary associate, you remain eligible for optional associate and optional dependent life insurance coverage for your eligible dependent children. As a part-time hourly associate or temporary associate, you are not eligible for spouse/partner coverage. If you have enrolled your spouse/partner in dependent life insurance coverage, it will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your spouse/partner dependent life insurance coverage to an individual policy. See the **Optional dependent life insurance** chapter of this 2027 *Associate Benefits Book* for information on how to request conversion to an individual policy.
Short-term disability	As a part-time hourly associate or temporary associate, you are not eligible for short-term disability coverage. Your prior full-time hourly short-term disability coverage as a ful-time hourly Vision Center manager will remain in effect through the last day of the pay period in which your transfer occurs and will not be effective after that date.
Long-term disability	As a part-time hourly associate or temporary associate, you are not eligible for long-term disability coverage. Your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date.

Full-time hourly Vision Center manager transferring to part-time OTR truck driver

- Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs.
- If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event.
- See the **Part-time OTR truck drivers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period.
- Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.
- If you became eligible as a full-time hourly Vision Center manager, and the initial enrollment period is still open as of the date of your transfer:
  - Your initial enrollment period remains unchanged.
  - You may make any election permitted under your full-time hourly Vision Center manager classification until your initial enrollment period ends.
- After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs.
- All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.

Medical Dental Vision Accident insurance Critical illness insurance AD&D	As a part-time OTR truck driver transferring from the full-time hourly Vision Center manager associate classification, you will remain eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children. As a part-time OTR truck driver, you are not eligible for spouse/partner coverage. If you were enrolled in coverage on the date of your transfer and covered your spouse/partner, your coverage is automatically adjusted to associate-only or associate + child(ren) coverage (depending on whether you cover your eligible dependent children), effective as of the first day of the pay period that begins after your transfer occurs. Your spouse/partner may be eligible for continuation coverage. See the **COBRA** chapter of this 2027 *Associate Benefits Book*. You may not make changes to your coverage as a result of the transfer because you already had the opportunity to enroll yourself and your eligible dependent children in coverage as a full-time hourly associate.
Company-paid life insurance	As a part-time OTR truck driver, you are not eligible for company-paid life insurance coverage. Your coverage will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your company-paid life insurance to an individual policy. See the **Company-paid life insurance** chapter of this 2027 *Associate Benefits Book* for information on how to request conversion to an individual policy.
Optional associate life insurance Optional dependent life insurance	As a part-time OTR truck driver, you remain eligible for optional associate life insurance and optional dependent life insurance for your eligible dependent children. As a part-time OTR truck driver, you are not eligible for spouse/partner coverage. If you have enrolled your spouse/partner in dependent life insurance coverage, it will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your spouse/partner dependent life insurance coverage to an individual policy. See the **Optional dependent life insurance** chapter of this 2027 *Associate Benefits Book* for information on how to request conversion to an individual policy.
Short-term disability	As a part-time OTR truck driver, you are not eligible for short-term disability coverage. Your prior full-time hourly short-term disability coverage as a full-time hourly Vision Center manager will remain in effect through the last day of the pay period in which your transfer occurs and will not be effective after that date.
Long-term disability	As a part-time OTR truck driver, you are not eligible for long-term disability coverage. If you were enrolled in long-term disability insurance coverage on the date of your transfer, your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date.

Full-time hourly Vision Center manager transferring to full-time hourly associate

- Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs.
- If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event.
- See the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period.
- Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.
- If you became eligible as a full-time hourly Vision Center manager, and the initial enrollment period is still open as of the date of your transfer:
  - Your initial enrollment period remains unchanged.
  - You may make any election permitted under your full-time hourly Vision Center manager classification until your initial enrollment period ends.
- After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs.
- All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.

Your benefits will not change as a result of the transfer. No changes are permitted as a result of the transfer other than changes to optional associate and dependent life insurance, which can be made at any time.

The amount of your company-paid life insurance will be updated to reflect your new salary, up to a maximum of $50,000. If the amount of your company-paid life insurance increases, the change will be effective as of the first day of the pay period in which your transfer occurs. If the amount of your company-paid life insurance decreases, the change will be effective as of the first day of the pay period beginning after the date of your transfer.

Full-time hourly Vision Center manager transferring to management associate (including full-time OTR truck driver)

- Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs.
- If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event.
- See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period.
- Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.
- If you became eligible as a full-time hourly Vision Center manager, and the initial enrollment period is still open as of the date of your transfer:
  - Your initial enrollment period remains unchanged.
  - You may make any election permitted under your full-time hourly Vision Center manager classification until your initial enrollment period ends.
- After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs.
- All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.

Medical Dental Vision Accident insurance Critical illness insurance AD&D Company-paid life insurance	As a management associate, you remain eligible for medical, dental, vision, AD&D, critical illness and accident insurance coverage and may cover your eligible dependent children and spouse/partner. Additionally, the maximum coverage amount for AD&D insurance coverage increases to $1,000,000. No changes are permitted as a result of the transfer other than changes to AD&D insurance coverage for increased coverage amounts.
Optional associate life insurance Optional dependent life insurance	As a management associate, you remain eligible for optional associate life insurance coverage, but the maximum coverage amount increases to $1,000,000. Proof of Good Health requirements apply if you increase your coverage. You also remain eligible for optional dependent life insurance for your spouse/partner and your eligible dependent children.

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Full-time hourly Vision Center manager transferring to management associate (including full-time OTR truck driver) (continued)	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a full-time hourly Vision Center manager, and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your full-time hourly Vision Center manager classification until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Short-term disability	***Management associate (non–truck driver):*** You are eligible for short-term disability coverage. You are automatically enrolled in the basic and maternity benefits under the **salaried short-term disability plan**. Coverage is effective the first day of the pay period in which your transfer occurs. Your coverage under the **full-time hourly short-term disability plan** will continue through the day immediately preceding the first day of the pay period in which your transfer occurs. ***Management associate (full-time OTR truck driver):*** You are eligible for short-term disability coverage. You are automatically enrolled in the basic and maternity benefits under the **truck driver short-term disability plan** effective the first day of the pay period in which your transfer occurs. Your coverage under the **full-time hourly short-term disability plan** will continue through the day immediately preceding the first day of the pay period in which your transfer occurs.
Long-term disability	***Management associate (non–truck driver):*** You remain eligible for long-term disability insurance coverage under **full-time hourly and salaried long-term disability**. Your coverage will not change as a result of the transfer and no changes are permitted as a result of the transfer. ***Management associate (full-time OTR truck driver):*** You are eligible for long-term disability insurance coverage under **truck driver long-term disability**. If you were enrolled in **full-time hourly and salaried long-term disability** on the date of your transfer, your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs. You are automatically enrolled in the same level of coverage (50% or 60%) in **truck driver long-term disability** at the five-year-duration option, effective the first day of the pay period in which your transfer occurs. ***This may result in increased payroll deductions from your pay.*** If you were not enrolled in **full-time hourly and salaried long-term disability** on the date of your transfer, you may enroll in **truck driver long-term disability**. Proof of Good Health requirements apply. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you were automatically enrolled in **truck driver long-term disability** because you were enrolled in **full-time hourly and salaried long-term disability** on the date of your transfer: – If you drop your enrollment in **truck driver long-term disability** or decrease your coverage, the change is effective the day after the online enrollment session. If you make your change by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs. – If you do not make changes to the coverage level (50% or 60%) that you were automatically enrolled in, but you change to the full-duration option, you will not be subject to Proof of Good Health requirements. Coverage will be effective the first day of the payroll period in which your transfer occurs. – If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level but remain in the five-year duration option, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received. If the increase in coverage is not approved, you will remain enrolled at the 50% level and coverage will be effective the first day of the pay period in which your transfer occurs. – If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level and change to the full-duration option, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, the increase in coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received. If the increase in coverage is not approved, you will remain enrolled at the 50% level and coverage will be effective the first day of the pay period in which your transfer occurs. However, the change to the full-duration option is not subject to Proof of Good Health requirements and will be effective the first day of the pay period in which the transfer occurs. • If you were not enrolled in **full-time hourly and salaried long-term disability** on the date of your transfer, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received.

Management associate (including full-time OTR truck driver) transferring to part-time hourly or temporary associate

- Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs.
- If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event.
- See the **Part-time hourly associates and temporary associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period.
- Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements.
- If the initial enrollment period is still open as of the date of your transfer:
  - Your initial enrollment period remains unchanged.
  - You may make any election permitted under your classification as a management associate (including full-time OTR truck driver) until your initial enrollment period ends.
- After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs.
- All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.

Medical Dental Vision Accident insurance Critical illness insurance AD&D	As a part-time hourly associate or temporary associate transferring from a management associate classification, you will be eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children. However, see the **If your job classification changes** section and **Your annual eligibility check** in the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in this chapter for important information about the period of time that you will remain eligible for medical benefits and future eligibility checks for medical benefits. As a part-time hourly associate or temporary associate, you are not eligible for spouse/partner coverage. If you were enrolled in coverage on the date of your transfer and covered your spouse/partner, your coverage is automatically adjusted to associate-only or associate + child(ren) coverage (depending on whether you cover your eligible dependent children), effective as of the first day of the first pay period in which your transfer occurs. Your spouse/partner may be eligible for continuation coverage. See the **COBRA** chapter of this 2027 *Associate Benefits Book*. You may not make changes to your coverage as a result of the transfer because you already had the opportunity to enroll yourself and your eligible dependent children in coverage as a management associate. If you were enrolled in AD&D insurance coverage for amounts in excess of $200,000, your coverage will be reduced to $200,000 effective the first day of the pay period in which your transfer occurs.
Company-paid life insurance	As a part-time hourly associate or temporary associate, you are not eligible for company-paid life insurance coverage. Your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your company-paid life insurance coverage to an individual policy. See the **Company-paid life insurance** chapter of this 2027 *Associate Benefits Book* for information on how to request conversion to an individual policy.
Optional associate life insurance Optional dependent life insurance	As a part-time hourly associate or temporary associate, you remain eligible for optional associate life insurance coverage but the maximum available coverage amount is reduced to $200,000. If you are enrolled in a coverage amount in excess of $200,000 on the day *prior* to the first day of the pay period in which your transfer occurs, coverage will be reduced to $200,000 effective the first day of the pay period in which your transfer occurs. As a part-time hourly associate or temporary associate, you remain eligible for optional dependent life insurance for your eligible dependent children, but you are not eligible for spouse/partner coverage. If you have enrolled your spouse/partner in dependent life insurance coverage, it will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your spouse/partner dependent life insurance coverage to an individual policy. See the **Optional dependent life insurance** chapter of this 2027 *Associate Benefits Book* for information on how to request conversion to an individual policy.
Short-term disability	As a part-time hourly associate or temporary associate, you are not eligible for short-term disability coverage. Your coverage will continue through the last day of the pay period in which your transfer occurs and will not be effective after that date.
Long-term disability	As a part-time hourly associate or temporary associate, you are not eligible for long-term disability coverage. If you were enrolled in long-term disability insurance coverage on the date of your transfer, your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date.

Management associate (including full-time OTR truck driver) transferring to part-time OTR truck driver	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Part-time OTR truck drivers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a management associate (including full-time OTR truck driver) and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your classification as a management associate (including full-time OTR truck driver) until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Medical Dental Vision Accident insurance Critical illness insurance AD&D	As a part-time OTR truck driver transferring from the management associate classification, you will remain eligible for medical, dental, vision, AD&D, critical illness, and accident insurance coverage and may cover your eligible dependent children. As a part-time OTR truck driver, you are not eligible for spouse/partner coverage. If you were enrolled in coverage on the date of your transfer and covered your spouse/partner, your coverage is automatically adjusted to associate-only or associate + child(ren) coverage (depending on whether you cover your eligible dependent children), effective as of the first day of the first pay period in which your transfer occurs. Your spouse/partner may be eligible for continuation coverage. See the **COBRA** chapter of this 2027 *Associate Benefits Book*. You may not make changes to your coverage as a result of the transfer because you already had the opportunity to enroll yourself and your eligible dependent children in coverage as a management (including full-time OTR truck driver) associate. If you were enrolled in AD&D insurance coverage for amounts in excess of $200,000, your coverage will be reduced to $200,000 effective the first day of the pay period in which your transfer occurs.
Company-paid life insurance	As a part-time OTR truck driver, you are not eligible for company-paid life insurance coverage. Your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your company-paid life insurance to an individual policy. See the **Company-paid life insurance** chapter of this 2027 *Associate Benefits Book* for information on how to request conversion to an individual policy.
Optional associate life insurance Optional dependent life insurance	As a part-time OTR truck driver, you remain eligible for optional associate life insurance coverage, but the maximum available coverage amount is reduced to $200,000. If you are enrolled in a coverage amount in excess of $200,000 on the day prior to the first day of the pay period in which your transfer occurs, coverage will be reduced to $200,000 effective the first day of the pay period in which your transfer occurs. As a part-time OTR truck driver, you remain eligible for optional dependent life insurance for your eligible dependent children, but you are not eligible for spouse/partner coverage. If you have enrolled your spouse/partner in dependent coverage, it will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date. You may be able to convert your spouse/partner dependent life insurance coverage to an individual policy. See the **Optional dependent life insurance** chapter of this 2027 *Associate Benefits Book* for information on how to request conversion to an individual policy.
Short-term disability	As a part-time OTR truck driver, you are not eligible for short-term disability coverage. Your prior salaried short-term disability coverage will remain in effect through the last day of the pay period in which your transfer occurs, and will not be effective after that date.
Long-term disability	As a part-time OTR truck driver, you are not eligible for long-term disability coverage. If you were enrolled in long-term disability insurance coverage on the date of your transfer, your coverage will continue through the day immediately preceding the first day of the pay period in which your transfer occurs and will not be effective after that date.

Management associate (including full-time OTR truck driver) transferring to full-time hourly associate	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a management associate (including full-time OTR truck driver), and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your classification as a management associate (including full-time OTR truck driver) until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Medical Dental Vision Accident insurance Critical illness insurance AD&D Company-paid life insurance	Your benefits will not change as a result of your transfer, except that if you were enrolled in AD&D insurance coverage for amounts in excess of $200,000, your coverage will be reduced to $200,000 effective the first day of the pay period in which your transfer occurs. Otherwise, no changes are permitted as a result of your transfer.
Optional associate life insurance Optional dependent life insurance	As a full-time hourly associate, you remain eligible for optional associate life insurance coverage, but the maximum available coverage amount is reduced to $200,000. If you are enrolled in a coverage amount in excess of $200,000 on the day *prior* to the first day of the pay period in which your transfer occurs, coverage will be reduced to $200,000 effective the first day of the pay period in which your transfer occurs. You also remain eligible for optional dependent life insurance for your spouse/partner and your eligible dependent children.
Short-term disability	As a full-time hourly associate, you are eligible for short-term disability coverage. Your enrollment in **salaried** or **truck driver short-term disability** continues through the last day of the pay period in which your transfer occurs. You are automatically enrolled in the **full-time hourly short-term disability enhanced plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York will be enrolled in the **New York short-term disability enhanced plan**. ***This will result in payroll deductions from your pay.*** **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • You may drop your enrollment in the **full-time hourly short-term disability enhanced plan** or, for associates in New York, the **New York short-term disability enhanced plan**. If you drop your enrollment in the **full-time hourly short-term disability enhanced plan** or, for associates in New York, the **New York short-term disability enhanced plan**, you will be automatically enrolled in the full-time hourly short-term disability basic plan or, for associates in New York, the **New York short-term disability basic plan** and your coverage is effective the day after the online enrollment session. If you drop coverage by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs. • If you do not drop your enrollment in the **full-time hourly short-term disability enhanced plan** or, for associates in New York, the **New York short-term disability enhanced plan**, your coverage is effective the first day of the pay period in which your transfer occurs.

(Continued on the next page)

Management associate (including full-time OTR truck driver) transferring to full-time hourly associate (continued)	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a management associate (including full-time OTR truck driver), and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your classification as a management associate (including full-time OTR truck driver) until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Long-term disability	***Transferring from management associate (non–truck driver):*** No changes are permitted as a result of your transfer. ***Transferring from management associate (full-time OTR truck driver):*** As a full-time hourly associate, you are eligible for the **full-time hourly and salaried long-term disability plan**. If you were enrolled in **truck driver long-term disability** on the date of your transfer, your coverage continues through the day immediately preceding the pay period in which your transfer occurs. You are automatically enrolled in the same level of coverage (50% or 60%) in **full-time hourly and salaried long-term disability** effective the first day of the pay period in which your transfer occurs. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you were automatically enrolled in **full-time hourly and salaried long-term disability** because you were enrolled in the **truck driver long-term disability** on the date of your transfer: – If you drop or decrease your automatic enrollment in **full-time hourly and salaried long-term disability**, the change is effective the day after the online enrollment session. If you drop coverage by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs. – If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level, coverage will be effective the first day of the pay period following the date you enroll. • If you were not enrolled in **truck driver long-term disability** prior to the date of your transfer and you choose to enroll in **full-time hourly and salaried long-term disability**: – If you enroll online, coverage is effective the later of 1) the first day of the pay period in which your transfer occurs or 2) the 12-month anniversary of your date of hire. – If you enroll by calling People Services, coverage is effective the later of the 12-month anniversary of your date of hire, or your choice of either 1) the date you enroll, or 2) the first day of the pay period in which your transfer occurs.

Management associate (including full-time OTR truck driver) transferring to full-time hourly Vision Center manager associate	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Full-time hourly Vision Center managers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a management associate (including full-time OTR truck driver), and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your classification as a management associate (including full-time OTR truck driver) until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Medical Dental Vision Accident insurance Critical illness insurance AD&D Company-paid life insurance	Your benefits will not change as a result of your transfer, except that if you were enrolled in AD&D insurance coverage for amounts in excess of $200,000, your coverage will be reduced to $200,000 effective the first day of the pay period in which your transfer occurs. Otherwise, no changes are permitted as a result of your transfer.
Optional associate life insurance Optional dependent life insurance	As a full-time hourly Vision Center manager, you remain eligible for optional associate life insurance coverage, but the maximum available coverage amount is reduced to $200,000. If you are enrolled in a coverage amount in excess of $200,000 on the day prior to the first day of the pay period in which your transfer occurs, coverage will be reduced to $200,000 effective the first day of the pay period in which your transfer occurs. You also remain eligible for optional dependent life insurance for your spouse/partner and your eligible dependent children.
Short-term disability	As a full-time Vision Center manager, you are eligible for short-term disability coverage. Your enrollment in **salaried** or **truck driver short-term disability** continues through the day immediately preceding the first day of the pay period in which your transfer occurs. You are automatically enrolled in the **full-time hourly short-term disability enhanced plan** unless you work in California, Hawaii, New Jersey, or Rhode Island. Associates in these states are eligible for legally mandated disability programs. Associates in New York will be enrolled in the **New York short-term disability enhanced plan**. ***This will result in payroll deductions from your pay.*** **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • You may drop your enrollment in the **full-time hourly short-term disability enhanced plan** or, for associates in New York, the **New York short-term disability enhanced plan**. If you drop your enrollment in the full-time hourly short-term disability enhanced plan or, for associates in New York, the New York short-term disability enhanced plan, you will be automatically enrolled in the full-time hourly short-term disability basic plan or, for associates in New York, the New York short-term disability basic plan and your coverage is effective the day after the online enrollment session. If you drop coverage by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs. • If you do not drop your enrollment in the **full-time hourly short-term disability enhanced plan** or, for associates in New York, the **New York short-term disability enhanced plan**, your coverage is effective on the first day of the pay period in which your transfer occurs.

(Continued on the next page)

Management associate (including full-time OTR truck driver) transferring to full-time hourly Vision Center manager associate (continued)	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Full-time hourly Vision Center managers** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a management associate (including full-time OTR truck driver), and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your classification as a management associate (including full-time OTR truck driver) until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Long-term disability	***Transferring from management associate (non–truck driver):*** No changes are permitted as a result of your transfer. ***Transferring from management associate (full-time OTR truck driver):*** As a full-time Vision Center manager associate, you are eligible for **full-time hourly and salaried long-term disability**. If you were enrolled in **truck driver long-term disability** on the date of your transfer, your coverage continues through the day immediately preceding the first day of the pay period in which your transfer occurs. You are automatically enrolled in the same level of coverage (50% or 60%) in **full-time hourly and salaried long-term disability** effective the first day of the pay period in which your transfer occurs. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you were automatically enrolled in **full-time hourly and salaried long-term disability** because you were enrolled in the **truck driver long-term disability** on the date of your transfer: – If you drop your enrollment in the full-time hourly and salaried long-term disability plan or decrease your coverage, the change is effective the day after the online enrollment session. If you make your change by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs. – If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level, coverage will be effective the first day of the pay period following the date you enroll. • If you were not enrolled in **truck driver long-term disability** prior to the date of your transfer and you choose to enroll in **full-time hourly and salaried long-term disability**: – If you enroll online, coverage is effective the first day of the pay period in which your transfer occurs. – If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs.

Management associate (full-time OTR truck driver) transferring to management associate (non–truck driver)	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a management associate (full-time OTR truck driver), and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your classification as a management associate (full-time OTR truck driver) until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Medical Dental Vision Accident insurance Critical illness insurance AD&D Company-paid life insurance Optional associate life insurance Optional dependent life insurance	Your benefits will not change as a result of your transfer. No changes are permitted as a result of your transfer.
Short-term disability	As a management associate (non–truck driver), you are automatically enrolled in the basic and maternity benefits under **salaried short-term disability**, effective the first day of the pay period in which your transfer occurs. Your enrollment in **truck driver short-term disability** continues through the day immediately preceding the first day of the pay period in which your transfer occurs.
Long-term disability	As a management associate (non–truck driver), you are eligible for the **full-time hourly and salaried long-term disability plan**. If you were enrolled in **truck driver long-term disability** on the date of your transfer, your coverage continues through the day immediately preceding the first day of the pay period in which your transfer occurs. You are automatically enrolled in the same level of coverage (50% or 60%) in **full-time hourly and salaried long-term disability** effective the first day of the pay period in which your transfer occurs. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you were automatically enrolled in **full-time hourly and salaried long-term disability** because you were enrolled in **truck driver long-term disability** on the date of your transfer: • If you drop your enrollment in **full-time hourly and salaried long-term disability** or decrease your coverage, the change is effective the day after the online enrollment session. If you make your change by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs. – If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level, coverage will be effective the first day of the pay period following the date you enroll. • If you were not enrolled in **truck driver long-term disability** prior to the date of your transfer and you choose to enroll in **full-time hourly and salaried long-term disability**: – If you enroll online, coverage is effective the first day of the pay period in which your transfer occurs. – If you enroll by calling People Services, you may choose an effective date that is either 1) the date you enroll or 2) the first day of the pay period in which your transfer occurs.

Management associate (non–truck driver) transferring to management associate (full-time OTR truck driver)	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a management associate (non-truck driver), and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your classification as a management associate (non-truck driver) until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Medical Dental Vision Accident insurance Critical illness insurance AD&D Company-paid life insurance Optional associate life insurance Optional dependent life insurance	Your benefits will not change as a result of your transfer. No changes are permitted as a result of your transfer.
Short-term disability	As a management associate (full-time OTR truck driver), you are automatically enrolled in the basic and maternity benefits under **truck driver short-term disability**, effective the last day of the pay period in which your transfer occurs. Your coverage under **salaried short-term disability** continues through the day immediately preceding the first day of the pay period in which your transfer occurs.

(Continued on the next page)

Management associate (non–truck driver) transferring to management associate (full-time OTR truck driver) (continued)	
• Make permitted changes within 60 days of the first day of the pay period in which your transfer occurs. • If you do not make changes, your next opportunity to do so will be during the next Annual Enrollment or when you have an election change event. • See the **Management associates** chart in the **Enrollment and effective dates by job classification** section in this chapter for rules that apply when you enroll or make changes after your initial enrollment period. • Enrollment after the initial enrollment period may be subject to Proof of Good Health requirements. • If you became eligible as a management associate (non-truck driver), and the initial enrollment period is still open as of the date of your transfer: – Your initial enrollment period remains unchanged. – You may make any election permitted under your classification as a management associate (non-truck driver) until your initial enrollment period ends. • After your initial enrollment period ends, the terms stated below will apply through the date 60 days from the first day of the pay period in which your transfer occurs. • All benefits are subject to the terms and conditions stated in this 2027 *Associate Benefits Book*.	
Long-term disability	As a management associate (full-time OTR truck driver), you are eligible for long-term disability coverage under **truck driver long-term disability**. If you were enrolled in **full-time hourly and salaried long-term disability** on the date of your transfer, your coverage will continue through the last day of the pay period in which your transfer occurs. You are automatically enrolled in the same level of coverage (50% or 60%) in **truck driver long-term disability** at the five-year-duration option, effective the first day of the pay period in which your transfer occurs. ***This may result in increased payroll deductions from your pay.*** If you were not enrolled in **full-time hourly and salaried long-term disability** on the date of your transfer, you may enroll in **truck driver long-term disability**. Proof of Good Health requirements apply. **If you take action within 60 days from the first day of the pay period in which your transfer occurs, coverage is effective as follows:** • If you were automatically enrolled in **truck driver long-term disability** because you were enrolled in **full-time hourly and salaried long-term disability** on the date of your transfer: – If you drop your enrollment in **truck driver long-term disability** or decrease your coverage, the change is effective the day after the online enrollment session. If you make your change by calling People Services, you may choose an effective date that is either 1) the date you call, or 2) the first day of the pay period in which your transfer occurs. – If you do not make changes to the coverage level (50% or 60%) that you were automatically enrolled in, but you change to the full-duration option, you will not be subject to Proof of Good Health requirements. Coverage will be effective the first day of the payroll period in which your transfer occurs. – If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level but remain in the five-year duration option, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received. If the increase in coverage is not approved, you will remain enrolled at the 50% level and coverage will be effective the first day of the pay period in which your transfer occurs. – If you increase the coverage level to 60% after you were automatically enrolled in the 50% coverage level and change to the full-duration option, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, the increase in coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received. If the increase in coverage is not approved, you will remain enrolled at the 50% level and coverage will be effective the first day of the pay period in which your transfer occurs. However, the change to the full-duration option is not subject to Proof of Good Health requirements and will be effective the first day of the pay period in which the transfer occurs. • If you were not enrolled in **full-time hourly and salaried long-term disability** on the date of your transfer, you will be subject to Proof of Good Health requirements and may be required to undergo a medical exam at your own expense. If approved, coverage is effective the first day of the pay period following the date notification of Lincoln's approval is received.

Eligibility, enrollment, and effective dates for associates in Hawaii

Eligibility waiting periods for medical coverage 80

Medical coverage options for Hawaii associates 80

Paying coverage costs during a leave of absence for Hawaii associates 80

Enrollment and effective dates for Hawaii associates 81

Eligibility, enrollment, and effective dates for associates in Hawaii

If you are an associate who works in Hawaii, the benefits described throughout this 2027 *Associate Benefits Book* apply to you, with the exception of some slight differences in eligibility terms applicable to medical and short-term disability benefits. To the extent information discussed in this chapter conflicts with information in the **Eligibility, enrollment, and effective dates** chapter, information in this chapter will control.

Resources		
Find what you need	**Online**	**Other resources**
Health Plan Hawaii (HMSA)	**hmsa.com**	**808-948-6372**
Kaiser Foundation Health Plan	**kaiserpermanente.org**	**800-966-5955**
Enroll in Walmart benefits	**One.Walmart.com/Enroll**	Call People Services at **800-421-1362**
Eligibility questions under the legally mandated Hawaii Temporary Disability Insurance program	**One.Walmart.com/TimeAndSupport > Leave of Absence**	Call Sedgwick at **800-492-5678**
Notify People Services within 60 days of an election change event	**One.Walmart.com**	Call People Services at **800-421-1362**
Paying for benefits while on a leave of absence		See the **Paying coverage costs during a leave of absence for Hawaii associates** section in this chapter for detailed information. Failure to pay amounts owed to keep coverage current will result in cancellation of coverage retroactive to the last date for which coverage payments were made. You may pay by credit or debit card with a Visa, MasterCard, American Express, or Discover card by going to **One.Walmart.com/Enroll** and choosing "make a payment" or 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) and work location on the check. If you are unable to pay the amount owed for coverage, the Plan will accept payments made by someone else on your behalf.

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**, or refer to the contact information for each option in the chart above.
- Because Hawaii has a legally mandated disability program, full-time hourly associates are generally not eligible to participate in a Walmart short-term disability plan. However, you may still be eligible for the maternity benefit under the Walmart short-term disability basic plan. See the **Full-time hourly short-term disability** chapter for details.
- 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, enrollment, and effective dates** 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, enrollment, and effective dates** 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 or temporary associate in Hawaii, your eligibility for medical coverage is subject to special rules applicable to Hawaii associates. For benefits other than medical and disability, eligibility terms are described in the **Eligibility, enrollment, and effective dates** chapter. Eligibility for other benefits is also described in charts under **Enrollment and effective dates for Hawaii associates** later in this chapter. For details refer to the appropriate chart.

Medical coverage options for Hawaii associates

Associates in Hawaii have two coverage options:

- Health Plan Hawaii (HMSA)
- Kaiser Foundation Health Plan

For details about these medical options, visit the websites listed in the chart at the beginning of this chapter.

Paying coverage costs during a leave of absence for Hawaii associates

Because the associate portion of the cost of medical coverage is wage-based, no payment is due from you if you are not receiving wages during an approved leave of absence. The only payment due for medical coverage while you are on an approved leave of absence with no wages is the dependent portion of your cost of medical coverage. All other benefit options require payment during an approved leave of absence as described in the **Eligibility, enrollment, and effective dates** 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 cost of the premium, but only up to 1.5% of their wages or 50% of the cost of the premium per pay period, whichever is less. For example: if your wages per pay period are $1,000 and you qualify for tobacco-free rates, you are not required to pay more than $15 for coverage per pay period (assuming that the entire premium is at least $30).

Enrollment and effective dates for Hawaii associates

Full-time hourly associates
Includes full-time hourly pharmacists, full-time hourly field supply chain, full-time hourly field supervisor positions in stores and clubs; excludes full-time hourly Vision Center managers and Optical managers

Note: Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.

<table>
<tr><th>Plan</th><th colspan="2">Enrollment periods and effective dates</th></tr>
<tr><td>Medical</td><td colspan="2">Initial enrollment period:
You must enroll in coverage between the date of your first payday and the day prior to your effective date.</td></tr>
<tr><td rowspan="2">Dental (enrollment is for two consecutive calendar years)
Vision
Critical illness insurance
Accident insurance
AD&D</td><td>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</td><td rowspan="2">If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until Annual Enrollment for the next calendar year unless you experience an election change event, as described in the Permitted election changes outside Annual Enrollment section of the Eligibility, enrollment, and effective dates chapter.</td></tr>
<tr><td>Initial enrollment period:
You must enroll in coverage between the date of your first payday and the day prior to your coverage effective date.</td></tr>
<tr><td></td><td colspan="2">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.</td></tr>
<tr><td>Company-paid life insurance</td><td colspan="2">You are automatically enrolled on the first day of the calendar month during which your 89th day of continuous full-time employment falls and your coverage is effective on that date.</td></tr>
<tr><td>Associate assistance resources
Business travel accident insurance</td><td colspan="2">You are automatically enrolled on your date of hire and your coverage is effective on that date.</td></tr>
<tr><td>Hawaii Temporary Disability Insurance (legally mandated program)
See the Full-time hourly short-term disability chapter for general information about state benefits
Walmart short-term disability basic plan
• Basic coverage (not available to associates who work in Hawaii)
• Maternity benefits (available to associates who work in Hawaii)</td><td colspan="2">For Hawaii Temporary Disability Insurance, see the Resources chart at the beginning of this chapter for contact information on eligibility and effective dates.
For maternity benefits under the short-term disability basic plan, you are enrolled automatically on the 12-month anniversary of your date of hire, and your coverage is effective on that date, subject to actively-at-work requirements described in the Eligibility, enrollment, and effective dates chapter.</td></tr>
</table>

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Full-time hourly associates (continued)
Includes full-time hourly pharmacists, full-time hourly field supply chain, full-time hourly field supervisor positions in stores and clubs; excludes full-time hourly Vision Center managers and Optical managers

Note: Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.

Plan	Enrollment periods and effective dates
Optional associate life insurance Optional dependent life insurance	**Initial enrollment period:** You must enroll in coverage between the date of your first payday and the day prior to 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:** • If you enroll for the guaranteed amount, coverage is effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. • If you enroll for **more than** the guaranteed amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. – If approved, coverage is effective on the later of 1) the date Prudential approves your coverage, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. – If any coverage above the guaranteed amount is not approved, you (or your spouse/partner) will be enrolled in coverage for the guaranteed amount and coverage will be effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. **If you enroll in or increase coverage after your initial enrollment period for a reason other than an election change event:** • Coverage for you and/or your spouse/partner (including an increase to previously elected coverage) is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. • If approved, your coverage is effective on the date Prudential approves your coverage. **If you enroll in or increase your coverage after your initial enrollment period due to an election change event:** • If you enroll for the guaranteed amount, coverage is effective on the date you enroll. • If you enroll for **more than** the guaranteed amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. – If approved, your coverage is effective on the date Prudential approves your coverage. – If any coverage above the guaranteed amount is not approved, you will be enrolled in coverage for the guaranteed amount and coverage will be effective on the date you enroll. See the **Permitted election changes outside Annual Enrollment** section of the **Eligibility, enrollment, and effective dates** chapter for information about election change events. You are not required to provide Proof of Good Health for children if you enroll in optional dependent coverage at any time. If your spouse/partner or dependent child is confined for medical treatment (at home or elsewhere), coverage is delayed until your spouse/partner or child has a medical release (does not apply to a newborn child). If you are required to provide Proof of Good Health, payroll deductions will not begin until your coverage is effective, as described above.

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Full-time hourly associates (continued)
Includes full-time hourly pharmacists, full-time hourly field supply chain, full-time hourly field supervisor positions in stores and clubs; excludes full-time hourly Vision Center managers and Optical managers
Note: Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.

Plan	Enrollment periods and effective dates
Long-term disability plan (including enhanced benefits)	**Initial enrollment period:** You must enroll in coverage between the date of your first payday and the day *prior* to 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 in coverage during your initial enrollment period:** Coverage is effective on the 12-month anniversary of your date of hire. • **If you enroll in or increase coverage after your initial enrollment period:** – If you enroll in or increase coverage following an election change event, your coverage is effective on the later of 1) the first day of the pay period following the date you enroll, or 2) the 12-month anniversary of your date of hire. If you enroll in or increase coverage during Annual Enrollment for the next Plan year, your coverage will be effective the later of 1) January 1 of that year, or 2) the 12-month anniversary of your date of hire. If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of the **Eligibility, enrollment, and effective dates** chapter.

Note: Some benefits require you to meet the definition of active work. See the **"Active work" or "actively at work"** section in the **Eligibility, enrollment, and effective dates** chapter for information.

Part-time hourly and temporary associates
Note: Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.

Plan	Enrollment periods and effective dates	
Medical	**Initial enrollment period:** You must enroll in coverage between the date of your first payday and the day *prior* to your effective date.	
Part-time hourly and temporary associates in Hawaii are not subject to the requirements described under **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** in the **Eligibility, enrollment, and effective dates** chapter.	**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	If you elect coverage, your election must remain in effect until the end of the calendar year containing the coverage effective date and may not be changed until the Annual Enrollment period for the next calendar year unless you experience an election change event, as described in the **Permitted election changes outside Annual Enrollment** section of the **Eligibility, enrollment, and effective dates** chapter.
Dental (enrollment is for two consecutive calendar years)	**Initial enrollment period:** You must enroll in coverage between the date of your first payday and the day *prior* to your coverage effective date.	
Vision Critical illness insurance Accident insurance AD&D	**When coverage is effective:** Your coverage is effective the first day of the calendar month during which your 89th day of continuous employment falls.	
Associate assistance resources Business travel accident insurance	You are automatically enrolled on your date of hire.	
Hawaii Temporary Disability Insurance (legally mandated program)	For Hawaii Temporary Disability Insurance, see the **Resources** chart at the beginning of this chapter for contact information on eligibility and effective dates.	

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Part-time hourly and temporary associates (continued)
Note: Do not mistake the initial enrollment period for the coverage effective date. You must enroll in coverage **prior** to the coverage effective date for most benefits.

Plan	Enrollment periods and effective dates
Optional associate life insurance Optional dependent life insurance	**Initial enrollment period:** You must enroll in coverage between the date of your first payday and the day prior to the first day of the calendar month during which your 89th day of continuous employment falls. **When coverage is effective:** **If you enroll during your initial enrollment period:** • If you enroll for the guaranteed amount, coverage is effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. • If you enroll for **more than** the guaranteed amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. – If approved, coverage is effective on the later of 1) the date Prudential approves your coverage, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. – If any coverage above the guaranteed amount is not approved, you (or your spouse/partner) will be enrolled in coverage for the guaranteed amount and coverage will be effective on the later of 1) the date you enroll, or 2) the first day of the calendar month during which your 89th day of continuous employment falls. **If you enroll in or increase coverage after your initial enrollment period for a reason other than an election change event:** • Coverage for you and/or your spouse/partner (including an increase to previously elected coverage) is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. • If approved, your coverage is effective on the date Prudential approves your coverage. **If you enroll in or increase your coverage after your initial enrollment period due to an election change event:** • If you enroll for the guaranteed amount, coverage is effective on the date you enroll. • If you enroll for **more than** the guaranteed amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to provide Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam. – If approved, your coverage is effective on the date Prudential approves your coverage. – If any coverage above the guaranteed amount is not approved, you will be enrolled in coverage for the guaranteed amount and coverage will be effective on the date you enroll. See the **Permitted election changes outside Annual Enrollment** section of the **Eligibility, enrollment, and effective dates** chapter for information about election change events. You are not required to provide Proof of Good Health for children if you enroll in optional dependent coverage at any time. If your spouse/partner or dependent child is confined for medical treatment (at home or elsewhere), coverage is delayed until your spouse/partner or child has a medical release (does not apply to a newborn child). If you are required to provide Proof of Good Health, payroll deductions will not begin until your coverage is effective, as described above.
Part-time hourly and temporary associates may only cover their eligible dependent children and may not cover their spouses/partners. Company-paid life insurance is not available to part-time hourly and temporary associates. **Note:** Some benefits require you to meet the definition of active work. See the **"Active work" or "actively at work"** section in the **Eligibility, enrollment, and effective dates** chapter for information.	

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

The medical plan

The Associates' Medical Plan (AMP)	88
Enrollment	88
Role of third-party administrator	89
Provider networks	89
AMP options available to you	91
When network benefits are paid for out-of-network services	94
Evaluating your options	95
Preventive care	99
Virtual care	102
Advanced imaging	102
Emergency, ground and air ambulance	103
Centers of Excellence	105
Diabetes and Metabolic Management by Twin Health	116
Helping you manage your health	117
Mental health and substance use disorder	123
What is covered by the AMP	123
Prenotification	125
Coordination with Centers of Excellence administrators	125
Prior authorization	126
When limited benefits apply to the AMP	127
What is not covered by the AMP	131
Filing a medical claim or appeal	133
If you have coverage under more than one medical plan	133
Break in coverage	135
When your medical coverage ends	136
If you leave Walmart and are rehired	136
Other information about the medical plan	136

The information in this chapter describes medical benefits that may be available to you if:

- You are an eligible hourly, temporary, part-time OTR truck driver, or salaried (management) associate
- You have met all requirements for coverage to be effective, and
- You have enrolled in a timely manner.

For questions about eligibility, enrollment, and requirements for coverage to be effective, see the **Eligibility, enrollment, and effective dates** chapter.

The medical plan

Resources			
Find what you need	**Online**	**By phone**	**Other resources**
Provider directory and price comparison tool Important information to help you navigate your benefits, find TPA network providers, manage your health care cost, and access expert medical opinions	**IncludedHealth.com/Walmart**	**800-941-1384**	**Included Health** **35 Canal Street, Suite 401** **Lewiston, Maine 04240**
Skai Blue Cross Blue Shield Premier PPO Plan, Contribution HRA Plan, and Saver HSA Plan	**One.Walmart.com/Health** or **skaibcbs.com**	**866-823-3790**	**Skai Blue Cross Blue Shield** **P.O. Box 50** **Little Rock, Arkansas 72203-0050**
UMR Premier PPO Plan, Contribution HRA Plan, and Saver HSA Plan	**One.Walmart.com/Health** or **UMR.com**	**855-870-9177**	**UMR** **P.O. Box 30541** **Salt Lake City, Utah 84130-0541**
Included Health Personalized Wellbeing Copay Plan	**One.Walmart.com/Health** or **IncludedHealth.com/Walmart**	**855-633-7073**	**Included Health** **35 Canal Street, Suite 401** **Lewiston, Maine 04240**
Consociate Health Cancer medical record review, heart surgery, kidney dialysis or ESRD medical record review, rare conditions, and related travel benefits (including family building)		**800-804-1289**	**Consociate Health** **P.O. Box 1002** **Mabelvale, Arkansas 72103**
Transplant		**479-621-2830**	
Carrum Health Hip and knee replacement, spine surgery, weight loss surgery programs, and related travel benefits	**Carrum.me/Walmart**	**888-890-7359**	**Carrum Health, Inc.** **100 1st Street, Suite 350** **San Francisco, California 94105**
Hinge Health Virtual physical therapy	**HingeHealth.com/Walmart**	**877-699-6844**	
Kindbody Family building benefits	**Kindbody.com/Walmart**	**855-454-7663**	Email: **Walmart@kindbody.com**
Request a paper copy of this 2027 *Associate Benefits Book*		Call People Services at **800-421-1362**	Scan the QR code below:

- This chapter describes medical benefits provided by the Premier PPO Plan, Contribution HRA Plan, Saver HSA Plan, and Personalized Wellbeing Copay Plan, which are offered under the Associates' Medical Plan (AMP). These are referred to as "AMP options."
- AMP options offer several tools that help you put your AMP benefits to work for you. These are described in the **Health management tools** chart in the **Helping you manage your health** section of this chapter. Access to these tools, and some of the services available through these tools, is no cost to you.
- In some locations, the AMP also offers health maintenance organization (HMO) options. Though offered under the AMP, HMOs are fully insured, and administered separately, by the HMO insurer. Benefits provided by those HMO options are not described in this chapter. However, the eligibility terms in the **Eligibility, enrollment, and effective dates** chapter override any inconsistent terms in any HMO documents. If an HMO is available at your work location, coverage details can be obtained by contacting the HMO insurer. HMO contact information can be found at **One.Walmart.com/HMO**.

The Associates' Medical Plan (AMP)

The information in this chapter applies to you if you enroll in one of the following options: the Premier PPO Plan, Contribution HRA Plan, Saver HSA Plan, or the Personalized Wellbeing Copay Plan. These options are referred to, for purposes of this chapter, as "AMP options."

The Associates' Medical Plan (AMP) provides medical benefits for eligible associates and their covered dependents through various AMP options. The AMP options discussed in this chapter are self-insured, which means that benefits provided under the options are not insured by an insurance company. In other words, an insurance company is not paying benefits out of its own assets. Instead, you and other associates enrolled in a self-insured AMP option make contributions through payroll deductions to cover a portion of the cost of coverage, and the rest of the cost is paid by Walmart. When you receive most covered services, you will pay a portion of the cost of those services, subject to applicable AMP terms and conditions of coverage, and the company will pay the rest, either from company assets or through a trust funded by Walmart.

While every AMP option generally provides benefits for the same services, a specific option may have an alternative design that includes different terms and conditions of coverage.

For important resources to help you manage your health:

- Provider directories are located at **IncludedHealth.com/Walmart**
- A price comparison tool is located at **IncludedHealth.com/Walmart**
- Information about covered services and claims is located at:
  - **skaibcbs.com**
  - **UMR.com**
  - **IncludedHealth.com/Walmart**
- Other information about AMP options is located on **One.Walmart.com/Health**

Associates who enroll in medical coverage through an HMO Plan option: HMO options, which are available in some work locations, are also offered under the AMP. Materials provided by the HMO insurer describe the HMO's benefits and terms and conditions of coverage.

- **The *Associate Benefits Book* describes eligibility conditions.** Materials provided by the HMO insurer may describe different eligibility conditions than those described in this 2027 *Associate Benefits Book*. If there is any difference between eligibility conditions described in materials provided by the HMO insurer and those described in this 2027 *Associate Benefits Book*, the *Associate Benefits Book* will control.
- **HMO materials describe all terms and conditions of medical coverage.** Materials provided by the HMO insurer describe all benefits and terms and conditions of coverage of the HMO. No information in this chapter applies to benefits or terms and conditions of coverage of any HMO.

See the **Eligibility, enrollment, and effective dates** chapter for information about eligibility conditions applicable to the AMP. Find more information about HMO coverage including how to contact the HMO at **One.Walmart.com/HMO**.

The AMP reserves the right to recover any benefits paid as a result of fraud or intentional misrepresentation of a material fact. Engaging in such conduct may result in loss of coverage for you and your covered dependents, and you may have to reimburse the AMP for any benefits paid in reliance on false or misleading information.

If the AMP determines that coverage must be rescinded (canceled or discontinued with retroactive effect) because of fraud or an intentional misrepresentation of a material fact, you will receive at least 30 days' advance written notice before the rescission takes effect. A cancellation of coverage that applies only prospectively, or that results from a failure to pay required contributions in a timely manner, is not a rescission.

Enrollment

Be sure to **enroll by the deadline** described in your enrollment materials. **You must enroll prior to your coverage effective date.**

You will be eligible to enroll in the AMP if you meet the eligibility conditions described in the **Eligibility, enrollment, and effective dates** chapter.

When and how to enroll

Do not confuse the enrollment period with the effective date of your coverage. The enrollment period is when you make your benefit elections. The coverage effective date is when those elections become effective, and you may begin receiving benefits from the AMP. Your specific enrollment period and coverage effective date will vary depending on a number of factors, including your job classification. **Enrollment materials will be sent to the address Walmart has on file. Be sure to enroll by the enrollment deadline provided in the enrollment materials that you receive. The AMP is not allowed to make exceptions** to let individual

associates enroll after the enrollment period ends. You must enroll by the deadline, or you will have to wait until the next Annual Enrollment unless you experience an election change event. See the **Permitted election changes outside Annual Enrollment** section in the **Eligibility, enrollment, and effective dates** chapter.

The online benefits enrollment tool is located at **One.Walmart.com/Enroll**.

Choosing a coverage tier

When you enroll in the AMP, you will select one of the following coverage tiers and eligible dependents you will cover:

- Associate only
- Associate + spouse/partner (not available for part-time hourly or temporary associates, or part-time OTR truck drivers)
- Associate + child(ren)
- Associate + family (not available for part-time hourly or temporary associates, or part-time OTR truck drivers)

See the **Dependent eligibility** section in the **Eligibility, enrollment, and effective dates** chapter for information on dependent eligibility, including which family members may be enrolled for coverage, and when.

Cost of coverage

The amount of your payroll deductions for medical coverage will vary, depending on the AMP option you choose, the coverage tier you choose, whether you are eligible for tobacco-free rates and whether you are enrolled in the AMP through COBRA continuation coverage. See the **Paying for your benefits** section in the **Eligibility, enrollment, and effective dates** chapter for information about payroll deductions and the **COBRA** chapter for more information about COBRA continuation coverage.

Role of third-party administrator

The AMP administrator has hired third-party administrators ("TPAs") who have the primary responsibility for ensuring the AMP pays benefits in accordance with the terms and conditions of coverage described in this chapter. TPAs are responsible for determining things like whether services you receive are covered by the AMP, whether you have met any applicable deductibles and out-of-pocket maximum, and the amount of any AMP benefit. The TPA that administers your AMP option is identified on your plan ID card. Your specific TPA will depend on your work location and will be either Skai Blue Cross Blue Shield ("Skai Blue") or UMR. If your work location changes during the year, your TPA may change. The AMP reserves the right to change your TPA at any time.

AMP benefits are self-insured by Walmart. While your TPA may be an insurance company, it also provides administrative services to self-insured plans like the AMP. The AMP administrator has delegated fiduciary authority to your TPA to make most claims and appeals decisions, including prior authorization determinations. The AMP administrator has also delegated fiduciary authority to other AMP service providers to make some prior authorization determinations. See the **Prior authorization** section in this chapter and the **Claims and appeals** chapter for information about AMP service providers who have the fiduciary authority to make claims and appeals decisions, including prior authorizations.

Provider networks

A network is a group of providers, including doctors, hospitals, or other health care professionals or facilities that have agreed to accept specific amounts for covered services. Whether the AMP will pay a benefit for services you receive and the amount of any benefit often depends on whether services are provided by a network provider. There are two types of networks discussed in this chapter: a "TPA network" and an "AMP network." A provider in your TPA network is a "TPA network provider" and a provider in an AMP network is an "AMP network provider." When you see a reference to a "network provider" in this chapter, it can mean either a TPA network provider or an AMP network provider. The discussion does not distinguish between the two unless it is important in the context of the specific benefit being discussed. If the type of network provider impacts whether, and to what extent, the AMP will pay a benefit, the discussion will include references to "TPA network provider" or "AMP network provider" so you know which one it means. Services received from a network provider may be referred to as "network services."

IMPORTANT Note: There may be different terms and conditions that apply to specific services, depending on whether those services are received from a TPA network provider or an AMP network provider, including whether the services are covered services; the amount of any benefit the AMP will pay; whether you must meet a deductible before the AMP will pay a benefit; and whether eligible medical expenses you pay will count toward any deductible or out-of-pocket maximum.

Examples include but are not limited to: Services provided through the Centers of Excellence program; some advanced imaging services; and, in some locations, services that are not provided by a Blue Select network provider when one is available. For more information, refer to the **Centers of Excellence** and **Advanced imaging** sections in this chapter. Blue Select networks are discussed in the **Provider networks** section.

Allowed amount

The **AMP benefit tables** in the **AMP options available to you** section show the AMP benefit—expressed as a percentage of the "allowed amount"—after any applicable deductible is met and other applicable terms and conditions of coverage are satisfied. For network services, the allowed amount is the amount the provider has agreed to accept for covered services provided to you. For most services, you and the AMP will each pay a portion of the allowed amount, after you have met any applicable deductible and satisfied any other applicable terms and conditions of coverage. The total amount that you and the AMP pay to the network provider will not exceed the allowed amount. A network provider is not allowed to bill you for amounts in excess of this amount.

TPA network providers

Your TPA provides access to a network of providers or facilities who have entered into contracts with the TPA to accept specific amounts for services provided to you. These providers are "TPA network providers." **Your plan ID card identifies your TPA network.**

For some services, the AMP may pay a reduced benefit, or no benefit, if the services are provided by a TPA network provider when the services are available through an AMP network provider. In that case, a TPA network provider will be considered a non-network provider and services received from that provider will be treated as out-of-network services. **Not all providers in your TPA network are providers in an AMP network.** See the **Centers of Excellence** and **Advanced imaging** sections in this chapter for important information about services that will be covered only if provided by an AMP network provider.

You can find TPA network providers in the Provider Directory at **IncludedHealth.com/Walmart**.

Note: If Skai Blue is your TPA and your work location is in **the District of Columbia, Florida, Georgia, Maryland, New Hampshire, Oklahoma, western Pennsylvania, Tennessee, northern Virginia, or Wisconsin,** the TPA network identified on your plan ID card will be one of the following **Blue Select networks**:

- Florida: NetworkBlue
- Georgia: Blue Open Access POS
- Maryland, northern Virginia, District of Columbia: Alternate Network
- New Hampshire: Blue Choice
- Oklahoma: BluePreferred
- Western Pennsylvania: Community Blue PPO Network
- Tennessee: Network S
- Wisconsin: Blue Preferred POS

If your plan ID card identifies one of those Blue Select networks as your TPA network, and you do not use a Blue Select network provider when one with the relevant specialty is available within 30 miles of your home, the provider will be considered a non-network provider, even if it is a provider in the Blue Cross Blue Shield network. However, if there is no Blue Select network provider with the relevant specialty available within 30 miles of your home, a provider in the Blue Cross Blue Shield network will be considered a TPA network provider. You will need to contact your TPA if you believe this situation applies to you. See the **When network benefits are paid for out-of-network services** section of this chapter. Call your health care advisor or care navigator at the number on the back of your plan ID card for more information about your TPA network.

If your work location is not in one of the areas listed above and you receive services in one of these areas (e.g., you are traveling in one of these areas), the TPA network identified on your plan ID card will continue to be your TPA network and you will not be required to use a Blue Select network provider.

In some locations, there may be direct or indirect agreements between the AMP and TPA network providers that include financial incentives for managing your care.

AMP network providers

Each AMP option provides access to providers or facilities who have entered into contracts with the AMP, either directly or indirectly, to accept specific amounts for services provided to you. These providers are "AMP network providers."

For some services, the AMP may pay the greatest benefit, or the only benefit, if the services are provided by an AMP network provider. If those services are provided by a provider who is not an AMP network provider—even if the provider is a TPA network provider for other purposes—the AMP may pay a reduced benefit, or no benefit for the services. **Not all providers in the TPA network are providers in an AMP network.** See the **Centers of Excellence** and **Advanced imaging** sections in this chapter for important information about services that will be covered services only if provided by an AMP network provider.

Non-network providers

A non-network provider is one who has not agreed to accept a contracted amount as full payment for covered services. This may include a provider who is otherwise a TPA network provider for some services, but not for others that are available through an AMP network. See the **What is covered by the AMP** section later in this chapter for information about how each TPA determines the allowed amount for covered services provided by a non-network provider. Services received from a non-network provider may be referred to as "out-of-network services."

The Personalized Wellbeing Copay Plan does not provide coverage for out-of-network services, except as otherwise provided in the **When network benefits are paid for out-of-network services** section of this chapter. Non-network providers are allowed to bill you for amounts in excess of the allowed amount in most cases. There are some exceptions, which are discussed in the **When network benefits are paid for out-of-network services** section. This is why you can generally expect to pay a greater share of the cost of covered services received from a non-network provider. Your TPA will inform you if you have received services from a non-network provider who is not allowed to bill you for amounts in excess of the allowed amount.



For important resources to help you manage your health:

- Provider directories are located at **IncludedHealth.com/Walmart**
- A price comparison tool is located at **IncludedHealth.com/Walmart**
- Information about covered services and claims is located at:
  - **skaibcbs.com**
  - **UMR.com**
  - **IncludedHealth.com/Walmart**
- Other information about AMP options is located on **One.Walmart.com/Health**

AMP options available to you

The specific AMP options available to you will depend on your work or assigned facility location ("work location"). If you are a remote worker or are receiving continuation coverage under COBRA, you will be assigned to a specific facility. If you are an OTR truck driver, the AMP options available to you may be determined by your home address on record rather than work location. The **AMP benefit tables** in this section provide a summary of the benefits available under each AMP option. Remember that in some locations, you may also have access to an HMO option through the AMP, but it will be described in materials provided by the HMO. Find more information about HMO coverage including how to contact your HMO at **One.Walmart.com/HMO**.

Premier PPO, Contribution HRA, Saver HSA plan options

The three main AMP options available nationwide are the Premier PPO, Contribution HRA, and Saver HSA Plans. However, if the Personalized Wellbeing Copay Plan is available in your work location (see below), it will replace the Contribution HRA Plan as an option. These three main AMP options provide coverage for out-of-network services, subject to applicable AMP terms and conditions of coverage.

Note for associates with a work location where the Personalized Wellbeing Copay Plan is offered: The Contribution HRA Plan is not available in locations where the Personalized Wellbeing Copay Plan is offered.

See the **Evaluating your options** section for more information about the AMP options available to you.

Personalized Wellbeing Copay Plan

The Personalized Wellbeing Copay Plan is available to eligible associates with a work location in **California, Kentucky, Louisiana, Mississippi, New Jersey, Tennessee, Washington, West Virginia, and certain parts of New York**. The Personalized Wellbeing Copay Plan provides predictable copays for most covered services, including office visits, hospital care, labs, and other services. It also offers access to a wellbeing agent that is available 24/7 to answer general health or benefits questions. This wellbeing agent is an artificial intelligence (AI) tool from Included Health called "Dot." Dot is designed to enhance your experience and streamline access to information. You also have access to a care navigator who can answer your questions and help you find the most appropriate care or provider. The Personalized Wellbeing Copay Plan does not provide benefits for out-of-network services, unless otherwise provided in the **When network benefits are paid for out-of-network services** section.

If you enroll in the Personalized Wellbeing Copay Plan, you are encouraged to complete an onboarding process through Included Health. This includes downloading the Included Health app, creating an account, answering some initial questions, and reviewing your plan benefits. Completing this process enables the Dot wellbeing agent and your care navigator to provide personalized support based on your health needs and preferences.

Completing the onboarding process, including answering any health-related questions, is entirely voluntary. Your eligibility for the Personalized Wellbeing Copay Plan, and the AMP benefits available to you, does not depend on whether you complete the onboarding process. AMP benefits are subject to the same terms and conditions of coverage whether or not you complete onboarding.

AMP benefit tables

The following tables summarize the benefit—expressed as a percentage of the allowed amount—the AMP will pay a benefit for different categories of services, depending on whether the services are provided by a network provider or a non-network provider. AMP benefits are subject to all terms and conditions described in this 2027 *Associate Benefits Book* and each AMP benefit shown in the following

tables and referenced throughout this chapter is the amount the AMP will pay after you have met any applicable deductible and all other applicable terms and conditions of coverage described in this chapter have been satisfied.

AMP Benefit Table: Premier PPO, Contribution HRA, Saver HSA Plans
All benefits are subject to terms and conditions of coverage described in this 2027 Associate Benefits Book

	Premier PPO Plan	Contribution HRA Plan	Saver HSA Plan
Walmart-provided funds (Individual/Family)	None	$250/$500 *Maximum annual company contribution to HRA*	$350/$700 *Maximum annual company matching contribution to HSA*
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
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
Preventive care • TPA network • Non-network	 100% (no deductible) 50% (no deductible)	 100% (no deductible) 50% (no deductible)	 100% (no deductible) 50% (no deductible)
Doctor office visits (in-person or virtual) *Including routine same-day diagnostic tests performed in doctor's office* **Primary care and mental health** • TPA network • Non-network **Specialist** • TPA 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
Virtual care through Doctor On Demand by Included Health and other AMP network providers	$0 copay (no deductible)	$0 copay (no deductible)	$0 copay (no deductible)
Diagnostic tests *Nonpreventive tests ordered or performed outside a doctor's office* • TPA network • Non-network	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Advanced imaging MRI and CT scans • AMP Alternate network[1] • TPA 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
Urgent care • TPA network • Non-network	 100% after $75 copay 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Emergency services[2] **Ground ambulance[3]**	100% after deductible and $300 copay	100% after deductible and $300 copay	100% after deductible and $300 copay
Other services *Inpatient and outpatient hospitalization including physician, surgeon, and facility charges; air ambulance and other provider/facility services not listed* • TPA network • Non-network	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible	 75% after deductible 50% after deductible
Centers of Excellence[1]	See the **Centers of Excellence** section of this chapter		
Pharmacy	See **The pharmacy benefit** chapter		

[1] This is an AMP network. See the **Provider networks**, **Advanced imaging**, and **Centers of Excellence** sections.
[2] This refers to emergency services required to stabilize. See the **When network benefits are paid for out-of-network services** and **Emergency, ground and air ambulance** sections. Emergency services discussed in that section may not apply to urgent care facilities in your state.
[3] Covered only as described in the **Emergency, ground and air ambulance** section and **When limited benefits apply to the AMP** section later in this chapter.

AMP Benefit Table: Personalized Wellbeing Copay Plan **In-Network Benefits Only** *No benefits for out-of-network services except as provided in the* **When network benefits are paid for out-of-network services** *and* **Emergency, ground and air ambulance** *sections* *All benefits are subject to terms and conditions of coverage described in this 2027 Associate Benefits Book*	
Annual deductible (Individual/Family)	None
Annual out-of-pocket maximum (Individual/Family)	$5,000/$10,000
Preventive care	$0 copay
Primary care office visits (in-person or virtual) (including mental health visits, pediatrics, and gynecology) *Includes routine same-day diagnostic tests performed in doctor's office*	$0 copay
Specialist office visits (in-person or virtual) (including dermatology, cardiology, home health, podiatry, etc.) *Includes routine same-day diagnostic tests performed in doctor's office*[1]	$50 copay/$0 copay (mental health)
Virtual care through Doctor On Demand by Included Health and other AMP-identified providers	$0 copay
Diagnostic tests (per encounter) *Nonpreventive tests ordered or performed outside a doctor's office or as a standalone service within a doctor's office setting, including labs, sleep study, etc.*[1]	$50 copay
Imaging (per service) Basic imaging (X-rays, bone density, PET, etc.)	$100 copay
Advanced imaging MRI and CT scans (per service) • AMP Alternate network[2] • TPA network	 $100 copay Not covered
Durable medical equipment	25% coinsurance/$100 copay (mental health)
Urgent care	$50 copay/$0 copay (mental health)
Emergency services[3] **Ground ambulance**[4]	$250 copay
Other covered services • Inpatient stay (includes physician/surgeon, facility charges, etc.) (per admission) • Outpatient surgery (includes physician/surgeon, facility charges, etc.) • Outpatient facility charges (occupational therapy, physical therapy, etc.) • Dialysis (per day) • Hearing aids (each ear) • Home health (every two hours) • Outpatient hospice (per day) • Air ambulance	 $1,500 copay $500 copay $500 copay $100 copay $500 copay/$100 copay (mental health) $50 copay $100 copay $1,500 copay/$250 copay (mental health)
Centers of Excellence[2]	See the **Centers of Excellence** section of this chapter
Pharmacy	See **The pharmacy benefit** chapter

[1] You may also be responsible for an outpatient facility charge copay for additional services related to testing or other procedures.
[2] This is an AMP network. See the **Provider networks**, **Advanced imaging**, and **Centers of Excellence** sections.
[3] This refers to emergency services required to stabilize. See the **When network benefits are paid for out-of-network services** and **Evaluating your options** sections. Emergency services discussed in that section may not apply to urgent care facilities in your state.
[4] Covered only as described in the **Emergency, ground and air ambulance** section and **When limited benefits apply to the AMP** sections.

For important resources to help you manage your health:

- Provider directories are located at **IncludedHealth.com/Walmart**
- A price comparison tool is located at **IncludedHealth.com/Walmart**
- Information about covered services and claims is located at:
  - **skaibcbs.com**
  - **UMR.com**
  - **IncludedHealth.com/Walmart**
- Other information about AMP options is located on **One.Walmart.com/Health**

When network benefits are paid for out-of-network services

The **AMP benefit tables** in the **AMP options available to you** section summarize the AMP benefit for covered services, which may depend on whether the services are network services or out-of-network services. This section describes circumstances in which the AMP will treat out-of-network services as network services for some purposes.

Out-of-network services treated as network services under plan-specific terms

In the situations described below, out-of-network services are treated as network services, except as otherwise provided. **Contact your TPA if you believe one of these situations applies to you.**

- If your dependent child under age 19 requires covered services (other than services available through the Centers of Excellence program) at a Children's Miracle Network hospital. The allowed amount will be determined under terms applicable to non-network providers and the non-network provider will be allowed to bill you for amounts in excess of that amount in most cases.
- If you receive out-of-network services (other than services available through the Centers of Excellence program) while on vacation or business travel in the U.S., where those services relate to a serious and complex course of treatment, as determined by your TPA, that began prior to travel and must be continued during travel; or could not have been reasonably foreseen prior to the travel. The allowed amount will be determined under terms applicable to non-network providers and the non-network provider will be allowed to bill you for amounts in excess of that amount in most cases.
- If you are newly enrolled in the AMP and are receiving out-of-network services (other than services available through the Centers of Excellence program or services related to the travel benefit for care), related to a serious and complex course of treatment, as determined by your TPA, that began prior to the effective date of your coverage, where there is no interruption of the provider/patient relationship. Services will be treated as network services until the earlier of 90 days from the effective date of your coverage or the first day of the calendar year that next follows the effective date of your coverage. The allowed amount will be determined under terms applicable to non-network providers and the non-network provider will be allowed to bill you for amounts in excess of that amount in most cases.
- If there are no TPA network providers with the relevant specialty within 30 miles of your home (not applicable to services available through the Centers of Excellence program, services related to the travel benefit for care, advanced imaging services, or if your TPA network is a Blue Select Network). The allowed amount will be determined under terms applicable to non-network providers and the non-network provider will be allowed to bill you for amounts in excess of that amount in most cases.

In the situations described below, covered services will be treated as indicated:

- If you receive advanced imaging services (MRI or CT scan) from a TPA network provider when there is no AMP Alternate network provider available within 30 miles of the provider ordering the advanced imaging services. Services provided by the TPA network provider will be treated as though they had been provided by an AMP Alternate network provider. See the **Advanced imaging** section of this chapter for more information about AMP Alternate network providers.
- If your TPA network is a Blue Select network and there is no provider with the relevant specialty in the Blue Select network within 30 miles of your home, services provided by a Blue Cross Blue Shield network provider will be treated as though they had been provided by a Blue Select network provider. See the **Provider networks** section for more information about Blue Select networks. **Contact your TPA if you believe this situation applies to you.**

Out-of-network services treated as network services under continuity-of-care protections

If your TPA network provider or AMP network provider leaves the respective network, services received from that provider after the provider leaves the network will be considered out-of-network services, except as otherwise provided. You will receive a notice if you are eligible for "continuity of care" protections, in which case, you may elect to continue receiving services from the provider under the same terms and conditions that applied when the provider was a network provider. These continuity-of-care protections are available until the earlier of 90 days from the date of the continuity-of-care notice or when the course of treatment ends, except as noted below.

- You are currently undergoing a course of treatment for a serious and complex condition from the former network provider. For continuity-of-care purposes, a serious and complex condition means:
  - An acute illness, which is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

  - A chronic illness or condition, which is a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time
- You are currently undergoing a course of institutional or inpatient care from the provider.
- You are scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care related to the surgery from the provider with respect to such surgery.
- You have a terminal illness, as determined by applicable law, and are receiving treatment for that illness from the provider.
- You are pregnant and undergoing a course of treatment for the pregnancy from the provider.

The AMP may continue to treat services received from the non-network provider as network services if the course of treatment continues after continuity-of-care protections would otherwise end, provided there is no interruption of the provider/patient relationship, until the first day of the next following calendar year (or in the case of pregnancy, six weeks after the date of delivery), if later. After the continuity-of-care protections would otherwise end, the allowed amount will be determined under terms applicable to non-network providers and the non-network provider will be allowed to bill you for amounts in excess of that amount in most cases.

Out-of-network emergency and air ambulance services treated as network services

In the following circumstances, out-of-network services will be treated as services received from a TPA network provider, except as otherwise provided.

- If you receive covered emergency services in a non-network emergency department or from a non-network provider in an emergency department to evaluate an "emergency medical condition," as defined in the **Emergency, ground and air ambulance** section. The allowed amount will be determined in accordance with applicable law, and the non-network emergency department or provider will not be allowed to bill you for amounts in excess of that allowed amount.
- If you receive "post-stabilization services" from a non-network provider or non-network facility after you are stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to emergency services to evaluate an emergency medical condition. The allowed amount will be determined in accordance with applicable law and the non-network provider or facility will not be allowed to bill you for amounts in excess of that allowed amount, unless the provider or facility has determined that a notice and consent exception applies and has obtained your consent to bill you for amounts in excess of the allowed amount. In that case, the services will be treated as out-of-network services for all purposes.
- If you receive covered services from a non-network provider who is subject to notice and consent requirements at a facility in your TPA network and that non-network provider has not obtained your consent to bill you for amounts in excess of the allowed amount. The allowed amount will be determined in accordance with applicable law, and the non-network provider or facility will not be allowed to bill you for amounts in excess of that allowed amount. However, if the non-network provider obtained your consent to bill you for amounts in excess of the allowed amount, the services will be treated as out-of-network services for all purposes.
- If you receive services from a non-network provider of air ambulance services that would be covered services under the AMP if provided by a TPA network provider of air ambulance services. The allowed amount will be determined in accordance with applicable law, and the non-network provider will not be allowed to bill you for amounts in excess of that allowed amount.

See the **Emergency, ground and air ambulance** section for additional details.

Coverage when you travel to a foreign country

If you travel abroad, follow these steps:

- Before you begin your travel, contact your TPA 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.

Evaluating your options

Walmart-provided funds

Saver HSA Plan—health savings account

The Saver HSA Plan gives you the opportunity to contribute to a health savings account ("HSA") through payroll deductions on a pretax basis. Walmart matches your contributions made through payroll deductions, dollar-for-dollar up to $350 if you have associate-only coverage or $700 if you have elected anything other than associate-only coverage. Combined contributions to your HSA (your own and Walmart's) cannot exceed the 2027 annual IRS limit of $4,500 for associate-only coverage or $9,000 for all other coverage tiers. This limit will increase by $1,000 if you are, or will be, age 55 on or before December 31, 2027.

You can choose to use money in your HSA to pay qualified medical expenses, including amounts that apply to your deductible(s), copays, coinsurance, or medical expenses for services not covered by the AMP. You can also save your HSA funds for future medical expenses. You are not taxed on HSA money you use to pay for qualified medical expenses. See the **Health savings account (HSA)** chapter for additional information.

Contribution HRA Plan—health reimbursement account

The Contribution HRA Plan includes a health reimbursement account ("HRA"). Each year, Walmart allocates an amount to the HRA for you to pay a portion of your eligible medical expenses, including amounts that apply to your deductible(s). You may not contribute your own money to the HRA. Amounts Walmart allocates may be used only for the purposes stated below and will be forfeited if you are no longer enrolled in the Contribution HRA Plan. The annual amount allocated to the HRA depends on whether you are enrolled in associate-only coverage (in which case you will be allocated the "individual" amount) or a level of coverage that includes eligible dependents (in which case you will be allocated the "family" amount).

At the beginning of each new year, Walmart will allocate that year's HRA funds to your HRA. The AMP automatically pays a portion of your eligible medical expenses (except for prescription drug expenses) from the HRA until the HRA funds are exhausted. Each year's allocation of HRA funds may initially be used only for eligible medical expenses for services that you receive within that year, except that any balance remaining in your HRA at the end of the year will roll over for use during the next year, provided you remain enrolled in the Contribution HRA Plan. HRA funds that roll over to the next year are then designated as "rollover funds." Your HRA balance (including your allocated HRA funds for the current year and any amount rolled over from the previous year) cannot exceed your network deductible under the Contribution HRA Plan for the current year. Any amount in excess of your network deductible will be forfeited.

Only amounts designated as "rollover funds" may be used to pay eligible medical expenses for services received in a previous year.

For example, if you were enrolled in the Contribution HRA Plan in 2026 and 2027, any HRA funds allocated in 2027 could be used only for eligible medical expenses for services received in 2027 but not those received prior to 2027 (such as an eligible expense for services received in 2026 but not processed until 2027). However, any "rollover funds"—HRA funds that roll over from 2026 to 2027—may be used for any eligible medical expense for services received while enrolled in the Contribution HRA Plan.

If you enroll in the Contribution HRA Plan midyear, Walmart will prorate your initial HRA allocation on a monthly basis. However, your deductible(s) and out-of-pocket maximum are not prorated. If you experience an election change event and change your coverage tier midyear from associate-only to associate + family coverage, Walmart adjusts your HRA allocation, deductible(s), and annual out-of-pocket maximum accordingly. However, if you change from associate + family coverage to associate-only coverage, amounts previously allocated to your HRA will not be reduced. See the **Permitted election changes outside Annual Enrollment** section in the **Eligibility, enrollment, and effective dates** chapter.

If you cancel your medical coverage, lose eligibility, or change from the Contribution HRA Plan to a different option, any unused HRA funds are forfeited but will still be available to pay eligible medical expenses for services received before your coverage under the Contribution HRA Plan ended. If you lose coverage due to a qualifying event and you continue to be enrolled in the Contribution HRA Plan through COBRA continuation coverage, HRA funds remain available to you under the terms described above and Walmart will continue to allocate funds to your HRA annually as long as you remain enrolled in the Contribution HRA Plan, subject to COBRA's restrictions on the duration of continuation coverage. See the **COBRA** chapter.

Note for associates with a work location where the Personalized Wellbeing Copay Plan is offered: The Contribution HRA Plan is not available in 2027 in locations where the Personalized Wellbeing Copay Plan is offered. If you were enrolled in the Contribution HRA Plan as of December 31, 2026, any remaining HRA funds may be used to pay eligible medical expenses for services received on or before December 31, 2026. Any HRA funds not used for such expenses will be forfeited.

Cost sharing

The AMP provides medical benefits only for certain services, referred to as "covered services," under the terms and conditions described in this chapter. The **AMP benefit tables** in the **AMP options available to you** section show the AMP benefit that will be paid for covered services. The AMP benefit is expressed as a percentage of the "allowed amount." This is the amount the AMP will pay after any deductible is met and all other applicable terms and conditions of coverage described throughout this chapter have been satisfied. See the **Provider networks** section for more information about the allowed amount. Responsibility for payment of the allowed amount is shared between you and the AMP. You are responsible for paying any deductible and copayment (sometimes referred to as a "copay") and

any "coinsurance," which are described in the following sections. The portion of the allowed amount you are responsible for paying is referred to as "cost sharing," and includes amounts to satisfy any deductible, copayments, and coinsurance. Cost sharing does not include any other expenses, such as amounts for services that are not covered services or amounts that you pay to a non-network provider that are in excess of the allowed amount.

Annual deductible

If applicable, your deductible is the amount of eligible medical expenses you pay each year for most covered services, including prescription drugs, before the AMP will pay a benefit. For example, if you are enrolled in associate-only coverage in the Contribution HRA Plan, you have a $1,750 annual network deductible and will generally need to pay the first $1,750 of the cost of network covered services before the AMP will pay a benefit, with some exceptions.

The Premier PPO, Contribution HRA, and Saver HSA Plans each have a separate network deductible (for in-network services) and an out-of-network deductible (for out-of-network services). Eligible medical expenses applied to your network deductible are also applied to your out-of-network deductible, and vice versa. For most covered services, the AMP will only pay a benefit for network services after you have met the network deductible, but the AMP will generally not pay a benefit for out-of-network services until the out-of-network deductible has been met. See exceptions in the **When network benefits are paid for out-of-network services** section.

If a covered service is not subject to a deductible, such as preventive care, you will not be required to meet your deductible before the AMP will pay a benefit.

There is an "individual" deductible amount and a "family" deductible amount. The "individual" amount is your deductible if you have elected associate-only coverage. The "family" amount is your deductible if you have elected any other level of coverage that includes eligible dependents. If you elect coverage for eligible dependents, the deductible(s) can be met by any combination of any covered individuals, but the AMP will not pay a benefit, except for services not subject to a deductible, for either you or your covered dependents until the entire applicable (network or out-of-network) deductible is met.

If you are enrolled in the Contribution HRA Plan you can meet all or a portion of your deductible with your company-provided HRA funds. See the **Walmart-provided funds** section above.

If you are enrolled in the Saver HSA Plan, you generally must pay the entire cost of covered network services and prescription drugs until you meet your network deductible. There are exceptions, which are identified in the **AMP benefit tables** in the **AMP options available to you** section.

Also see the **Helping you manage your health** section later in this chapter and **The pharmacy benefit** chapter for other services that may not be subject to a deductible.

The following expenses paid by you or on your behalf, if applicable, **do not count** toward the network or out-of-network deductible.

- Copays
- Coinsurance for hip or knee replacement services outside the Centers of Excellence program without a network exception or for prescription drugs under the pharmacy benefit
- Amounts in excess of the allowed amount paid to non-network providers who are allowed to bill you for amounts in excess of the allowed amount
- Amounts paid for services that the AMP does not cover and/or does not pay any benefit for, including services that are not covered services or services not covered after you have met the maximum benefit amount through the Centers of Excellence program for family-building services
- Amounts paid for covered preventive services received from a non-network provider, and
- Payroll deductions toward cost of coverage

Copayments

A "copayment" (or "copay") is a fixed amount that you pay for a covered service or prescription drug and is usually paid when you receive the service or fill a prescription. For covered services subject to a copayment, you must continue to pay the copayment, even after the deductible has been met, until you meet your out-of-pocket maximum.

Coinsurance

For most covered services not subject to a copayment, you will be required to pay the coinsurance after you meet any applicable deductible. Your coinsurance will be the difference between the allowed amount and the amount of the AMP benefit. For example, if the AMP benefit is 75% of the allowed amount, your coinsurance will be 25% of the allowed amount. Network providers are not allowed to bill you for amounts in excess of the allowed amount. However, if you receive services from a non-network provider, you will generally be responsible for amounts in excess of the

allowed amount in most cases. This is referred to as "balance billing." See the **When network benefits are paid for out-of-network services** section for important exceptions.

Annual out-of-pocket maximum

The annual out-of-pocket maximum amount is the most you could pay during each calendar year for your share of the costs of covered network services. Generally, amounts you pay for covered out-of-network services do not count toward your out-of-pocket maximum. See exceptions in the **When network benefits are paid for out-of-network services** section.

After you meet the out-of-pocket maximum, the AMP will pay 100% of the cost of covered network services for the remainder of the calendar year, excluding amounts paid by you that do not count toward the out-of-pocket maximum. You will be required to continue paying your share of the cost of covered out-of-network services after you meet your out-of-pocket maximum. See exceptions in the **When network benefits are paid for out-of-network services** section.

There is an individual out-of-pocket maximum and a family out-of-pocket maximum. Regardless of the coverage tier you choose, you and each covered dependent are subject to the individual out-of-pocket maximum. Once you or any covered dependents have met the individual out-of-pocket maximum, the AMP will pay the cost of covered network services as described above. The family out-of-pocket maximum is a combination of all covered individuals' eligible medical expenses that count toward the out-of-pocket maximum. Eligible medical expenses of two or more covered individuals can be combined to meet the family out-of-pocket maximum. Once you meet the family out-of-pocket maximum, the AMP will pay the cost of covered network services as described above for each covered individual, even if each individual has not met the individual out-of-pocket maximum.

The following eligible medical expenses paid by you, if applicable, **do count** toward the annual out-of-pocket maximum:

- Amounts paid toward your network and out-of-network deductibles
- Copays
- Coinsurance for network services or out-of-network services that are treated as network services as described in the **When network benefits are paid for out-of-network services** section
- Pharmacy copays/coinsurance

The following expenses paid by you or on your behalf, if applicable, **do not count** toward the annual out-of-pocket maximum:

- Coinsurance for out-of-network services
- Amounts paid for hip or knee replacement services outside of the Centers of Excellence program without a network exception, even if the services are provided by a TPA network provider; advanced imaging services from a TPA network provider without a network exception when an AMP Alternate network provider is available within 30 miles of the provider ordering the advanced imaging services; or services from a Blue Cross Blue Shield network provider when a Blue Select network provider is available within 30 miles of your home (in applicable locations). See the **Provider networks**, **Advanced imaging** and **Centers of Excellence** sections
- Amounts in excess of the allowed amount paid to non-network providers who are allowed to bill you for amounts in excess of the allowed amount
- Amounts paid for services that the AMP does not cover and/or does not pay any benefit for, including services that are not covered services or services not covered after you have met the maximum benefit amount through the Centers of Excellence program for family-building services
- Payroll deductions toward cost of coverage

IMPORTANT Note: There may be different terms and conditions that apply to specific covered services, depending on whether you receive services from a TPA network provider or an AMP network provider, including whether the services are covered services; the amount of any benefit the AMP will pay for the services; whether you must meet an applicable deductible before the AMP will pay a benefit; and whether eligible medical expenses you pay will count toward your applicable deductible or out-of-pocket maximum.

Examples include but are not limited to: Covered services through the Centers of Excellence program; some advanced imaging services; and, in some locations, services received when a Blue Select network provider through Skai Blue is available. For more information, refer to the **Provider networks**, **Centers of Excellence**, and **Advanced imaging** sections in this chapter.

Preventive care

Unless otherwise provided below, the AMP will pay a benefit for covered preventive care services, as follows:

- If you are enrolled in the **Premier PPO, Contribution HRA, or Saver HSA Plan:** the AMP will pay a benefit of 100% for preventive care services received from a TPA network provider or a benefit of 50% for preventive care services received from a non-network provider. You will not be required to meet your deductible before the AMP pays a benefit. Amounts you pay for covered out-of-network preventive care services will not apply to your deductible(s) or out-of-pocket maximum.
- If you are enrolled in the **Personalized Wellbeing Copay Plan:** the AMP will pay a benefit of 100% for preventive care services received from a TPA network provider and no copay will be required. There is no AMP benefit for out-of-network services.

A special rule applies to covered preventive care services performed during office visits. The AMP may not pay a benefit of 100%, and the deductible or a copay may apply, if the preventive care services are billed separately from the office visit or are not the primary purpose of an office visit. In that case, the AMP will pay the benefit it would pay for covered services that are not considered preventive care services, including application of your deductible or a copay, as described in the **AMP benefit tables** in the **AMP options available to you** section.

For a preventive care service to be eligible under this section, it must fall under a recommendation 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.

The AMP may use reasonable medical management procedures, as permitted by law, when determining which preventive care services are paid at 100%, such as only covering generic drugs or requiring a prescription or that preventive care be performed by a TPA network provider to be covered at 100%. If your attending physician believes that it is medically necessary for these preventive care services or drugs to be delivered in a different manner, you or your attending physician may request an exception. For the covered preventive care services listed below, you or your attending physician should request an exception by calling the TPA at the number on your plan ID card. Your TPA may ask your physician to answer questions about why an exception is medically necessary. To request an exception related to preventive care drugs or contraceptives, see the **Preventive care exceptions process** later in **The pharmacy benefit** chapter.

Covered preventive care services include those listed on the following pages. Refer to your TPA for more information about preventive care services that might not be listed here. For the most up-to-date list of covered preventive services, go to **One.Walmart.com/Health** or call your TPA 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
- **Anxiety screening** for adults age 64 years or younger
- **Blood pressure** screening for all adults
- **Colorectal cancer** screening for adults age 45 and over, including follow-up colonoscopy after a positive stool-based screening test or direct visualization screening test
- **Depression** screening for adults
- **Diabetes (type 2) and prediabetes** screening for adults age 35–70 who are overweight or obese, and offer or referral of preventive interventions for patients with prediabetes
- **Diet and physical activity** counseling for adults at higher risk for cardiovascular disease
- **Falls-prevention and exercise interventions** 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 all adults age 18 to 79
- **HIV** screening for all adults to age 65, and older adults at higher risk
- **Immunization** vaccines for adults—doses, recommended ages and recommended populations vary:
  - COVID-19
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Herpes zoster
  - Human papillomavirus
  - Influenza (flu shot)
  - Measles, mumps, rubella
  - Meningococcal
  - Mpox
  - Pneumococcal
  - Respiratory syncytial virus (RSV)

  - Tetanus, diphtheria, pertussis
  - Varicella

  The list above is illustrative and may not reflect all covered immunizations. Learn more about immunizations and see the latest vaccine schedules at **cdc.gov/vaccines/imz-schedules**.
- **Latent tuberculosis infection (LTBI)** screening in populations at increased risk
- **Lung cancer** screening for certain adults age 50–80 who have a smoking history
- **Obesity** behavioral interventions for adults with a BMI of 30 or higher
- **Preexposure prophylaxis ("PrEP")** with effective antiretroviral therapy and related preventive services to persons who are at increased risk of HIV acquisition. See **The pharmacy benefit** chapter for more information.
- **Sexually transmitted infection (STI)** prevention counseling for adults at higher risk
- **Skin cancer** counseling for young adults to age 24
- **Statin** for the primary prevention of cardiovascular disease for adults aged 40 to 75 years who have one or more cardiovascular disease risk factors and an estimated 10-year risk of a cardiovascular event of 10% or greater (prescription required). See **The pharmacy benefit** for more information.
- **Syphilis** screening for all adults at higher risk
- **Tobacco use** screening for all adults and cessation interventions for tobacco users
- **Unhealthy drug use** screening (i.e., asking questions) for adults age 18 and older

Covered preventive services for women, including pregnant women

- **Anxiety** screening in adolescent and adult women, including those who are pregnant or postpartum
- **Aspirin (low dose)** for women at least 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 ages 40 through 74. Other breast cancer screening and follow-up services are covered without cost sharing to the extent required under applicable preventive care guidelines.
- **Breast cancer risk-reducing prescription medications** (such as tamoxifen or raloxifene or aromatase inhibitors) for certain women at increased risk for breast cancer
- **Breastfeeding** comprehensive support and up to three counseling visits from trained providers for the mother; if the newborn is enrolled in the AMP the newborn is also eligible for up to three counseling visits. Includes access to breastfeeding supplies for pregnant and nursing women. Check with your third-party administrator (TPA) for details on how to obtain breastfeeding equipment and supplies including, but not limited to, a breast pump.
- **Cervical cancer** screening every three years for women age 21 to 29 using cytology (Pap test) and every five years for women ages 30 to 65 using high-risk human papillomavirus (HPV) testing or cytology and HPV co-testing, and additional imaging and/or pathology evaluation if indicated.
- **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.
- **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
- **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 or after and those at high risk of developing gestational diabetes
- **Gonorrhea** screening for younger women and other women at increased risk
- **Healthy weight and weight gain** counseling for pregnant women
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human immunodeficiency virus (HIV)** screening and counseling
- **Hypertensive disorders of pregnancy** screening with blood pressure measurements throughout pregnancy
- **Maternal depression** screening for mothers at certain well-child visits

- **Obesity prevention** counseling in midlife women aged 40 to 60 with normal or overweight body mass index
- **Osteoporosis** screening for women over age 65, and younger postmenopausal women depending on risk factors
- **Perinatal depression** counseling interventions or referrals for pregnant and postpartum women who are at increased risk of perinatal depression
- **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
- **Urinary incontinence** screening annually, and facilitating for further evaluation and treatment if indicated
- **Well-woman** visits to obtain recommended preventive services for women

Covered preventive services for children

- **Anemia** screening for children at 12 months
- **Anxiety** screening in children and adolescents aged 8 to 18 years
- **Autism** screening for children at 18 and 24 months
- **Behavioral/social/emotional** screening 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
- **Critical congenital heart defect** screening for newborns
- **Depression and suicide risk** screening for adolescents age 12 and older
- **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). See **The pharmacy benefit** for more information.
- **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 at high risk
- **Immunization** vaccines for children from birth to age 18—doses, recommended ages, and recommended populations vary:
  - COVID-19
  - Dengue
  - 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
  - Mpox
  - Pneumococcal
  - Rotavirus
  - Respiratory syncytial virus (RSV)
  - Varicella

  The list above is illustrative and may not reflect all covered immunizations. Learn more about immunizations and see the latest vaccine schedules at **cdc.gov/vaccines/imz-schedules**.
- **Lead** screening for children at risk of exposure
- **Medical history** for all children throughout development
- **Obesity** behavioral interventions for children 6 years or older with a high BMI
- **Oral health** risk assessment for young children, newborn to 10 years
- **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
- **Sudden cardiac arrest and sudden death** screening for adolescents
- **Tobacco, alcohol, or drug use assessment** for adolescents at higher risk

- **Tobacco use** interventions in school-aged children and adolescents who have not started to use tobacco
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children

Virtual care

The AMP provides access to several virtual care services at no cost to you. These services are not subject to a deductible or copay and include:

- Doctor On Demand by Included Health
  - Primary care
  - Urgent care
  - Mental health services, including psychology & psychiatry
- Physical therapy through Hinge Health for joint and muscle health
- Digestive health care through Cylinder

For more details, please see the **Health management tools** chart in the **Helping you manage your health** section.

You also have access to an AMP network of providers through Lyra. Many Lyra providers offer virtual care. If you access a Lyra provider through virtual care, covered services are available at no cost to you and are not subject to a deductible or copay. Lyra provides some mental health services and neuropsychological assessments through Lyra providers under regular AMP terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

Advanced imaging

Advanced imaging (MRI and CT scans) services are available through an alternate network of providers. This alternate network of providers is an AMP network. All AMP Alternate network providers are also in your TPA network but not all providers in your TPA network are AMP Alternate network providers. If you use an AMP Alternate network provider, your MRI or CT scan may receive an extra level of review, using advanced artificial intelligence (AI) technology. This review is only available to your provider and is intended to assist your provider; it does not replace your provider's medical judgment.

The AMP benefit for advanced imaging services will depend on the availability of an AMP Alternate network provider, whether you receive services from an AMP Alternate network provider, and, if applicable, whether you have received a network exception to receive advanced imaging services from a TPA network provider who is not an AMP Alternate network provider. **Prior authorization is required for advanced imaging services**—see the **Prior authorization** section later in this chapter. Your health care advisor or care navigator will assist you with any questions and can be reached at the number on your plan ID card.

If you are in the **Premier PPO, Contribution HRA, or Saver HSA Plan**, the AMP will pay the following benefit after you have met your deductible:

- 75% of the allowed amount for covered services received from an AMP Alternate network provider
- 50% of the allowed amount for covered services received from a TPA network provider who is not an AMP Alternate network provider, when an AMP Alternate network provider is available within 30 miles of the provider ordering the services, unless you receive a network exception
- 75% of the allowed amount for covered services received from a TPA network provider who is not an AMP Alternate network provider if no AMP Alternate network provider is located within 30 miles of the provider ordering the services, or if you have received a network exception
- 50% of the allowed amount for covered out-of-network services

You may request a network exception, in which case, the AMP will pay a benefit of 75% of the allowed amount for services received from a TPA network provider when an AMP Alternate network provider is available within 30 miles of the provider ordering the services.

If you receive covered services from a TPA network provider who is not an AMP Alternate network provider when an AMP Alternate network provider is available within 30 miles of the provider ordering the advanced imaging services, and you do not receive a network exception, your coinsurance for advanced imaging services received from the TPA network provider will not count toward your out-of-pocket maximum.

If you are in the **Personalized Wellbeing Copay Plan**, the AMP will pay a benefit of 100% of the allowed amount per covered service, after your required copay, if the services are received from an AMP Alternate network provider, or from a TPA network provider when no AMP Alternate network provider is located within 30 miles of the provider ordering the services. The AMP will not pay a benefit for services received from a TPA network provider who is not an AMP Alternate network provider when an AMP Alternate network provider is available within 30 miles of the provider ordering the advanced imaging services, unless you receive a network exception.

You may request a network exception to have the AMP pay a benefit of 100% of the allowed amount, after your required copay, for services received from a TPA network provider when an AMP Alternate network provider is available within 30 miles of the provider ordering the services.

Network exception request for advanced imaging services

You may request a network exception to have the AMP pay the benefit it would otherwise pay for covered services received from an AMP Alternate network provider when you receive covered services from a TPA network provider and an AMP Alternate network provider is available within 30 miles of the provider ordering the services, and either of the following apply:

- You are currently undergoing treatment for active malignancy or a serious or complex medical condition (e.g., multiple sclerosis, lung nodules, etc.), the advanced imaging services for which you are requesting prior authorization are related to treatment of such active malignancy or serious or complex medical condition, and you have had prior imaging related to the treatment of such active malignancy or serious or complex medical condition from the TPA network provider
- You require IV sedation to undergo the advanced imaging services

Depending on whether you have already received advanced imaging services, your request will be treated as a pre-service claim ("pre-service exception request") or a post-service claim ("post-service exception request"). See the **Advanced imaging: requesting a network exception to receive services from a TPA network provider who is not an AMP Alternate network provider** section in the **Claims and appeals** chapter for procedures to request a network exception.

Emergency, ground and air ambulance

Emergency services

When you seek treatment in an emergency department for services that are not "emergency services" for an "emergency medical condition," your out-of-pocket costs could be significant, especially if the facility or provider is not in your TPA network. **Please review this section carefully.**

The AMP will pay the benefit described below for emergency services.

This section describes, in part, the benefit the AMP will pay for emergency services provided in an emergency department to evaluate an "emergency medical condition," as described below, and to stabilize you.

Emergency services that are "post-stabilization services," as defined below, are paid in accordance with other AMP terms, as described in the **AMP benefit tables** in the **AMP options available to you** section of this chapter. **For example, if you are admitted to a hospital as an inpatient from the emergency department, AMP benefits applicable to inpatient hospital services would apply.** See the **When network benefits are paid for out-of-network services** section of this chapter for information about patient protections available to you when you receive emergency services, including post-stabilization services. Emergency services discussed in this section may not apply to urgent care facilities in your state.

Generally, "emergency services" include an appropriate medical screening in an emergency department of a hospital or an independent freestanding emergency department to evaluate an "emergency medical condition." **An "emergency medical condition" means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity such that a prudent layperson with an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would (i) place the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) result in serious impairment to bodily functions; or (iii) result in serious dysfunction of any bodily organ or part.**

"Emergency services" may also include "post-stabilization services," which are additional covered services that are provided by a non-network provider or non-network emergency department after you have been stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the initial emergency services were provided.

Emergency department copays

Premier PPO, Contribution HRA, and Saver HSA Plan: $300 per visit and any remaining deductible

Personalized Wellbeing Copay Plan: $250 per visit

Note that these cost-sharing amounts cover services to stabilize you. Refer to this section for important details and conditions regarding coverage of visits to emergency departments.

Emergency services provided in an emergency department

Regardless of the AMP option you are enrolled in, if you receive emergency services in a network or non-network emergency department or from a network or non-network provider in an emergency department, the AMP will pay a benefit of 100% of the allowed amount for covered services, after you have paid the applicable copay and met your network deductible, if applicable. The copay will be waived if you are admitted as an inpatient from the emergency department or you pass away prior to admission.

See the **AMP benefit tables** in the **AMP options available to you** and the **When network benefits are paid for out-of-network services** sections of this chapter for more information.

Non-emergency services provided in an emergency department

If you receive covered services in a TPA network emergency department or from a TPA network provider in an emergency department that do not relate to an "emergency medical condition," the AMP will pay a benefit of 100% of the allowed amount for covered services after you have paid the applicable copay and met your network deductible, if applicable. The copay will be waived if you are admitted as an inpatient from the emergency department or you pass away prior to admission.

If you receive covered services in a non-network emergency department or from a non-network provider in an emergency department that do not relate to an "emergency medical condition," the services will be considered out-of-network services. In that case:

- If you are enrolled in the **Premier PPO, Contribution HRA, or Saver HSA Plan**, the AMP will pay a benefit of 50% of the allowed amount for covered services after you have paid the copay and met your out-of-network deductible. You will be responsible for billed amounts in excess of the AMP benefit in most cases. The copay will be waived if you are admitted as an inpatient from the emergency department or you pass away prior to admission.
- If you are enrolled in the **Personalized Wellbeing Copay Plan**, services provided by the non-network facility or provider will be considered out-of-network services. In that case, the AMP will not pay any benefit for the services received from the non-network emergency department or non-network provider in the emergency department. You will be responsible for the billed amount.

See the **AMP benefit tables** in the **AMP options available to you** section of this chapter for more information.

Ground and air ambulance

Ground ambulance for an emergency medical condition

Regardless of the AMP option you are enrolled in, if you receive ground ambulance services for a condition that is an "emergency medical condition," as defined above, the AMP will pay a benefit of 100% of the allowed amount after you have paid the applicable copay and met the deductible, if applicable. The copay applies to each ground ambulance service you receive and will be waived if you are admitted as an inpatient at the hospital to which the ground ambulance transports you or you pass away prior to admission at that hospital.

If the ground ambulance services are provided by a non-network provider for a condition that is an "emergency medical condition," the allowed amount will be determined according to the following terms:

- If you are not admitted as an inpatient at a hospital to which the ground ambulance transports you and you do not pass away prior to admission to that hospital, the allowed amount will be 200% of Medicare's allowed amount.
- If you are admitted as an inpatient at a hospital to which the ground ambulance transports you or you pass away prior to admission at that hospital, the allowed amount will be 200% of 200% of Medicare's allowed amount.

See the **AMP benefit tables** in the **AMP options available to you** section for more information.

Ground ambulance not for an emergency medical condition

If you receive ground ambulance services for a condition that is not an "emergency medical condition," as described above, those services will not be covered, regardless of whether the services are provided by a TPA network provider or non-network provider, even if you are in an AMP option that provides out-of-network coverage, except as described in the **When limited benefits apply to the AMP** section.

If you receive ground ambulance services for a condition that is not an "emergency medical condition," but are covered services as described in the **When limited benefits apply to the AMP** section:

- If you are enrolled in the **Premier PPO, Contribution HRA, or Saver HSA Plan**, the AMP will pay a benefit of 100% of the allowed amount, after you pay the copay and any deductible, regardless of whether the services are provided by a network or non-network provider. The copay applies to each ground ambulance service you receive and will be waived if you are admitted as an inpatient at the

hospital to which the ground ambulance transports you or you pass away prior to admission at that hospital. If the ground ambulance transports you to a facility other than a hospital, the copay will not be waived.

- If you are enrolled in the **Personalized Wellbeing Copay Plan**, the AMP will pay a benefit of 100% of the allowed amount, after you pay the copay, if you receive services from a network provider. The copay applies to each ground ambulance service you receive and will be waived if you are admitted as an inpatient at the hospital to which the ground ambulance transports you or you pass away prior to admission at that hospital. If the ground ambulance transports you to a facility other than a hospital, the copay will not be waived. The AMP will not pay any benefit for services received from a non-network provider.

If you are enrolled in the **Premier PPO, Contribution HRA, or Saver HSA Plan**, the allowed amount for a non-network provider will be determined according to the following terms:

- If you are not admitted as an inpatient at a hospital to which the ground ambulance transports you and you do not pass away, the allowed amount will be 200% of Medicare's allowed amount.
- If you are admitted as an inpatient at a hospital to which the ground ambulance transports you or you pass away prior to admission at that hospital, the allowed amount will be 200% of 200% of Medicare's allowed amount.
- If you are currently admitted as an inpatient at a hospital and are transported by ground ambulance to a facility other than a hospital, the allowed amount will be 200% of Medicare's allowed amount.

A non-network provider will be allowed to bill you for amounts in excess of the allowed amount in most cases.

See the **AMP benefit tables** in the **AMP options available to you** section of this chapter for more information.

Air ambulance

Regardless of the AMP option you are enrolled in, the AMP covers air ambulance services from a non-network provider of air ambulance services in the same manner as such services are covered for a TPA network provider of air ambulance services.

If you are enrolled in the **Personalized Wellbeing Copay Plan**, the copay applies to each air ambulance service you receive. The copay will be waived if you pass away prior to admission at the hospital to which you are transported.

See the **AMP benefit tables** in the **AMP options available to you** and the **When network benefits are paid for out-of-network services** sections of this chapter for more information.

Centers of Excellence

The Centers of Excellence (COE) program works with specific facilities to provide covered services related to a range of conditions and illnesses. Through this program, you have access to specialists at facilities selected for their expertise in certain complex procedures.

The AMP and each COE facility are considered an "Organized Health Care Arrangement" (OHCA) for purposes of the HIPAA privacy rules. This means the AMP and each COE facility may share information to determine eligibility for and administer the COE program, as permitted by HIPAA.

The COE program covers:

- Medical records review by Mayo Clinic for cancer (all ages), other than localized skin cancer, including on-site evaluation or treatment, when recommended by Mayo Clinic
- Family-building services (age 18 and up) at Kindbody network clinics, including but not limited to in vitro fertilization (IVF) and intrauterine insemination (IUI)
- Medical record e-review by Cleveland Clinic for certain heart conditions (age 18 and up) including on-site heart surgery or cardiac ablation procedure, when recommended by Cleveland Clinic
- Hip or knee replacement surgery (all ages)
- Surgeries for certain spine conditions (age 18 and up, or under age 18 for certain spine conditions such as scoliosis)
- Medical record review by Mayo Clinic for outpatient kidney dialysis or end-stage renal disease (ESRD) (all ages), including on-site evaluation or treatment, when recommended by Mayo Clinic
- Transplant services at Mayo Clinic (all ages), including 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)
- On-site evaluation for certain rare conditions (all ages), including multiple sclerosis (MS), Parkinson's disease, or amyotrophic lateral sclerosis (ALS), which may include a treatment recommendation
- Weight loss surgeries (age 14 and up), including gastric bypass, gastric sleeve, and duodenal switch

The charts that follow are summaries of COE program benefits only. Read all the information in this **Centers of Excellence** section to understand all COE program benefits and terms and conditions of coverage, including when you may request a network exception to receive covered services at a non-COE facility under regular AMP terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section.

Centers of Excellence: Premier PPO, Contribution HRA, and Saver HSA Plans			
	Centers of Excellence Program		Benefit when COE is not used
	Administrator	COE benefit	
Cancer medical record review, on-site evaluation and treatment May include on-site evaluation and treatment, when recommended by Mayo Clinic	**Consociate Health** **800-804-1289**	100% No deductible[1]	Regular terms of coverage apply[2]
Family building Treatment at Kindbody network clinics	**Your TPA** **(see plan ID card)** **Travel by Consociate Health** **800-804-1289**	75% after network deductible $20,000 maximum	No coverage
Heart surgery E-review by Cleveland Clinic and on-site surgery or cardiac ablation procedure when recommended by Cleveland Clinic	**Your TPA** **(see plan ID card)** **Travel by Consociate Health** **800-804-1289**	100% No deductible[1]	Regular terms of coverage apply[2]
Hip and knee replacement	**Carrum Health** **888-890-7359**	100% No deductible[1]	50% after out-of-network deductible Coinsurance will not apply to out-of-pocket maximum[3]
Spine surgery	**Carrum Health** **888-890-7359**	100% No deductible[1]	No coverage[3]
Kidney dialysis (outpatient) or ESRD medical records review, on-site evaluation and treatment May include on-site kidney transplant evaluation or treatment when recommended by Mayo Clinic	**Consociate Health** **479-621-2830**	100% No deductible[1]	Regular terms of coverage apply[2]
Transplant Mayo Clinic only. Excludes cornea and intestinal transplant	**Consociate Health** **479-621-2830**	100% No deductible[1]	No coverage[3]
Rare conditions On-site evaluation	**Consociate Health** **800-804-1289**	100% No deductible[1]	Regular terms of coverage apply[2]
Weight loss surgery Gastric bypass, gastric sleeve, and duodenal switch	**Carrum Health** **888-890-7359**	75% after network deductible	No coverage

[1] Participants enrolled in the Saver HSA Plan must meet their network deductible before the AMP pays any benefits.

[2] Regular terms of coverage apply, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

[3] Exceptions may apply. See the specific program details in this section.

Centers of Excellence: Personalized Wellbeing Copay Plan			
	Centers of Excellence Program		Benefit when COE is not used
	Administrator	COE benefit	
Cancer medical record review, on-site evaluation and treatment May include on-site evaluation and treatment, when recommended by Mayo Clinic	**Consociate Health** **800-804-1289**	100% No copays	Regular terms of coverage apply[1]
Family building Treatment at Kindbody network clinics	**Your TPA** **(see plan ID card)** **Travel by Consociate Health** **800-804-1289**	Applicable office visit, lab, and outpatient copays apply[1]—up to $20,000 maximum	No coverage
Heart surgery E-review by Cleveland Clinic and on-site surgery or cardiac ablation procedure when recommended by Cleveland Clinic	**Your TPA** **(see plan ID card)** **Travel by Consociate Health** **800-804-1289**	100% No copays	Regular terms of coverage apply[1]
Hip and knee replacement	**Carrum Health** **888-890-7359**	100% No copays	No coverage[2]
Spine surgery	**Carrum Health** **888-890-7359**	100% No copays	No coverage[2]
Kidney dialysis (outpatient) or ESRD medical records review, on-site evaluation and treatment May include on-site kidney transplant evaluation or treatment when recommended by Mayo Clinic	**Consociate Health** **479-621-2830**	100% No copays	Regular terms of coverage apply[1]
Transplant Mayo Clinic only. Excludes cornea and intestinal transplant	**Consociate Health** **479-621-2830**	100% No copays	No coverage[2]
Rare conditions On-site evaluation	**Consociate Health** **800-804-1289**	100% No copays	Regular terms of coverage apply[1]
Weight loss surgery Gastric bypass, gastric sleeve, and duodenal switch	**Carrum Health** **888-890-7359**	Applicable office visit, lab and outpatient copays apply[1]	No coverage

[1] Regular terms of coverage apply, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

[2] Exceptions may apply. See the specific program details in this section.

The AMP will pay a benefit of 100% of the allowed amount for covered services received through the COE program (excluding family building and weight loss surgery). You will not be required to meet your network deductible, if applicable, before the AMP pays a benefit unless you are enrolled in the Saver HSA Plan. If you participate in the COE program, the AMP benefit described in the charts above only applies to covered services that are provided under the COE program. If you receive other covered services from a provider at the COE facility that are not covered under the COE program, the AMP will pay for those services, subject to regular terms of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

If you believe you may be a candidate for covered services under the COE program, call your health care advisor or care navigator at the number on your plan ID card. If you qualify, you will be connected to the appropriate COE program administrator to begin the process.

In performing evaluation services or in making determinations about medical treatment and care at a COE facility, including whether to treat you or continue to treat you, the COE facility and providers at that facility are not acting as agents for the AMP, but as your health care provider. The AMP cannot require a COE facility or a provider at that facility to provide specific services to you, or to provide any services to you.

General terms and conditions of Centers of Excellence program participation

The AMP reserves the right to recover any benefits paid as a result of fraud or intentional misrepresentation of a material fact. Engaging in such conduct may result in loss of coverage for you and your covered dependents, and you may be required to reimburse the AMP for any benefits paid in reliance on false or misleading information.

If the AMP determines that coverage must be rescinded (canceled or discontinued with retroactive effect) because of fraud or an intentional misrepresentation of a material fact, you will receive at least 30 days' advance written notice before the rescission takes effect. A cancellation of coverage that applies only prospectively, or that results from a failure to pay required contributions in a timely manner, is not a rescission.

- You may be ineligible for the COE program if either of the following applies to you:
  - If you are eligible for, and covered by, more than one medical plan, including Medicare (e.g., if you are enrolled in Medicare Part A but are not enrolled in Medicare Part B), the AMP must be the primary payer, except when coordinating with Medicare in the case of transplant services or cancer treatment, or as otherwise required by law. If there is a possibility that any other medical plan is, or could be, the primary payer under any circumstance (if you are enrolled in that plan), contact the COE program administrator listed in the appropriate chart on the previous pages for more information about your eligibility for the COE program. If the COE program administrator confirms that the AMP is not the primary payer, except when coordinating with Medicare in the case of transplant services and cancer treatment, you will not be eligible for the COE program and the AMP will pay a benefit for covered services received outside the COE program according to the AMP's terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.
  - If your hip or knee replacement or spine surgery relates to a work-related accident for which workers' compensation benefits are paid, or may be paid if properly claimed; or are the result of an injury or accident due to the conduct of another party, and you may recover amounts from that third party to compensate for the injury or harm caused by that third party, you are not eligible for the COE program. You will be asked to attest, prior to participating in the COE program, that the hip or knee replacement or spine surgery is not related to a workers' compensation claim or an injury or accident for which a third party may be responsible for compensating you. If the AMP later determines that the hip or knee replacement or spine surgery is compensable through workers' compensation or a third-party claim, the AMP may choose to seek reimbursement of benefits paid, as described in **The Plan's subrogation and reimbursement rights** section in the **Claims and appeals** chapter or to seek repayment of all COE program benefits paid if you knew at the time of your attestation that you were ineligible for hip or knee replacement or spine surgery through the COE program. If hip or knee replacement or spine surgery relates to a work-related accident or an injury or accident due to the conduct of another, and you are not eligible for the COE program as described above, the AMP will pay a benefit for covered services received outside the COE program according to the AMP's terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.
- All services must be coordinated and approved by the applicable COE program administrator before you receive services at a COE facility. See the appropriate **Centers of Excellence** chart earlier in this chapter for the COE program administrators.
- The program administrator and COE facility must receive necessary medical records before your eligibility for the COE program can be determined.
- For most covered services, you must be able to safely travel for medical care and must not require emergency care at the time of travel to the COE facility for medical care and must not require treatment for an emergency medical condition, as that term is defined in the **Emergency, ground and air ambulance** section of this chapter.
- For most covered services offered through the COE program, you must supply contact information for a local provider who has agreed to manage your follow-up care after you return home from the COE.
- For most covered services, you must designate an adult caregiver who is willing and able to meet caregiver requirements, which will be explained to you by the COE program administrator.
- If you receive services at a COE facility through the COE program, travel benefits may be provided for travel to the COE facility and may include airfare, mileage, lodging, and a daily expense allowance for food and other expenses, for both you and your adult caregiver. Travel benefits must be preapproved and scheduled through the COE program administrator. Some travel benefits are considered taxable earnings and will be reflected on your Form W-2. Travel benefits are subject to applicable IRS and AMP limits.
- You, your caregiver, and any visitors must abide by all rules and policies of the COE facility, hotel, and transport service,

including those that apply to communications and on-site conduct. Failure to do so may result in loss of eligibility for benefits under the COE program. Any communications or interactions with COE facility or staff that the COE facility determines are abusive or disruptive may also result in loss of eligibility for benefits under the COE program.

If you receive eligible services outside the Centers of Excellence program

Services will be considered "services received outside the COE program" if you receive services that are otherwise covered services through the COE program from a facility (or provider at a facility) that: 1) is not a COE program facility for those services, even if the provider is a TPA network provider, or 2) is a COE program facility for those services, but you do not coordinate with the COE program administrator prior to receiving services at the COE facility, or have not been approved for the COE program. If you receive covered services outside the COE program, see the appropriate **Centers of Excellence** chart earlier in this chapter for coverage terms when covered services are received outside the COE program without a network exception, where applicable. In some cases, the AMP may not pay a benefit for services received outside the COE program.

Covered services received prior to arrival at, or following discharge from, a COE facility, including services recommended by the COE program administrator, are paid in accordance with the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

Cancer medical record review, on-site evaluation, and treatment at Mayo Clinic

If you have been diagnosed with cancer, excluding a localized skin cancer, you are eligible for the Centers of Excellence program for cancer medical record review, which may include on-site evaluation and treatment if recommended by Mayo Clinic:

- **Review of medical records.** Mayo Clinic will review your medical records to make a recommendation about whether an on-site evaluation is appropriate.
- **On-site evaluation at Mayo Clinic for possible treatment at Mayo Clinic.** Based on a review of your medical records, Mayo Clinic may make a recommendation about whether treatment at Mayo Clinic is appropriate.
- **Treatment at Mayo Clinic.** Mayo Clinic may recommend treatment at Mayo Clinic.

If Mayo Clinic recommends an on-site evaluation or treatment at Mayo Clinic, and you choose to participate in the COE program, the AMP will pay 100% of the allowed amount for covered services received through the COE program. You will not be required to meet any deductible before the AMP pays a benefit, unless you are enrolled in the Saver HSA Plan. If you are enrolled in the Personalized Wellbeing Copay Plan, no copay is required.

If Mayo Clinic does not recommend an on-site evaluation or treatment at Mayo Clinic through the COE program or you choose not to participate in the COE program, the AMP will pay a benefit for covered services according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter, even if you receive services at Mayo Clinic outside of the COE program.

If Mayo Clinic does not recommend an on-site evaluation or treatment at Mayo Clinic through the COE program, those decisions are not subject to the AMP's claims and appeals procedures.

Contact Consociate Health if you are interested in participating in the COE program for cancer medical record review. See the appropriate **Centers of Excellence** chart earlier in this chapter.

Family building at Kindbody

If you are enrolled in the **Premier PPO, Contribution HRA, or Saver HSA Plan**, the AMP will pay a benefit of 75% of the allowed amount for covered services, including fertility medications, received from a Kindbody network clinic through the COE program, up to a $20,000 maximum lifetime benefit paid by the AMP per individual AMP participant. You will be required to meet your deductible first. Covered services received through the COE program are subject to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

If you are enrolled in the **Personalized Wellbeing Copay Plan**, the AMP will pay a benefit for covered services, including fertility medications, received from a Kindbody network clinic through the COE program, after you pay your applicable copay, up to a $20,000 maximum lifetime benefit paid by the AMP per individual AMP participant. Covered services received through the COE program are subject to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

The AMP will not pay a benefit under the COE program after you have reached the $20,000 maximum lifetime benefit. This maximum lifetime benefit will not be reset, including if you terminate employment and are rehired, regardless of when you terminate or are rehired; are currently an eligible dependent enrolled in the AMP and then become a Walmart associate who is directly eligible to enroll in medical coverage; are currently a Walmart associate enrolled in the AMP and

then become an eligible dependent of another associate; or are currently an eligible dependent of one associate and then become an eligible dependent of another associate. The $20,000 maximum lifetime benefit does not apply to covered services received outside the COE program that may be covered under the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter, independent of the COE program.

If you do not participate in the COE program, the AMP will not pay a benefit for fertility treatment services received outside the COE program unless those services are covered services under other AMP terms and conditions of coverage, even if the services are provided by a Kindbody network clinic.

Covered comprehensive fertility services include:

- In vitro fertilization (IVF)—fresh and frozen
- Intrauterine insemination (IUI)
- Frozen embryo transfers (FET)
- Frozen oocyte thaw and fertilization
- Preimplantation genetic testing (PGT-A; PGT-M, PGT-SR, etc.)
- Male infertility treatments due to azoospermia or history of vasectomy (TESE; PESE)
- Donor eggs, embryos, and sperm (considered taxable)
- Cryopreservation (freezing) of oocyte (egg)/embryo/sperm (if the patient is under age 18, a provider at a Kindbody network clinic may recommend for medical reasons, such as for tissue storage following a cancer diagnosis or other medical condition). Payment for Kindbody's storage of cryopreserved oocyte/embryo/sperm will be provided for one year. Payment for additional years of storage by a Kindbody network clinic will be your responsibility.

AMP benefits for fertility medications prescribed by a Kindbody network clinic must be filled by Schraft's Pharmacy and are subject to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter. AMP benefits for fertility medications prescribed by a Kindbody network clinic through the COE program count toward the $20,000 maximum lifetime benefit.

If you are interested in participating in the COE program for family building, you should contact your health care advisor or care navigator at the number on your plan ID card.

Heart surgery e-review and surgery or cardiac ablation procedure at Cleveland Clinic

Before you receive non-emergency heart surgery or a cardiac ablation procedure, check with your health care advisor or care navigator to find out whether you are eligible for the COE program for e-review, including on-site heart surgery or a cardiac ablation procedure if recommended by Cleveland Clinic:

- **Review of medical records.** Cleveland Clinic will review your medical records and make a recommendation about whether an on-site evaluation and treatment is appropriate.
- **On-site evaluation and heart surgery or a cardiac ablation procedure at Cleveland Clinic.** Based on a review of your medical records, Cleveland Clinic may recommend that you travel to Cleveland Clinic for an on-site evaluation and either heart surgery or a cardiac ablation procedure.

If Cleveland Clinic recommends an on-site evaluation or heart surgery or a cardiac ablation procedure, and you choose to participate in the COE program, the AMP will pay 100% of the allowed amount for covered services received through the COE program. You will not be required to meet any deductible before the AMP pays a benefit, unless you are enrolled in the Saver HSA Plan. If you are enrolled in the Personalized Wellbeing Copay Plan, no copay is required.

If Cleveland Clinic does not recommend an on-site evaluation or heart surgery or a cardiac ablation procedure at Cleveland Clinic through the COE program or you choose not to participate in the COE program, the AMP will pay a benefit for covered services according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter, even if you receive services at Cleveland Clinic outside of the COE program.

If Cleveland Clinic does not recommend on-site evaluation and either heart surgery or a cardiac ablation procedure at Cleveland Clinic through the COE program, Cleveland Clinic's determination is not subject to the AMP's claims and appeals procedures.

Contact your health care advisor or care navigator at the number on your plan ID card to start the e-review process. If you are eligible for e-review of your medical records, Cleveland Clinic recommends on-site evaluation and heart surgery or a cardiac ablation procedure, and you choose to participate in the COE program, you will be connected with Consociate Health to arrange your travel benefits.

Hip or knee replacement and spine surgery

If you are eligible to participate in the COE program for hip or knee replacement and spine surgery, and choose to do so, the AMP will pay a benefit of 100% of the allowed amount for covered services received through the COE program. You will not be required to meet your deductible, if applicable, before the AMP pays a benefit, unless you are enrolled in the Saver HSA Plan. If you are enrolled in the Personalized Wellbeing Copay Plan, no copay is required.

If you are eligible to participate in the COE program and choose not to do so, the AMP will pay a portion of the cost of covered services received outside the COE program if you receive a network exception, as described below. If you receive a network exception, the AMP will pay the cost of covered services according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

In some cases, a COE facility may determine that travel to a COE facility would, with a high degree of medical certainty, pose a significant and immediate risk of paralysis or loss of life or that you have a concurrent medical condition that makes you an inappropriate candidate for surgery through the COE program. In that case, the AMP will pay a benefit for covered services received outside the COE program according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

A decision by a COE facility to not perform hip or knee replacement or spine surgery is not subject to review under the network exception request process if the COE facility's decision is based on your refusal to follow the COE facility's medical recommendations or the terms and conditions of the COE program described in the **General terms and conditions of Centers of Excellence program participation** section. See **Network exception request for hip or knee replacement or spine surgery** for information about requesting a network exception.

Contact Carrum Health if you are interested in participating in the COE program for hip or knee replacement and spine surgery. See the appropriate **Centers of Excellence** chart earlier in this chapter.

Hip or knee replacement outside the Centers of Excellence program with no network exception

If you choose not to participate in the COE program for hip or knee replacement and do not receive a network exception:

- If you are enrolled in the **Premier PPO, Contribution HRA, or Saver HSA Plan**, the AMP will pay a benefit of 50% of the allowed amount for covered services, regardless of whether the services are provided by a TPA network provider or non-network provider, after you have met your out-of-network deductible. Coinsurance will not count toward your out-of-pocket maximum.
- If you are enrolled in the **Personalized Wellbeing Copay Plan**, the AMP will not pay a benefit for services received outside the COE program.

See the **Network exception request for hip or knee replacement or spine surgery** section for more information.

Spine surgery

If you choose not to participate in the COE program for spine surgery, the AMP will not pay the cost of any services received outside the COE program unless you receive a network exception.

Network exception request for hip or knee replacement or spine surgery

If you receive a network exception, the AMP will pay a benefit for covered services received outside the COE program according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

Depending on whether you have already received services when you request a network exception, your request will be treated as a pre-service claim ("pre-service network exception request") or a post-service claim ("post-service network exception request") as described in the section in the **Claims and appeals** chapter titled **Hip and knee replacement and spine surgery: requesting network exception for coverage outside the Centers of Excellence program**. The network exception process is summarized below.

Pre-service network exception request: If you have not yet received a hip or knee replacement or spine surgery, you may request a pre-service network exception. If you receive an exception, the AMP will pay a benefit for covered services received outside the COE program according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter. You may request a pre-service network exception if:

- **Imminent risk due to travel:** Travel to a COE facility would, with a high degree of medical certainty, pose a significant and immediate risk of paralysis or loss of life.
- **COE facility's pre-surgical recommendations are not reasonable:** The COE facility's pre-surgical recommendations for risk factor optimization, when evaluated in the context of generally accepted evidence-based medical standards (e.g., clinical practice guidelines and evidence-based protocols), are not likely to reduce the risk of surgical complications (e.g., surgical site infection, implant dislocation, need for explant and/or revision) and medical complications (e.g., pneumonia, thromboembolic disease, myocardial infarction, stroke) or to improve clinical outcomes.
- **Hip or knee replacement or spine surgery is not appropriate:** The COE facility does not recommend hip or knee replacement or spine surgery because it is not the appropriate medical course of treatment.

Pre-service network exception requests should be filed in accordance with the procedures described in the section in the

Claims and appeals chapter titled **Hip and knee replacement and spine surgery: requesting network exception for coverage outside the Centers of Excellence program**.

Post-service network exception request: If you have already received services outside the COE program, you may request a post-service network exception if your circumstances called for immediate surgery, without which you would have been, with a high degree of medical certainty, at a significant and immediate risk of paralysis or loss of life.

Post-service network exception requests should be filed with the AMP in accordance with the procedures described in the section in the **Claims and appeals** chapter titled **Hip and knee replacement and spine surgery: requesting network exception for coverage outside the Centers of Excellence program**.

Physical therapy for hip or knee replacement and spine surgery

If you participate in the COE program for hip or knee replacement or spine surgery, you may have access to virtual physical therapy at no cost. This app-based approach is designed to help you prior to and after surgery. This service is not available outside of the COE program, including when a network exception is granted for hip or knee replacement or spine surgery. Contact Carrum Health for more details on this program.

Kidney dialysis or ESRD medical record review

If you have been diagnosed with end-stage renal disease (ESRD), are on kidney dialysis, or kidney dialysis has been recommended as a course of treatment, you are eligible for the COE program for kidney dialysis or ESRD medical record review, which may include on-site evaluation and treatment if recommended by Mayo Clinic:

- **Review of medical records.** Mayo Clinic will review your medical records to make a recommendation about whether an on-site evaluation is appropriate.
- **On-site evaluation at Mayo Clinic for possible treatment at Mayo Clinic.** Based on a review of your medical records, Mayo Clinic may make a recommendation about whether treatment at Mayo Clinic is appropriate.
- **Treatment at Mayo Clinic.** Mayo Clinic may recommend treatment at Mayo Clinic.

If Mayo Clinic recommends an on-site evaluation or treatment at Mayo Clinic, and you choose to participate in the COE program, the AMP will pay 100% of the allowed amount for covered services received through the COE program. You will not be required to meet any deductible before the AMP pays a benefit, unless you are enrolled in the Saver HSA Plan. If you are enrolled in the Personalized Wellbeing Copay Plan, no copay is required.

If Mayo Clinic does not recommend an on-site evaluation or treatment at Mayo Clinic through the COE program or you choose not to participate in the COE program, the AMP will pay a benefit for covered services according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter, even if you receive services at Mayo Clinic outside of the COE program.

If Mayo Clinic does not recommend an on-site evaluation or treatment at Mayo Clinic through the COE program, those decisions are not subject to the AMP's claims and appeals procedures.

If a transplant is recommended, see the **Transplant services at Mayo Clinic** section later in this chapter for COE terms and conditions applicable to transplant services.

Contact Consociate Health if you are interested in participating in the COE program for kidney dialysis or ESRD medical record review. See the appropriate **Centers of Excellence** chart earlier in this chapter.

Transplant services at Mayo Clinic

The COE program for transplant services at Mayo Clinic covers liver, kidney, heart (including durable ventricular assist devices [VADs] and total artificial hearts [TAHs]), lung (including lung volume reduction surgery [LVRS]), pancreas, simultaneous kidney/pancreas, multiple organ, and bone marrow/stem cell transplants (including CAR T-cell treatment). Benefits through the COE program for transplant services continue until you are one year post-transplant or after a one-year post-transplant evaluation is performed.

Coverage under the COE program is limited to transplantation of human organs. The AMP does not cover transplantation of other body parts (e.g., face, hands, feet, legs, arms, uterus). Experimental and/or investigational transplant-related services are not covered under the COE program unless those services are recommended and performed by Mayo Clinic.

Cornea and intestinal transplant services are not covered under the COE program but may be covered services under the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

Contact Consociate Health for more information about the COE program for transplant services. See the appropriate **Centers of Excellence** chart earlier in this chapter.

If you are age 19 or older, you will be required to undergo a pretransplant evaluation at Mayo Clinic. Mayo Clinic will then make a recommendation regarding whether transplant services are the appropriate medical course of treatment or whether you are an appropriate candidate for transplant services through the COE program. If Mayo Clinic

determines that transplant services are the appropriate medical course of treatment for you, and you choose to receive transplant services at Mayo Clinic, the AMP will pay a benefit of 100% of the allowed amount for covered services received through the COE program. You will not be required to meet your deductible, if applicable, before the AMP pays a benefit, unless you are enrolled in the Saver HSA Plan. If you are enrolled in the Personalized Wellbeing Copay Plan, no copay is required. If you choose not to participate in the COE program, or Mayo Clinic determines that transplant services are not the appropriate medical course of treatment for you, the AMP will not pay a benefit for services received outside the COE program unless you receive a network exception.

If you are under the age of 19, you must undergo a pretransplant medical records review by Mayo Clinic. Mayo Clinic will then make a recommendation regarding whether transplant services are the appropriate medical course of treatment or whether you are an appropriate candidate for transplant services. If you are under the age of 19 and:

- You do not agree to a pretransplant medical records review by Mayo Clinic, the AMP will not pay a benefit for transplant services unless you receive a network exception.
- You do agree to a pretransplant medical records review by Mayo Clinic and Mayo Clinic determines that transplant services:
  - Are not the appropriate medical course of treatment for you, or you are not an appropriate candidate, the AMP will not pay a benefit for transplant services unless you receive a network exception, or
  - Are the appropriate medical course of treatment for you:
    - The AMP will pay a benefit of 100% of the allowed amount for covered services received at Mayo Clinic through the COE program, or
    - The AMP will pay a benefit for covered services received at a facility other than Mayo Clinic according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

In some cases, Mayo Clinic may determine that travel to a Mayo Clinic facility would, with a high degree of medical certainty, pose a significant and immediate risk of loss of life or that you have a concurrent medical condition that makes you not an appropriate candidate for transplant services at Mayo Clinic. In that case, the AMP will pay a benefit for covered services received outside the COE program according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

A decision by Mayo Clinic to not provide transplant services is not subject to review under the network exception request process if Mayo Clinic's decision is based on your refusal to follow Mayo Clinic's medical recommendations or the terms and conditions of the COE program described in the **General terms and conditions of Centers of Excellence program participation** section.

Network exception request for transplants

If you receive a network exception, if applicable, the AMP will pay a benefit for covered services received outside the COE program according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

Depending on whether you have already received services when you request a network exception, your request will be treated as a pre-service claim ("pre-service network exception request") or a post-service claim ("post-service network exception request") as described in the section in the **Claims and appeals** chapter titled **Transplant services: requesting network exception for coverage outside the Centers of Excellence program**. The network exception process is summarized below.

Pre-service network exception request: If you have not yet received a transplant, you may request a pre-service network exception, in which case the AMP will pay a benefit for covered services received outside the COE program according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter. You may request a pre-service network exception if:

- **Imminent risk due to travel (if you are age 19 or older):** Travel to Mayo Clinic would, with a high degree of medical certainty, pose a significant and immediate risk of loss of life.
- **Imminent risk due to Mayo Clinic's review of medical records (if you are under age 19):** Mayo Clinic's review of your medical records would, with a high degree of medical certainty, pose a significant and immediate risk of loss of life.
- **Transplant services are not appropriate (if you are any age):** Mayo Clinic does not recommend transplant services, including VAD, TAH, LVRS or CAR-T services because they are not the appropriate medical course of treatment or you are not an appropriate candidate.

Pre-service network exception requests should be filed in accordance with the procedures described in the section in the **Claims and appeals** chapter titled **Transplant services: requesting network exception for coverage outside the Centers of Excellence program**.

Post-service network exception request: If you have already received transplant services outside the COE program, you may request a post-service network exception if your circumstances called for immediate transplant

services, without which you would have been, with a high degree of medical certainty, at a significant and immediate risk of loss of life.

Post-service network exception requests should be filed with the AMP in accordance with the procedures described in the section in the **Claims and appeals** chapter titled **Transplant services: requesting network exception for coverage outside the Centers of Excellence program**.

Other services

Pretransplant weight loss surgery: If you are receiving transplant services at Mayo Clinic, Mayo Clinic may recommend gastric sleeve weight loss surgery at Mayo Clinic prior to your transplant to help you qualify for placement on an organ transplant waiting list ("pretransplant weight loss surgery"). You must be at least 14 years of age to receive pretransplant weight loss surgery through the COE program.

If you are eligible for the COE program for pretransplant weight loss surgery, are receiving transplant services at Mayo Clinic, and are enrolled in the **Premier PPO**, **Contribution HRA**, or **Saver HSA Plan**, the AMP will pay a benefit of 75% of the allowed amount for covered services received through the COE program. You will be required to meet your deductible first. The AMP benefit for pretransplant weight loss surgery is **not** paid at 100%.

If you are eligible for the COE program for pretransplant weight loss surgery, are receiving transplant services at Mayo Clinic, and are enrolled in the **Personalized Wellbeing Copay Plan**, the AMP will pay a benefit for covered services received through the COE program according to the Centers of Excellence chart earlier in this section. The AMP benefit for pretransplant weight loss surgery is **not** paid at 100%.

To be eligible for pretransplant weight loss surgery, you must meet the following requirements:

- 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 be enrolled in the AMP for at least 12 months. See **12-month waiting period for weight loss surgery** in the **Weight loss surgery** section later in this chapter for the rules that apply to the 12-month waiting period determination.

In some cases, Mayo Clinic may determine that travel to Mayo Clinic for pretransplant weight loss surgery would, with a high degree of medical certainty, pose a significant and immediate risk of loss of life or that you have a concurrent medical condition that makes you not an appropriate candidate for pretransplant weight loss surgery at Mayo Clinic. In that case, the AMP will pay a benefit for covered pretransplant weight loss surgery, as described in this section, at a facility other than Mayo Clinic.

A decision by Mayo Clinic to not recommend or provide pretransplant weight loss surgery is not subject to the AMP's claims and appeals procedures. However, you may be eligible to receive weight loss surgery under the COE program for weight loss surgery described in the **Weight loss surgery** section later in this chapter.

If Mayo Clinic recommends pretransplant weight loss surgery at Mayo Clinic and you do not want to travel to Mayo Clinic, you may be eligible to receive weight loss surgery under the COE program for weight loss surgery described in the **Weight loss surgery** section later in this chapter.

If Mayo Clinic recommends pretransplant weight loss surgery at Mayo Clinic, you will be connected with Consociate Health.

Transplant donor expenses: If you choose to participate in the COE program for transplant services at Mayo Clinic, the AMP will pay 100% of the cost of covered services provided by a living donor who donates to you, the recipient. The services provided to the donor must be provided by Mayo Clinic and relate directly to your transplant. The AMP will pay for these services for up to 120 days following your transplant, except to the extent that another medical plan or insurer covers those services. You are responsible for providing donor contact information for the COE program administrator to the eligible transplant donor before appointments.

The AMP may also pay travel expenses of the donor, provided those expenses relate directly to being a donor for you. Those travel expenses are generally subject to the same terms and conditions that apply to travel benefits available to you, the recipient.

Cadaver organ acquisition and procurement expenses are covered only when the expenses are eligible medical expenses under the AMP.

Services unrelated to a transplant: Services unrelated to a transplant, as determined by Mayo Clinic, that are performed at Mayo Clinic are not covered through the COE program. The AMP will pay a benefit for those services according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter. This includes certain bariatric procedures performed at Mayo Clinic during a liver transplant, or to help you qualify for placement on an organ transplant waiting list.

Rare conditions

If you have been diagnosed with, or are being evaluated for, multiple sclerosis (MS), Parkinson's disease, or amyotrophic lateral sclerosis (ALS), you may be eligible for the COE program for rare conditions, which will include an on-site evaluation at a COE facility.

If you participate in the COE program for rare conditions, the AMP benefit described in this section applies to covered services that are provided as part of the on-site evaluation visit. If you receive other covered services from a provider at the COE facility that are not covered under the COE program for rare conditions, the AMP will pay a benefit for those services according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter. This is the case, even if those services are recommended by the COE facility. Notwithstanding the preceding sentence, the COE program will cover an implantable neurostimulation surgical procedure if recommended by the COE facility for the treatment of Parkinson's disease.

If you are eligible to participate in the COE program for rare conditions and choose to participate in the COE program, the AMP will pay 100% of the allowed amount for covered services that are part of the on-site evaluation. You will not be required to meet any deductible before the AMP pays a benefit, unless you are enrolled in the Saver HSA Plan. If you are enrolled in the Personalized Wellbeing Copay Plan, no copay is required.

If you are eligible to participate in the COE program for rare conditions and choose not to participate in the COE program, the AMP will pay a benefit for covered services according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter, even if you receive services at a COE facility outside of the COE program.

Contact Consociate Health if you are interested in participating in the COE program for rare conditions. See the appropriate **Centers of Excellence** chart earlier in this chapter.

Weight loss surgery

The following weight loss surgeries are covered through the COE program for weight loss surgery: gastric bypass, gastric sleeve, and duodenal switch surgeries. You must be at least 14 years of age to participate.

If you are eligible for the COE program for weight loss surgery and are enrolled in the **Premier PPO, Contribution HRA, or Saver HSA Plan**, the AMP will pay a benefit of 75% of the allowed amount for covered services received through the COE program. You will be required to meet your deductible first.

If you are eligible for the COE program for weight loss surgery and enrolled in the **Personalized Wellbeing Copay Plan**, the AMP will pay a benefit for covered services received through the COE program according to the **Centers of Excellence** chart earlier in this section.

If you do not participate in the COE program, the AMP will not pay a benefit for services received outside the COE program, except as described below.

To participate in the COE program for weight loss surgery, you must meet the following requirements:

- 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, including the rules and policies listed elsewhere in this chapter

If you meet the requirements stated above and your doctor recommends weight loss surgery, call your health care advisor or care navigator at the number on your plan ID card to obtain a Provider Verification Form (PVF). The PVF must be completed by you and your local provider and submitted to Carrum Health. Your completed submission will be treated as a prior authorization request and will be determined under the procedures for pre-service claims described in the **Medical, pharmacy, Centers of Excellence, dental, and vision benefits claims** section of the **Claims and appeals** chapter.

If you had a previous weight loss surgery or procedure for weight loss purposes, and now need surgical revision based on medical complications, you can request to be evaluated by a COE facility to determine if you would be an appropriate candidate for a revision or a conversion to a covered weight loss surgery. You will be required to provide documentation demonstrating that you met the required clinical criteria for bariatric surgery prior to the original surgery or procedure. Contact Carrum Health for more information.

In some cases, a COE facility may determine that travel to a COE facility would, with a high degree of medical certainty, pose a significant and immediate risk to your health. In that case, the AMP will pay a benefit for covered services received outside the COE program according to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter.

Contact Carrum Health if you are interested in participating in the COE program for weight loss surgery. See the **Centers of Excellence** chart earlier in this chapter.

12-month waiting period for weight loss surgery

To be eligible for the COE program for weight loss surgery, you must be enrolled in the AMP for at least 12 months. If you are enrolled in an HMO option, you are not eligible for the COE program for weight loss surgery described in this chapter. However, if you later enroll in one of the eligible AMP options, your time enrolled in an HMO option will count toward the 12-month waiting period. Any time enrolled in critical illness insurance or accident insurance will not count toward the 12-month waiting period.

The 12-month waiting period applies separately to each individual enrolled in the AMP who is at least 14 years of age; i.e., each covered individual must meet their own 12-month waiting period. Any time enrolled in the AMP prior to attaining age 14 counts toward the 12-month waiting period.

The 12-month waiting period is waived for localized associates and their covered dependents.

If you were previously enrolled in the AMP and coverage terminated for any reason after you had met the 12-month waiting period (e.g., you terminated employment and were rehired or you voluntarily dropped coverage), your prior period of enrollment in the AMP will count toward your 12-month waiting period. However, if you had not met the 12-month waiting period prior to termination of coverage, prior time enrolled in the AMP will not count toward the 12-month waiting period and you must meet a new 12-month waiting period following your reenrollment.

Diabetes and Metabolic Management by Twin Health

If you have been diagnosed with type 2 diabetes, prediabetes, or have a body mass index of 35 or greater, you may be eligible for the Diabetes and Metabolic Management by Twin Health program. The goal of this program is to help you build a healthy lifestyle that promotes activity, nutrition, flexibility, strength, healthy weight, improved glycemic control, reduced A1C, and decreased dependence on medications for metabolic conditions like diabetes. Participation is voluntary, and Twin Health must determine that you meet the program's eligibility requirements. You must be at least age 18 to participate and have a compatible smartphone. The program is provided at no cost to you.

If you choose to participate in the program, Twin Health will use smart devices and wearables to gather real-time data to help them develop your "digital Twin," which replicates your metabolism and predicts how your body responds to food, exercise, sleep, stress, and other lifestyle and environmental factors. Using this information, Twin Health provides you with personalized, evidence-based recommendations to help you build a healthier lifestyle.

- **Education and intake process:** If you are interested in enrolling in the Twin Health program, you will enroll online and agree to Twin's program terms, including privacy practices. You will also download the Twin Health app and schedule a call with Twin Health to determine your initial clinical eligibility. You may have the option of engaging with a Twin Health artificial intelligence agent to support this process.
- **Enrollment and medical appropriateness:** Twin Health will evaluate whether you are a medically appropriate candidate for the program services, including asking questions about your health and lifestyle behaviors like diet, exercise, sleep, and stress management, and obtaining and reviewing your lab work. Note that certain conditions may mean that Twin Health determines the program is not medically appropriate for you, such as pregnancy, cancer, and end-stage renal disease.
- **Wearable devices:** Upon enrollment, Twin Health will mail you one or more wearable devices for your use while enrolled in the program. These may include a continuous glucose monitor (CGM), digital body composition scale, digital blood pressure cuff, and an activity tracker. Twin Health will help you sync these devices to your Twin Health app, and the data will help build your digital Twin to provide personalized, daily recommendations. Some devices may be subject to applicable taxes if you do not return them upon request, at the end of your participation in the program.
- **Program engagement:** Your participation in the program will require you to actively engage with the Twin Health care team, which consists of physicians, advanced practice providers, and certified health coaches who will coordinate your care with your primary care provider and specialists. Your engagement includes talking or chatting with the Twin Health care team, logging your food intake, taking blood tests, adopting lifestyle recommendations (i.e., diet and exercise), and reviewing medications according to evidence-based protocols. If you need to pause the program, there is a 60-day grace period coordinated by Twin Health. If you do not resume participation within 60 days, you will be discharged and must complete the initial evaluation again to determine eligibility to rejoin. Any communications or interactions with your Twin Health care team that are abusive or disruptive may result in loss of eligibility for benefits under the program.

Helping you manage your health

In addition to the specific covered services discussed in the prior sections, there are a number of services offered under the AMP that help you put all the AMP's benefits to work for you. The chart below and on the following pages outlines these programs and services. Note that the chart is divided into subsections based on participant eligibility for the services described. The details in the first column outline who is eligible for the services in that section. Access to these services is voluntary and many are available at no cost to you.

Health management tools	
The services in this section are available to you if you are enrolled in any of the following plans: • **Premier PPO Plan** • **Contribution HRA Plan** • **Saver HSA Plan** • **Personalized Wellbeing Copay Plan**	**Provider directories and price comparison tool** Provider directories can also be found on your third-party administrator's website: • **skaibcbs.com** • **UMR.com** These directories include a list of TPA network providers but do not include Embold Health's evaluation of individual providers. To visit the Embold Health Provider Guide, which includes a provider directory and Embold Health's evaluation of individual providers, go to **IncludedHealth.com/Walmart** if you are enrolled in the Premier PPO, Contribution HRA, or Saver HSA Plan. Included Health will then route you to the Embold Health Provider Guide. If you are enrolled in the Personalized Wellbeing Copay Plan, you will stay with Included Health. A price comparison tool is located at **IncludedHealth.com/Walmart**. Also, be sure to check out **One.Walmart.com/Health**. *Although provider directories are regularly updated, they may not reflect current network status. You should confirm network status with the provider prior to receiving services. Prices provided by the price comparison tool are only estimates and may vary when the claim is processed under the AMP terms.* **Included Health: provider search, expert second opinions, and claims advocacy** Included Health provides a variety of services designed to help you navigate your health benefits, access expert second opinions, find TPA network providers, and understand the financial and clinical aspects of your health. These resources—offered through self-service tools and live support—assist you at every step of your health care journey. Register at **IncludedHealth.com/Walmart** or by calling Included Health at **800-941-1384**. You can also download the Included Health app from the App Store or Google Play. There is no cost to you to use the Included Health tool, but any medical expenses you incur as a result of your use of these services and tools will be subject to the AMP's regular terms and conditions of coverage, as summarized in the **AMP benefit tables** in the **AMP options available to you** section and described throughout this chapter. **Included Health live support** Call Included Health at **800-941-1384** for help scheduling and preparing for an appointment. **Expert second opinions** Participants and dependents enrolled in the AMP can obtain an expert second opinion with Included Health, such as when you have received a diagnosis or been recommended for surgery or a certain treatment. **Claims advocacy** Included Health's specialized team can help you understand medical bills and explanations of benefits, organize insurance paperwork, audit provider charges, advocate to correct billing errors, and negotiate with providers and insurers on your behalf in case of claim denials. **Treatment decision support** Speak by phone directly with Included Health's clinicians to gain clinical education and guidance on your specific condition, symptoms, and treatment options.

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Health management tools

The services in this section are available to you if you are enrolled in any of the following plans:

- **Premier PPO Plan**
- **Contribution HRA Plan**
- **Saver HSA Plan**
- **Personalized Wellbeing Copay Plan**

Travel benefit for care

In some cases, the AMP may consult with Included Health to determine whether you are eligible for a travel benefit for care where an in-person visit is required. You may be eligible for the benefit if:

- You reside more than 100 miles from a provider who has sufficient experience to provide necessary covered services, as defined by Included Health.
- You reside in a state where a provider who has sufficient experience is prohibited from providing the necessary covered services and you reside more than 100 miles from a provider that Included Health has determined does have sufficient experience and is legally permitted to provide the necessary covered services.

If you are eligible, the AMP will pay covered travel costs if you travel to the provider identified by Included Health. Travel benefits may include airfare, mileage, lodging, and a daily expense allowance for food and other expenses, for both you and a caregiver. Some travel benefits are considered taxable earnings and will be reflected on your Form W-2. Travel benefits are subject to applicable IRS and AMP limits.

The travel benefit is available only for medical or mental health care, as determined by Included Health. It does not include the following, which is not an exhaustive list:

- Services that are not covered by the AMP
- Services that are covered under the Centers of Excellence program
- Neuropsychological assessments by a provider in the Lyra network
- Audiology service for the purpose of obtaining hearing aids/devices
- Clinical trials
- Dental services
- Hospice care
- Podiatry for purposes of insoles, bunions, etc.
- Reconstructive surgery (not breast cancer-related)
- Vision services related to routine vision checks

Travel benefits for care must be preapproved by Included Health. If Included Health determines that you are eligible for the travel benefit, Included Health will identify a provider with sufficient experience to provide the necessary covered services that is closest to your residence and, at your request, will assist with scheduling an appointment with the identified provider.

The travel benefit for care provides a travel benefit only for travel to the provider identified by Included Health. If Included Health preapproves travel, that preapproval applies only to the travel expenses paid by the AMP under this benefit. It does not apply to services that you may receive from the identified provider at the travel destination, which are subject to all applicable AMP terms and conditions of coverage, including any limitations and exclusions.

If you choose not to travel to the identified provider to receive services, or travel is not preapproved by Included Health, the AMP will not pay travel expenses, even if they would have otherwise been provided if they had been preapproved.

If travel benefits are preapproved, they must be prearranged by Consociate Health.

Neither Included Health nor the AMP can guarantee the identified provider at the travel destination will agree to provide covered services, and neither Included Health nor the AMP is responsible for decisions about services you may receive from the identified provider. Decisions about medical care from the identified provider are between you and that provider.

If you would like to confirm your eligibility for travel benefits, call the number on your plan ID card. Included Health will determine whether you are eligible for the travel benefit. If you do not agree with Included Health's eligibility decision, you may file a pre-service claim for benefits. See the **Travel benefit for care** section in the **Claims and appeals** chapter for more information.

Inclusive Health

Included Health will provide you with assistance in finding network LGBTQ+ and Black or African American–affirming health care providers. You will also receive advocacy and support services to assist with family, social, and workplace questions pertaining to being LGBTQ+. Enroll by visiting **IncludedHealth.com/Walmart** or calling **800-941-1384**.

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Health management tools

The services in this section are available to you if you are enrolled in any of the following plans:

- **Premier PPO Plan**
- **Contribution HRA Plan**
- **Saver HSA Plan**
- **Personalized Wellbeing Copay Plan**

Care management

You have the benefit of voluntary care management services, including a personal medical team. Care management brings consistency to the full range of care and services provided under the AMP. 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 potentially lower out-of-pocket medical expenses.

Circumstances in which a 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 mental health/substance use disorder
- 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
- You are participating in the Life with Baby Maternity Program
- Your child is in the neonatal intensive care unit (NICU) (if your TPA is Skai Blue, see the discussion of the NICU program below)

Your care manager, working with your medical team, 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 applicable deductibles and coinsurance continue to apply to any additional benefits authorized by the care management program. The services must also be medically necessary.

Your medical team may also be able to review medical costs for "involuntary" out-of-network services. In some cases, out-of-network benefits may be paid as network benefits (see **When network benefits are paid for out-of-network services** earlier in this chapter). In other cases, your TPA may negotiate with non-network providers before or after services are rendered to reduce the billed charges for which you are responsible under the AMP'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 health care advisor or care navigator, depending on the nature of your inquiry, you may be routed to your care manager. On other occasions, your care manager may reach out to you, for example to invite you to participate in a health management program or to assist you in locating certain resources and services in your community.

To reach your care manager, call your health care advisor or care navigator at the number on your plan ID card. Participation in the program is voluntary and does not affect your eligibility to participate in the AMP.

Virtual primary care

In addition to using Doctor On Demand by Included Health for video visits for urgent care and mental health services, you can also use Doctor On Demand for Virtual Primary Care. You can get help with everyday health needs or serious ongoing health issues from a Virtual Primary Care doctor who can refer you to clinical specialists when necessary. Visit Doctor On Demand online at **DoctorOnDemand.com/Walmart** or call **800-941-1384**.

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Health management tools

The services in this section are available to you if you are enrolled in any of the following plans:

- **Premier PPO Plan**
- **Contribution HRA Plan**
- **Saver HSA Plan**
- **Personalized Wellbeing Copay Plan**

Nicotine cessation 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 quit smoking, chewing tobacco, or vaping, Walmart offers a nicotine cessation program for you and your eligible dependents, at no cost to you, even if not enrolled in a Walmart medical plan. Please refer to the **Associate assistance resources** chapter for information about the program.

If you or your spouse/partner uses nicotine products, and during initial enrollment or Annual Enrollment you agree to enroll and participate in the nicotine cessation program or a program of your choice by the end of the Plan year for which you are enrolling, you will 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 throughout the Plan year for which you are enrolling. Your eligibility for tobacco-free rates can be established only at your initial enrollment and each year during Annual Enrollment. Please refer to the **Eligibility, enrollment, and effective dates** chapter.

The AMP is committed to helping you achieve your best health. Rewards for participating in a wellness program such as the nicotine cessation program are available to all associates and their spouses/partners. If you think you might be unable to meet a standard for tobacco-free rates under this wellness program, you might qualify for an opportunity to receive tobacco-free rates by different means. Contact the nicotine cessation program at **800-825-3555** and they will work with you (and, if you wish, with your doctor) to find a wellness program that is right for you in light of your health status.

To enroll in the program, call **800-825-3555**. Learn more at **Walmart.LyraHealth.com**.

Life with Baby maternity program

Life with Baby is a prenatal care program offered at no cost to you.

Whether you are starting a family, adding to one, or just thinking about it, the Life with Baby Maternity Program can help you have a safe, successful pregnancy. The program assists with preconception, pregnancy, delivery (including up to six lactation support visits—three for you and three for the child, if enrolled), and child development education. Enroll in Life with Baby by calling your health care advisor or care navigator at the 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.

You also have access to:

- Pregnancy and parenting apps through Ovia Health by Labcorp
- A digital payment card issued by IQPay to purchase breastfeeding supplies, including a breast pump, storage bags, etc., online at **Walmart.com** or in a Walmart store

Doula services are available. See **When limited benefits apply to the AMP** later in this chapter for more details.

Neonatal Intensive Care Unit (NICU) program

If your newborn child is admitted to a neonatal intensive care unit (NICU) at any time prior to initial discharge from the hospital following birth, your child is enrolled in the AMP, and Skai Blue is your TPA, care management services are provided by ProgenyHealth at no cost to you. Please refer to the **Eligibility, enrollment, and effective dates** chapter for information about enrolling your child in the Plan.

The NICU program provides you with personalized support and partners with you and your child's healthcare providers to address your child's medical and developmental needs, as well as your family's needs.

You and your child receive assistance throughout their first year of life, and the program works closely with you to coordinate care, connect you to appropriate resources, and help support a successful transition from hospital to home. Through ongoing guidance and care management, the program aims to help reduce the risk of unplanned hospital readmissions and support positive health outcomes for your child and family.

Support for women's health

From preventive and general health to trying to conceive, pregnancy, parenting, and menopause, Ovia Health by Labcorp provides personalized support designed to meet you where you are.

Personalized tools, resources, and content

When you register through the Ovia Health app, you can track cycles, symptoms, moods, and more while gaining insights into patterns and trends across menstrual health, fertility, pregnancy, perimenopause, and menopause. You also have access to clinically backed articles, videos, and personalized programs tailored to your unique needs and goals.

A dedicated care team

You have access to a dedicated care team with backgrounds and training in women's health, pediatrics, mental health, nutrition, and more. They're available via in-app messaging, phone, or video appointments, 7 days a week, 365 days a year.

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Health management tools

The services in this section are available to you if you are enrolled in any of the following plans:

- **Premier PPO Plan**
- **Contribution HRA Plan**
- **Saver HSA Plan**
- **Personalized Wellbeing Copay Plan**

Specialty medication redirection program

If you receive infused or injected specialty medications, this optional program supports a transition of services from a hospital setting to alternative sites of care such as a physician's office, infusion suite, or your home. Program clinicians evaluate appropriate infusion sites based on detailed case reviews and provide you with proposed alternative sites of care. For more information, call your health care advisor or care navigator at the number on your plan ID card.

Mental/emotional health care

Proactive outreach by Humankind

You will have the benefit of voluntary care management services through Humankind, in addition to the other care management resources described in this section. 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 by looking at you as a whole individual.

Humankind is a clinical services company offering a data-driven, comprehensive clinical approach to care management services that relate to the treatment of emotional and mental health conditions. Humankind reviews AMP data to identify participants in the AMP who might benefit from care management services. Humankind's licensed clinicians may reach out to you proactively to offer support and counseling, and connect you with other AMP benefits, including mental health services, and, as appropriate, community resources to augment care.

You are not required to utilize the services of Humankind or engage with a Humankind licensed clinician that reaches out directly to you. This care management resource is voluntary.

Mental health services through Lyra

You have access to virtual and in-person care for therapy services, neuropsychological assessments, and medication management through a network of Lyra providers. Lyra's virtual care services are available at no cost and are not subject to a deductible or copay. You can also access in-person care through Lyra under the AMP's regular terms and conditions of coverage. Lyra's mental health coaching services are not covered under the AMP.

Specific to neuropsychological assessments through Lyra, the AMP may pay covered travel costs if Lyra determines that an in-person neuropsychological assessment is required and you reside more than 100 miles from a provider who has sufficient experience to provide necessary covered services, as determined by Lyra.

- If you are eligible, the AMP will pay covered travel costs if you travel to the provider identified by Lyra. Travel benefits may include airfare, mileage, lodging, and a daily expense allowance for food and other expenses, for both you and a caregiver. Some travel benefits are considered taxable earnings and will be reflected on your Form W-2. Travel benefits are subject to applicable IRS and AMP limits.
- Travel benefits for care must be preapproved by Lyra. If Lyra determines that you are eligible for the travel benefit, Lyra will identify a provider with sufficient experience to provide the necessary covered services that is closest to your residence and, at your request, will assist with scheduling an appointment with the identified provider.
- The travel benefit for care provides a travel benefit only for travel to the provider identified by Lyra. If Lyra preapproves travel, that preapproval applies only to the travel expenses paid by the AMP under this benefit. It does not apply to services that you may receive from the identified provider at the travel destination, which are subject to all applicable AMP terms and conditions of coverage, including any limitations and exclusions.
- If you choose not to travel to the identified provider to receive services, or travel is not preapproved by Lyra, the AMP will not pay travel expenses, even if they would have otherwise been provided if they had been preapproved.
- If travel benefits are preapproved, they must be prearranged by Consociate Health.
- The AMP cannot guarantee the identified provider at the travel destination will agree to provide covered services, and the AMP is not responsible for decisions about services you may receive from the identified provider. Decisions about medical care from the identified provider are between you and that provider.
- If Lyra does not preapprove your travel benefits for care and you disagree with that determination, you may file a written pre-service claim for benefits. Claim forms are located on **One.Walmart.com/Medical** or you can call Lyra to request a paper copy.
- Claims for travel benefits for an in-person neuropsychological assessment will be decided under the general procedures and time frames for pre-service medical claims discussed in the **Claims and appeals** chapter.

Physical therapy through Hinge Health for joint and muscle health

You have access to Hinge Health, an app-based program for virtual physical therapy. The program can help with injury prevention, recovery, and pain management, at no cost to you. Hinge Health includes a dedicated physical therapist, exercise therapy sessions, a wearable pain-relief device, and unlimited chat and video visits with a care team. Visit Hinge Health online at **HingeHealth.com/Walmart**.

Note: State law may not permit virtual physical therapy.

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Health management tools	
	Digestive health care through Cylinder You have access to Cylinder, an app-based program paired with a care team for gastrointestinal care. Cylinder offers a personalized digital health program for relief of digestive conditions and improvement of gut health. The program can help provide relief for a wide range of digestive health symptoms, at no cost for eligible participants. Cylinder includes unlimited appointments with a registered dietitian and health coach, personalized action plans, an at-home gut microbiome test, and proven methods for coping with stress and anxiety affecting your gut health. Download the app at **Cylinder.com/Walmart**. **Diabetes self-care** If you have been diagnosed with type 2 diabetes, additional resources may be available to you. See **Diabetes and Metabolic Management by Twin Health** earlier in this chapter.
The services in this section are available to you if you are enrolled in any of the following plans: • **Premier PPO Plan** • **Contribution HRA Plan** • **Saver HSA Plan**	**Embold Health Provider Guide** The Embold Health Provider Guide is available to assist you in selecting a provider by including Embold Health's evaluation of how well a provider follows evidence-based medical standards of care. The information in the Embold Health Provider Guide is intended to provide you with additional information you can consider as you choose the appropriate provider for your unique health care needs. Embold Health's evaluation is provided only for those providers who have entered into contracts with your TPA to be included in the TPA network. The Embold Health evaluations are based on historical clinical performance data for previous patient visits. The evaluations do not take your specific health care needs or medical conditions into consideration and are not a guarantee of the quality of care you will receive in the future from a provider that Embold Health has evaluated. Other factors may also be relevant in selecting a provider, including geographic convenience and appointment wait times. The evaluations of providers are created solely by Embold Health—not by Walmart or the Plan, including the AMP. Embold Health is a doctor-led health care analytics company that uses objective clinical performance data at the individual-provider level to benchmark the provider's use of diagnostic tests, recommendation of appropriate treatments, and overall patient outcomes against national peers. Individual providers are evaluated using specific quality measures that indicate how well they follow evidence-based medical standards of care. Only providers in the following specialties are reviewed: allergy; cardiology; dermatology; ear, nose, and throat; endocrinology; gastroenterology; general surgery; lung surgery; medical oncology; neurology; obstetrics; ophthalmology; ortho-joint; pediatrics; podiatry; primary care; pulmonology; rheumatology; spine surgery; and urology. Other specialties may be added from time to time. You can see the complete list of performance quality measures Embold Health uses for its evaluation of all specialties by visiting the Embold Health Provider Guide and selecting "Performance Quality Measures" from the "Support" menu at the top of the page. Embold Health uses a large, independent dataset covering 230 million people over a four-year period. To make sure the results are reliable, a provider's quality status is shown only if the provider has enough information to be evaluated, which is at least 10 patients' cases, and results across four or more measures relevant to their specialty. Embold Health will meet with any provider, upon request, to answer questions about their individual score and the data on which it is based. To visit the Embold Health Provider Guide, which includes a provider directory and Embold Health's evaluation of individual providers, go to **IncludedHealth.com/Walmart**. Included Health will then route you to the Embold Health Provider Guide. **Health care advisor** Your health care advisor is your single point of contact for all inquiries. Depending on the nature of your issue, they will answer your question or direct you to the right place. Just call the number of the health care advisor on your plan ID card.

Health management tools	
The services in this section are available to you if you are enrolled in: • **Personalized Wellbeing Copay Plan**	**Care navigator** Your care navigator is your single point of contact for all inquiries. Depending on the nature of your issue, they will answer your question or direct you to the right place. Call your care navigator at the number on your plan ID card. Participants in the Personalized Wellbeing Copay Plan also have access to an artificial intelligence (AI) virtual wellbeing agent ("Dot") from Included Health that can answer questions 24/7 via chat and direct you to the appropriate care. Available on the Included Health app. Register at **IncludedHealth.com/Walmart** or by calling Included Health at **855-633-7073**. **Included Health provider quality approach** Included Health is a physician-led health care company that uses data and clinical expertise to evaluate provider quality and help you find the right provider through a comprehensive, objective assessment. Included Health assesses the performance of over 96% of physicians in the United States. Each provider is evaluated on measures that reflect their ability to provide high-quality care within their specialty, subspecialty, and clinical focus areas. These measures include (but are not limited to): Each provider's experience with specific conditions and procedures; how consistently the provider follows published clinical guidelines when recommending tests and treatments; and the provider's success in helping patients avoid preventable complications. For each measure, providers are evaluated based on their past performance relative to their national peers, with risk adjustment applied to control for differences in the patients treated by each clinician. The results are then weighted based on the clinical significance of each measure, with the highest weight assigned to measures associated with the greatest impact on health outcomes. Included Health's provider recommendations also consider your individual needs. When you search for a specific condition or procedure, additional weight is applied to measures most relevant to that clinical need. For example, if you are seeking a specific knee procedure, Included Health would recommend orthopedic surgeons with extensive experience and excellent post-surgical outcomes for that particular procedure. Recommendations also account for your clinical history, location, and whether a provider is in your TPA network. Included Health uses a dataset that encompasses over 200 million lives and 15 years of longitudinal data on the conditions clinicians have managed, how they have treated them, and patient outcomes over time. The measurement of quality is determined solely by Included Health—not Walmart or the AMP.

Health management tools	
This service is available to you if you are enrolled in: • **Personalized Wellbeing Copay Plan** ***or*** **if you live in select areas in Arizona, Florida, Georgia, Illinois, Ohio, Oklahoma, or Texas and you are enrolled in:** • **Premier PPO Plan** • **Contribution HRA Plan** • **Saver HSA Plan**	**Care navigation** You may be offered voluntary care navigation services, including a personal, specialized, clinical team. Care navigation extends beyond the care management benefit, providing you with high-touch support for the full range of covered services provided under the AMP. The goal of care navigation is to provide you with enhanced services, which may include scheduling of appointments, accompaniment to medical appointments, in-home visits, remote monitoring, and collaboration with local community resources. Circumstances in which care navigation may work with you include the following: • You are sick or injured and hospitalized • You are scheduled for surgery • You are at risk of developing a health condition • You find out you have a chronic illness or are dealing with an ongoing chronic illness • You have a mental health/substance use disorder If you are eligible, you will receive an outreach to invite you to participate in the program or to assist you in locating certain resources and services in your community. Participation in the program is voluntary.

Mental health and substance use disorder

Subject to other AMP terms, the AMP includes coverage for mental health and substance use disorder services in the same manner as other medical and hospitalization benefits, including care at a mental health facility. A mental 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.

What is covered by the AMP

The AMP will pay benefits for covered services, which are procedures, services, equipment, and supplies that are:

- Not in excess of the AMP's allowed amount
- Medically necessary (unless otherwise indicated)
- Not excluded under the AMP (see **What is not covered by the AMP** later in this chapter)
- Not in excess of AMP limits

Allowed amount

The "allowed amount" is the most the AMP will pay for a covered service. This amount is important because it determines the benefit the AMP will pay and how much you owe when you receive covered services. The allowed amount is determined differently, depending on whether you receive services from a network provider or non-network provider.

Services from a network provider: When you receive services from a network provider, the allowed amount is the price that provider has agreed to accept for the service. In the case of Skai Blue, this includes contracts with an independent licensee company of the Blue Cross Blue Shield Association. This also includes providers in an AMP network. A network provider is not allowed to bill you for amounts in excess of this agreed amount. You are only responsible for your share of the cost, such as your deductible, copay, or coinsurance.

Services from a non-network provider: From time to time, and notwithstanding any AMP provisions that state otherwise, the AMP may enter into an agreement with a non-network provider (directly or indirectly) that sets the AMP's allowed amount for an item or service. In these cases, the allowed amount will be the amount established in the agreement with the non-network provider. For most other services from a non-network provider, how the allowed amount is determined depends on your TPA and may depend on the type of services you receive from a non-network provider. If you receive covered services from a non-network provider and that provider charges more than the allowed amount, the provider will be able to bill you for the difference in most cases.



The following sections describe how each TPA determines the allowed amount for most services when you receive services from a non-network provider. There are exceptions to the terms discussed below. See the **When network benefits are paid for out-of-network services** and **Emergency, ground and air ambulance** sections, which discuss how the allowed amount is determined for services subject to continuity-of-care protections; advanced imaging services; services when a Blue Select network provider is not available (in some locations); emergency services, including post-stabilization services; services received from an out-of-network provider in a network facility; ground ambulance services; and out-of-network air ambulance services.

Each TPA has its own specific method for determining the allowed amount for a service.

Skai Blue Cross Blue Shield

Premier PPO, Contribution HRA, Saver HSA Plans: Unless otherwise provided in the **When network benefits are paid for out-of-network services** section, the allowed amount for out-of-network services will be the lesser of the provider's billed charges or the amount as determined below:

- An amount established in an agreement with the non-network provider. In this case, the non-network provider will not be allowed to bill you for amounts in excess of the allowed amount.
- If there is no agreement with the non-network provider and the non-network provider is an individual provider:
  - 200% of Medicare's allowed amount based upon the geographical area.
  - 200% of the Hospital Outpatient Prospective Payment System ("OPPS") rate. This is sometimes referred to as the CMS outpatient fee schedule.
  - If neither the Medicare allowed amount nor the CMS outpatient fee schedule apply, the allowed amount will be 70% of the provider's billed charges.
- If there is no agreement with the non-network provider, covered services from hospitals and facilities or for other covered items and services (e.g., drugs, medical devices, products or implants, equipment, or supplies):
  - Inpatient facility:
    - An amount based on a national standardized base payment rate, adjusted for geography and facility type.
    - If a national standardized base payment rate is unavailable, the allowed amount will be an amount set by Skai Blue based on its local Blue Cross Blue Shield Plan provider pricing methodology, which means payment is calculated based on reimbursement amounts for health care providers in a specific geographic area, based on factors such as historical cost data and negotiated rates.
  - Outpatient facility and other covered items and services:
    - 200% of the CMS outpatient fee schedule.
    - If the CMS outpatient fee schedule is not available, the allowed amount will be an amount set by Skai Blue based on its local Blue Cross Blue Shield Plan provider pricing methodology.
    - If the CMS outpatient fee schedule and local Blue Cross Blue Shield Plan pricing methodologies are unavailable, the allowed amount will be 70% of billed charges.
  - If the service is for dialysis, the allowed amount will be 200% of CMS dialysis rate and will be geographically adjusted.

Personalized Wellbeing Copay Plan: This AMP option does not provide out-of-network coverage except as provided in the **When network benefits are paid for out-of-network services** and **Emergency, ground and air ambulance** sections.

UMR

Premier PPO, Contribution HRA, Saver HSA Plans: Unless otherwise provided in the **When network benefits are paid for out-of-network services** section, the allowed amount for out-of-network services will be the lesser of the provider's billed charges or the amount as determined below:

- For covered services from individual providers:
  - The AMP may enter into an agreement with a non-network provider (directly or indirectly) that sets the AMP's allowed amount for an item or service.
  - 200% of Medicare's allowed amount based on the geographical area.
  - If no Medicare amount is available, the TPA will use a gap methodology to determine the allowed amount. This means payment is calculated based on reimbursement amounts for health care providers in the same geographic area, based on factors such as historical cost data and negotiated rates.
  - If neither the Medicare amount nor another method is available, the allowed amount will be 70% of the provider's billed charges.
- For covered services from hospitals and facilities or for other covered items and services (e.g., drugs, medical devices, products or implants, equipment, or supplies):
  - 200% of Medicare's allowed amount based on the geographical area.
  - An amount based on a national standardized base payment rate, adjusted for geography and facility type.
  - If a national standardized base payment rate is not available, the allowed amount will be an amount set by UMR based on its local provider pricing methodology, which means payment is calculated based on reimbursement amounts for health care providers in a specific geographic area, based on factors such as historical cost data and negotiated rates.

Personalized Wellbeing Copay Plan: This AMP option does not provide out-of-network coverage except as provided in the **When network benefits are paid for out-of-network services** and **Emergency, ground and air ambulance** sections.

Medically necessary

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

- Appropriate for the symptoms, diagnosis, or treatment of a medical or mental health and substance use disorder 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
- 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 AMP 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
- 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

The TPAs follow their own internal policies in determining whether a procedure, service, equipment, or supply is medically necessary. Your AMP benefits are subject to all terms, conditions, limitations, and exclusions set forth in the coverage policies administered by your TPA regarding medical necessity. Contact your TPA for more information.

Prenotification

You or your provider may voluntarily contact your TPA for information regarding coverage prior to your obtaining most medical and mental health services by calling the number on your plan ID card. If you choose to notify your TPA of a scheduled medical or mental health admission, do so at least 24 hours prior to the admission. For urgent medical care, your TPA 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.

Your TPA's response to a prenotification inquiry does not guarantee payment or ensure coverage under the AMP. Statements made by the TPA do not create a contract, bind the AMP, or waive any AMP condition applicable to your claim for benefits, and are not subject to appeal.

Coordination with Centers of Excellence administrators

You will not be eligible to participate in any Centers of Excellence (COE) program if you do not coordinate with the correct party identified in the **Centers of Excellence** charts in the **Centers of Excellence** section.

You must file a prior authorization request for the following COE services:

- Hip and knee replacement network exception request
- Spine surgery network exception request
- Transplant services network exception request
- Weight loss surgery

See the **Centers of Excellence** section and the **Claims and appeals** chapter for more information.

The AMP administrator has delegated fiduciary authority to the parties identified below to make determinations on Centers of Excellence claims, including prior authorization requests, where applicable.

• Heart surgery e-review	Your TPA
• Cancer medical records review • Rare conditions • Kidney dialysis (outpatient) or ESRD medical record review • Transplant services,[1] or • Travel arrangements for these COE programs or heart surgery or cardiac ablation procedure, family building COE programs, and covered services received through the travel benefit	Consociate Health
• Hip and knee replacement • Spine surgery[1] • Weight loss surgery,[1] or • Travel arrangements related to these Centers of Excellence programs	Carrum Health
• Family building benefits	Your TPA

[1] See the **Centers of Excellence** section of this chapter for details about requesting an exception to receive transplant services or hip or knee replacement or spine surgery outside the COE program or prior authorization for weight loss surgery. See the **Claims and appeals** chapter for important information about how to file your prior authorization request.

Prior authorization

In addition to the COE services described above, some services require prior authorization, or those services may not be covered. A prior authorization request, including prior authorization requests for exceptions under the COE program, is considered a "pre-service claim." You must file your prior authorization request as described in the **Claims and appeals** chapter.

If you use a TPA network provider, your TPA network provider may be contractually required to obtain prior authorization for certain services. If you use a non-network provider, you or your provider should call your TPA at the number on your plan ID card to verify whether prior authorization is required.

Some claims for benefits may still be reviewed after you have received services to determine whether they were medically necessary, even if you did not request prior authorization.

Whether prior authorization is required or not, all services are still subject to the applicable AMP terms and conditions of coverage, as described in this chapter.

Where prior authorization is not required, you still may want to notify your TPA in advance, as indicated above, although prenotification is not a guarantee that services will be covered.

The following additional services, which are described in this 2027 *Associate Benefits Book*, require prior authorization.

- **Advanced imaging services—MRI and CT scans.** See the **Advanced imaging** section for more information, including how to request an exception.
- **Travel benefit** (as described in the **Health management tools** chart in the **Helping you manage your health** section).

If you are enrolled in the **Personalized Wellbeing Copay Plan**, these services also require prior authorization:

- **Specialty medications** obtained through the AMP medical benefit (i.e., those that are administered, infused, or injected during medical treatment, not through the pharmacy benefit).
- **Infusion care** (services involving the administration of infused or injected medications at a hospital, infusion suite, physician's office, or home setting).

The list of other services that require prior authorization differs, depending on the party deciding your pre-service claim. Services that **may** require prior authorization include:

- **Inpatient admissions** (including but not limited to acute, long-term, skilled nursing, residential treatment, hospice care)
- **Ambulance**
- **Outpatient surgery** (including but not limited to potentially cosmetic procedures)
- **Outpatient diagnostic services** (including but not limited to genetic testing)
- **Outpatient continuing care services** (including but not limited to chemotherapy, some durable medical equipment)
- **Outpatient mental health services** (including but not limited to applied behavior analysis)
- **Certain specialty medications** obtained through the AMP medical benefit (i.e., those that are administered, infused, or injected during medical treatment, not through the pharmacy benefit)



The list of services that require prior authorization differs, depending on the party deciding your pre-service claim. For a complete list of services that require prior authorization, call your TPA at the number on your plan ID card. Your TPA will direct you to the party that will process your prior authorization request.

The AMP administrator has delegated fiduciary authority to make determinations on prior authorization requests other than those under the Centers of Excellence program to various service providers. See the **Administration of routine medical, pharmacy, dental, and vision claims** section in the **Claims and appeals** chapter for more information.

When limited benefits apply to the AMP

Some services are subject to specific restrictions and limitations. The limitations and restrictions described below are in addition to other AMP rules, including deductibles, coinsurance/copayments, network requirements, and exclusions. If you are receiving the AMP's care management services, your care manager may authorize services under different terms. See the **Care management** section. If you have a question on the coverage of a particular service, contact the TPA at the number on your plan ID card.

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

Refer also to **What is not covered by the AMP**, later in this chapter.

Ambulance: Coverage of ground 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 AMP covers ground ambulance or air ambulance transportation where a medical director of a TPA recommends transport to a specific facility as medically necessary based on your condition and other contributing factors cited by the treating physician, and where such transportation is medically necessary compared to transportation methods of lower cost and safety.

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

The AMP covers air ambulance transportation from non-network providers of air ambulance services in the same manner as such services are covered for network air ambulance providers.

Ambulance charges for the sole convenience of you, your 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
- Condoms purchased by a woman, 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 or your physician may request an exception for coverage of the brand-name drug. See **Preventive care exceptions process** in **The pharmacy benefit** chapter.

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

- Abortion, except as provided under **Termination of pregnancy** in this section
- Prescription abortifacient medication, including but not limited to RU-486
- 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 TPA and required by law, are covered. 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.

Doula services: The AMP covers doula services for pregnant women, regardless of medical necessity. The benefit is limited to $1,000 per pregnancy and is available before you have met any applicable deductible. No coinsurance or copay is required. Amounts paid for doula services in excess of the $1,000 benefit limitation do not apply to any deductible or your out-of-pocket maximum. The benefit is part of the Life with Baby program. To get started, call your TPA at the number on your plan ID card and the care manager who supports the Life with Baby program will guide you in accessing doula services. You may also access a virtual doula through Kindbody. This virtual doula program provides virtual doula care, education, and resources to support you through pregnancy, birth, and postpartum, all with a goal to facilitate optimal outcomes for you and your baby. Learn more at **Kindbody.com/Walmart**. In-person doulas must be credentialed through DONA International or the National Black Doula Association or agree to sign an attestation form indicating that they have completed professional doula training if affiliated with another doula organization. Amounts for doula services are taxable to you. Contact Consociate Health about in-person doula services and Kindbody about virtual doula services.

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

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
- 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
- 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, home ultraviolet light therapy system, whirlpool bath equipment, bed pan, portable paraffin bath, heating pad, heat lamp, steam/hot/cold packs, devices that measure or record blood pressure (except when provided in conjunction with Virtual Primary Care through Doctor On Demand by Included Health), and other such medical equipment or items determined to be investigational or not medically necessary.

Family building treatment: Fertility services such as IVF and IUI may be covered under the COE program. Such covered services are subject to a $20,000 maximum lifetime benefit per individual participant, and only when services are provided by a Kindbody network clinic. See the **Centers of Excellence** section of this chapter for more detail.

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
- 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 a maximum of three provider visits per calendar year. 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
- Psychotherapy visits

Gender reassignment surgery is not considered medically necessary for individuals under the age of 18. Cosmetic services that are not medically necessary are not covered.

Hearing devices: External hearing aids and related doctor visits are covered, subject to otherwise applicable AMP terms—once every five years for adults and once every two years for children age 18 and under. Battery replacement 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. This maximum does not apply to mental health conditions.

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 generally are covered under otherwise applicable AMP terms. Some fertility services, such as IVF and IUI, may be covered under the COE program subject to a $20,000 lifetime maximum benefit. Refer to the **Centers of Excellence** section in this chapter for information on covered fertility services. Refer to **What is not covered by the AMP** later in this chapter for a list of non-covered infertility services.

International business travel medical coverage: Walmart provides international business medical insurance through an insurance policy from Blue Cross Blue Shield Global Solutions. If you participate in the Saver HSA 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 Blue Cross Blue Shield Global Solutions 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.

Marital, family, or relationship counseling or counseling to assist in achieving more effective intra- or interpersonal development: Services are covered only when the diagnosis is for a mental health condition or substance use disorder.

Nutritional counseling: Nutritional counseling is covered if it is medically necessary for a chronic disease (e.g., PKU, Crohn's disease, celiac disease, galactosemia, etc.) or an eating disorder in which dietary adjustment has a therapeutic role when prescribed by a physician and furnished by a provider (e.g., a registered dietitian, licensed nutritionist, or other qualified licensed health professional) recognized under the AMP. Benefits are limited to three visits per condition per year for chronic diseases. This visit limit does not apply to mental health conditions and substance use disorders. See the **Preventive care** 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):

- AHFS Drug Information
- Clinical Pharmacology
- 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 AMP's coverage for any type of prescription drug, verify coverage details by calling your TPA 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):

- AHFS Drug Information
- Clinical Pharmacology

The AMP 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, including those that are not covered under the pharmacy benefit
- Emergency department 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, if 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
- 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 ages 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
    - 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)
    - 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 provided by a licensed physical therapy provider or licensed occupational therapy provider.

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. This maximum does not apply to mental health conditions and substance use disorders.

Pregnancy benefits: Pregnancy expenses are covered the same as any other medical condition. See **Doula services** earlier in this section for information about doula services. (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 an election change event** in the **Eligibility, enrollment, and effective dates** 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 and conditions of the AMP. Replacement prostheses are allowed only with a change of prescription. A licensed prosthetist 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
- 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
- Transitional care facility

You must be admitted to one of the above facilities within 30 days of discharge from an acute care hospital confinement. 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 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
- Congenital and severe developmental speech disorders

The visit limit does not apply to mental health conditions or substance use disorders

Termination of pregnancy: Charges for procedures, services, drugs, and supplies related to the termination of pregnancy, including abortion services, are not covered, except, where legally permissible: 1) when a woman's attending physician determines that her health would be in danger if the fetus were carried to term, the fetus could not survive until the time of delivery or the birthing process, or death of the fetus would be imminent after birth, 2) in cases where a woman is pregnant due to rape or incest, or 3) in the event of an ectopic pregnancy or miscarriage. See **Travel benefit for care** in the **Health management tools** chart for more information about travel services that may be available.

Transplant services: See the **Centers of Excellence** section in this chapter for information on transplant services that are covered under the COE program. Cornea and intestinal transplant services are not covered under the COE program but are covered services under otherwise applicable AMP terms. Transplantation of body parts (e.g., face, hands, feet, legs, arms, uterus) is not covered under any circumstance.

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. Some of these services may be covered under the vision plan. See **The vision plan** chapter.

Weight loss treatment: Weight loss surgery is covered only under the COE program for weight loss surgery and the COE program for transplant services (for pretransplant weight loss surgery at Mayo Clinic). You must meet specific eligibility guidelines and clinical criteria to be eligible. Weight loss treatments, including but not limited to medications, diet supplements, and surgeries outside the scope of the COE program, are not covered. See the **Centers of Excellence** section of this chapter for information about weight loss surgery and pretransplant weight loss surgery. Prescription drugs prescribed solely for weight loss are also not covered under the pharmacy benefit. See **The pharmacy benefit** chapter for detailed information about other prescription drugs not covered by the pharmacy benefit.

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 HSA 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 AMP, call your TPA at the number on your plan ID card or see **For more information** at the end of this book for contact details.

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's or entity's license, or services provided in a jurisdiction where such services may not be legally provided.

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 AMP.

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 The **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.

Copays and/or discounts, deductibles, and/or coinsurance

Cosmetic health services or reconstructive surgery: Except for congenital abnormality, services covered by law (see The **Women's Health and Cancer Rights Act of 1998** later in this chapter), medically necessary gender dysphoria treatment, 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: The fact that a drug, item, or piece of equipment is FDA-approved does not guarantee that it is a covered item or service.

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), but excluding services that are preventive services described in the **Preventive care** section.

Elective inpatient and outpatient 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 TPA. For COE services, the COE program 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.

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, including:

- Charges to reverse a sterilization procedure
- Charges for, or related to, the services of a surrogate

Some fertility services may be provided under the COE—see the **Centers of Excellence** section in this chapter.

Judgments/settlements

Late claims: Claims received more than 12 months past the date of service. See **Filing a medical claim or appeal** later in this chapter for more information.

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 included as a benefit in this *Associate Benefits Book*
- Services provided after exceeding the benefit or visit maximum for specified services
- Services for which you are responsible for payment, such as non-covered charges
- Services delivered in a jurisdiction where such services may not be legally provided
- Services that are not medically necessary (unless otherwise indicated)

- Charges for services in excess of the AMP's allowed amount
- Charges for completion of leave of absence certification paperwork
- 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 immediate 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: Fees related to surrogacy (other than maternity care costs for a participant otherwise covered under the AMP), whether paying for another's services or serving as a surrogate.

Travel and lodging, except as specified under COE or travel benefits for care: See **Travel benefit for care** in the **Health management tools** chart for more information about travel services that may be available.

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

Work hardening or similar vocational programs

Workers' compensation: Treatment of any compensable injury, as defined by applicable workers' compensation law, regardless of whether you file a timely claim for workers' compensation benefits.

Filing a medical claim or appeal

You have the right to appeal a claim denial, as described in the **Claims and appeals** chapter. That chapter contains instructions on how to file a claim for benefits, appeal a denied claim, applicable time frames and other requirements. Procedures for filing a claim or appeal may depend on what covered service the claim relates to and who the claim administrator is.

If you use a TPA network provider, the provider will generally file the claim for you. If your plan provides coverage for non-network providers and you receive covered services from a non-network provider, you may need to file a claim yourself. You are responsible for your cost-sharing, plus any amount above the allowed amount. As a convenience to you, payment may be made to a non-network provider. 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 right, claim, or cause of action (whether known or unknown).

The claims and appeals processes explained in the **Claims and appeals** chapter describe the only available methods to dispute a claim denial. Failure to follow the AMP's claims and appeals processes could adversely impact your ability to dispute a claim denial.

When the AMP pays benefits directly to the provider, payment to the provider discharges the AMP's obligation to you for the benefit.

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 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
- 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 plan's terms 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 under the other plan and the other plan is the primary plan, benefits under the AMP will be delayed or denied until an explanation of benefits is received showing a claim was 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.

Other rules:

- The AMP has first priority with respect to its right to reduction, reimbursement, and subrogation.
- The AMP does not coordinate benefits with an HMO or similar managed care plan where you pay only a copayment or fixed dollar amount.
- The AMP 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 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 AMP, but are first paid by the state plan, payment by the AMP 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 a Medicare prescription drug plan, you are not eligible to enroll in the AMP. If your dependent is enrolled in a Medicare prescription drug plan and you are not, you are eligible to enroll in the AMP, 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 Walmart and are age 65 or older
- You are employed by Walmart 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 Walmart
- 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 Walmart

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
- 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 Walmart, 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 is secondary. 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 share of the cost of medical coverage 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). Failure to pay the required amount by the due date may result in an interruption in the payment of any benefit claims and/or cancellation of your coverage effective back to the date for which payment is current.

For details on the impact a break in coverage may have, and on how to make personal payments to continue your coverage, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** 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 **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter.

When your medical 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, enrollment, and effective dates** chapter). You and/or your covered 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 your coverage is canceled due to your failure to pay for the coverage, coverage ends on the last day for which payment was made. See **Paying for your benefits** in the **Eligibility, enrollment, and effective dates** chapter for information. There is no right to continue coverage under COBRA when coverage is canceled due to nonpayment.

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

If you voluntarily drop coverage after an election change event or at Annual Enrollment, coverage ends as follows:

- **After an election change event:** coverage ends on the effective date of the event. See the **Permitted election changes outside Annual Enrollment** section of the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave Walmart and are rehired

If you are a part-time or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work. For details regarding the impact to any applicable deductibles, out-of-pocket maximum, and HRA balance, see below.

If you are a full-time hourly, management, or OTR truck driver associate, see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work. For details regarding the impact to any applicable deductibles, out-of-pocket maximum, and HRA balance, see below.

Impact to deductible, out-of-pocket maximum, and HRA:

- If you terminate and then return to work within 30 days of your termination date, your deductible, out-of-pocket maximum, and HRA (if applicable) will not reset unless you terminate in one calendar year and return to work in the following calendar year.[1]
- If you terminate and then return to work more than 30 days but less than 13 weeks from your termination date, your deductible, out-of-pocket maximum, and HRA (if applicable) will reset.[1]
- If you terminate and then return to work 13 weeks or more from your termination date, you will be considered a new associate and will be required to complete any applicable eligibility waiting period or other requirements. See the **Eligibility, enrollment, and effective dates** chapter for details.[1]

[1] If you or an eligible dependent were enrolled in the AMP and had accrued amounts toward, or had reached, the maximum lifetime benefit applicable to fertility benefits through the COE family building program, no portion of the maximum lifetime benefit will reset for any reason.

Other information about the medical plan

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 treatment of 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 deductibles and coinsurance/copayment provisions under the AMP. 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

The pharmacy benefit	140
Preventive care	143
What is not covered by the pharmacy benefit	144
Filing a request for reimbursement or pharmacy benefit claim	145
Privacy and security	145

The information in this chapter describes pharmacy benefits that may be available to you if you are enrolled in the Associates' Medical Plan. See **The medical plan** chapter for details.

For questions about eligibility, enrollment, and requirements for coverage to be effective, see the **Eligibility, enrollment, and effective dates** chapter.

The pharmacy benefit

Keep yourself 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	**One.Walmart.com** or **welcome.optumrx.com/walmart-comprehensivedruglist/landing**	
Contact Walmart Specialty Pharmacy	**One.Walmart.com**	Call Walmart Specialty Pharmacy at **800-284-9770**
Find an OptumRx network pharmacy	**welcome.optumrx.com/walmart-comprehensivedruglist/landing**	Call OptumRx at **844-705-7493**
Get information about home delivery	**welcome.optumrx.com/walmart-comprehensivedruglist/landing**	Call OptumRx at **844-705-7493**
For pharmacy benefit inquiries	**welcome.optumrx.com/walmart-comprehensivedruglist/landing**	Call OptumRx at **844-705-7493**
Get the list of covered brand-name drugs	**One.Walmart.com** or **welcome.optumrx.com/walmart-comprehensivedruglist/landing**	Call OptumRx at **844-705-7493**
Prior authorization, non-formulary clinical review, or appeal questions	Electronic Prior Authorization (ePA) can be submitted via CoverMyMeds or Surescripts by your provider	You or your provider call TruDataRx at **833-575-0755** or fax a PA to **888-707-7324**

What you need to know about the pharmacy benefit

- You are automatically covered under the pharmacy benefit if you are enrolled in one of the following options under the Associates' Medical Plan (AMP): the Premier PPO Plan, Contribution HRA Plan, Saver HSA Plan, or Personalized Wellbeing Copay Plan. If you are enrolled in an HMO plan, your pharmacy benefits are provided through the HMO and are described separately in materials provided by the HMO insurer.
- Any drugs that are excluded under the terms of the AMP, including drugs prescribed for weight loss, are not eligible for coverage under the pharmacy benefit.
- The pharmacy benefit covers only prescription medications that are listed on the applicable formulary—either the Zero Dollar tier or a Covered Copay tier—or approved through the non-formulary clinical review process described in this chapter. A non-formulary clinical review is available only for medications classified as "non-formulary" on the AMP's prescription drug list. Medications that are "excluded" on the AMP's prescription drug list are not eligible for a non-formulary clinical review.
- For all AMP options, the formulary is managed by TruDataRx. However, you can look up covered medications through the OptumRx drug lookup tool or by calling OptumRx customer service.
- OptumRx provides pharmacy customer service, a list of network pharmacies, and a formulary lookup tool. TruDataRx makes pharmacy prior authorization determinations, non-formulary clinical review determinations, and appeal determinations.
- The pharmacies discussed in this chapter include Walmart or Sam's Club pharmacy, Walmart Specialty Pharmacy, and Optum Home Delivery, and, where a pharmacy network exception applies, an OptumRx network pharmacy.
- Maintenance medications must be filled through any Walmart or Sam's Club pharmacy or Optum Home Delivery unless a pharmacy network exception applies. Maintenance medications are drugs commonly prescribed to treat a chronic or long-term medical condition and are taken on a regular, recurring basis. Examples of maintenance medications include, but are not limited to, medications used to treat high blood pressure, heart disease, diabetes, asthma, and arthritis.
- Specialty medications, with the exception of fertility medications and certain limited distribution drugs not available through Walmart Specialty Pharmacy, must be filled through Walmart Specialty Pharmacy and are limited to a 30-day supply.
- All other covered medications must be filled at a Walmart or Sam's Club pharmacy or Optum Home Delivery unless a pharmacy network exception applies.

The pharmacy benefit

You must enroll in medical coverage under the AMP to obtain prescription drug coverage under the pharmacy benefit. If you enroll in medical coverage, your prescription drug coverage is effective on the date your medical coverage under the AMP is effective and ends on the date your medical coverage ends.

The pharmacy benefit covers eligible prescription drugs purchased from certain retail and mail-order network pharmacies. No pharmacy benefits are paid if you use a non-network pharmacy, unless the AMP has approved a pharmacy network exception as described in the **Pharmacy options** section of this chapter. The cost of medications purchased outside an approved AMP network pharmacy will not apply to your out-of-pocket maximum or, in the case of Saver HSA participants, to your deductible.

The specific retail and mail-order network pharmacies that you are required to use depend on the type of prescription you are filling.

Covered prescription medications

The pharmacy benefit covers only prescription medications specifically listed on the AMP's prescription drug list (the "formulary") as "covered" medications. This means it is a "closed formulary." Medications on the formulary are selected for their high clinical effectiveness. They are chosen based on scientific data, including comparative effectiveness research. Not all therapeutic classes are included.

Medications are classified on the formulary as "covered," "non-formulary," or "excluded."

Covered (formulary) medications: These are medications identified on the formulary as "covered." They are subject to the applicable copay tier described in the **Pharmacy benefits** chart on the following page. The fact that a medication is FDA-approved does not guarantee that it is a covered medication. Some covered medications require a prior authorization.

Non-formulary medications: These are medications identified on the formulary as "non-formulary medications." A non-formulary medication is not covered unless TruDataRx approves coverage of a non-formulary drug following a clinical review. This review is available only when your prescribing physician demonstrates that all covered formulary alternatives are clinically inappropriate for you due to medical necessity, contraindication, or documented treatment failure. The review is a clinical determination and cannot be used to obtain coverage based on participant or provider preference alone. If TruDataRx approves coverage following your request or a clinical review, the medication will be treated as a covered medication for you and will be subject to the applicable copay tier.

Excluded medications: These are medications that the AMP has affirmatively excluded from coverage and are identified on the formulary as "excluded." Excluded medications are not covered under any circumstances and are not eligible for a non-formulary clinical review. A claim for an excluded medication will not be approved, and an appeal of that determination cannot overturn an AMP exclusion or create coverage where the AMP provides none.

Only covered medications (including non-formulary medications for which a non-formulary clinical review request made on your behalf has been received and approved) are eligible for benefits under the pharmacy benefit.

The formulary is available through the OptumRx drug lookup tool. You can view an abbreviated list of medications on **One.Walmart.com**, use the OptumRx drug lookup tool, or call OptumRx at **844-705-7493** for help reviewing whether your medication is on the formulary.

The formulary is subject to change without prior notice at any time.

Notwithstanding the formulary classifications, exclusions, and quantity limits described in this chapter, the AMP covers preventive medications that are required to be covered under the ACA, as described in the **Preventive care** section of this chapter.

Your copays for covered prescription medications

See the **Pharmacy benefits** chart on the following page for details about copays and copays.

If you are in the **Premier PPO Plan, Contribution HRA Plan,** or **Personalized Wellbeing Copay Plan**, you are required to pay any applicable copay when you purchase covered prescription medications. If you are in the Contribution HRA Plan, HRA funds cannot be used to purchase prescriptions or to reimburse copays related to prescriptions. Any copays do not count toward your deductible, if applicable, but do count toward your out-of-pocket maximum. Once you meet your out-of-pocket maximum, the AMP will pay 100% of the cost of covered medications for the remainder of the year. See the **Evaluating your options** section of **The medical plan** chapter to learn more about copays, deductibles, and the out-of-pocket maximum.

If you are in the **Saver HSA Plan**, you generally must pay the entire cost of covered prescription medications until you meet your network deductible. However, the AMP covers Saver HSA Plan preventive medications (Saver HSA Preventive Medications) at the applicable copay tier before you meet the Saver HSA Plan network deductible. You can find a list of Saver HSA Preventive Medications on **One.Walmart.com**. The OptumRx drug lookup tool will also indicate whether a medication is a Saver HSA Preventive Medication. Amounts you pay for covered prescription medications will count toward your deductible. Once you meet your network deductible, you will be required to pay any applicable copay when you purchase

covered prescription medications. Amounts you pay before you meet your deductible and your copays count toward your out-of-pocket maximum. Once you meet your out-of-pocket maximum, the AMP will pay 100% of the cost of covered medications for the remainder of the year. See the **Evaluating your options** section of **The medical plan** chapter to learn more about copays, deductibles, and the out-of-pocket maximum.

Regardless of whether you are in the **Premier PPO Plan, Contribution HRA Plan, Saver HSA Plan**, or **Personalized Wellbeing Copay Plan**, the AMP will pay a benefit of 100% for preventive medications required under the Affordable Care Act (ACA) (ACA Preventive Medications). If you are in the **Saver HSA Plan**, the AMP will pay a benefit of 100% for ACA Preventive Medications before you meet your deductible.

Pharmacy options

All prescriptions for covered medications must be filled through a Walmart or Sam's Club pharmacy, Optum Home Delivery, or Walmart Specialty Pharmacy, unless a pharmacy network exception applies.

A network exception may be available under limited circumstances, in which case you may fill prescriptions at an OptumRx network pharmacy. These circumstances include:

- If the AMP determines that a covered medication is not currently available at a Walmart or Sam's Club pharmacy located within your work location ZIP code or through Optum Home Delivery or Walmart Specialty, if applicable.
- If a medication is necessary to address an immediate health issue.
- If your specialty medication (including a limited distribution drug) is unavailable at Walmart Specialty Pharmacy.
- If a pharmacy is located in one of the following areas: the state of North Dakota; the District of Columbia; Alameda, San Francisco, San Mateo, and Santa Clara Counties in California; Hudson County, New Jersey; Bronx, Kings, New York, and Queens Counties in New York; Alexandria City, Arlington County, Fairfax City, Fairfax County, and Falls Church City in Virginia; and King County, Washington.

Locate network pharmacies in your area by going to **welcome.optumrx.com/walmart-comprehensivedruglist/landing**.

Note: Certain restrictions apply to filling prescriptions for narcotics and other controlled substances. Call OptumRx at **844-705-7493** for more details.

Pharmacy benefits
Applies to the Premier PPO Plan, Contribution HRA Plan, Saver HSA Plan, and Personalized Wellbeing Copay Plan

Tier	Supply	You pay	Notes and additional information
Zero Dollar—Covered (includes generics, brands, and specialty medications)	1- to 30-day supply 31- to 60-day supply 61- to 90-day supply	$0 $0 $0	For the Saver HSA Plan, the deductible rules described above apply unless the medication is an ACA Preventive Medication or a Saver HSA Preventive Medication. Some brand medications and all specialty medications are limited to a 30-day supply.
Generic Copay—Covered	1- to 30-day supply 31- to 60-day supply 61- to 90-day supply	Up to $4 Up to $8 Up to $12	For the Saver HSA Plan, the deductible rules described above apply unless the medication is an ACA Preventive Medication or a Saver HSA Preventive Medication.
Brand Copay—Covered	1- to 30-day supply	Up to $50	Brand medications are limited to a 30-day supply. For the Saver HSA Plan, the deductible rules described above apply unless the medication is an ACA Preventive Medication or a Saver HSA Preventive Medication.
Specialty Copay—Covered	1- to 30-day supply	Up to $250	Specialty medications are limited to a 30-day supply and must be filled through Walmart Specialty Pharmacy, except fertility medications filled through Kindbody's specialty pharmacy and limited distribution drugs that are not available through Walmart Specialty Pharmacy. For the Saver HSA Plan, the deductible rules described above apply unless the medication is an ACA Preventive Medication or a Saver HSA Preventive Medication.
Non-formulary medications	Not applicable	Not covered unless clinical review is approved by TruDataRx.	If TruDataRx approves coverage, the medication will be covered at the applicable copay tier, depending on whether the drug is classified as generic, brand, or specialty medication, with corresponding cost-share and supply limitations. Amounts you pay for a non-formulary medication do not count toward your deductible or out-of-pocket maximum unless coverage is approved by TruDataRx through a non-formulary clinical review.
Excluded medications	Not applicable	Not covered	Excluded medications are not covered and are not eligible for a coverage exception. You may file a claim and appeal a denied claim, but an appeal cannot overturn an AMP exclusion or create coverage where the AMP provides none.

To find out whether your drug is covered as indicated, go to **welcome.optumrx.com/walmart-comprehensivedruglist/landing**. Drugs may be identified as Zero Dollar Tier, Copay Tier, Non-formulary, or Excluded. If you have questions about what those terms mean, call OptumRx at **844-705-7493**.

When purchasing mail-order drugs: You must use Optum Home Delivery and can get a 30-, 60-, or 90-day supply. Your cost for a 60- or 90-day supply is two or three times, respectively, the cost of a 30-day supply purchased at a Walmart or Sam's Club pharmacy, as listed above.

Filling your prescriptions

- Present your plan ID card at a Walmart or Sam's Club pharmacy.
- Prescription refills are available after 75% of your previous prescription has been used.
- Maintenance medications must be filled at any Walmart or Sam's Club pharmacy or Optum Home Delivery unless a pharmacy network exception applies.
- Mail-order medications must be filled through Optum Home Delivery.
- Specialty medications must be filled through Walmart Specialty Pharmacy, except fertility medications and limited distribution drugs that are not available through Walmart Specialty Pharmacy.
- If the AMP determines that a covered medication is not available at a Walmart or Sam's Club pharmacy or Walmart Specialty Pharmacy for an extended time, you may be able to obtain the medication from an OptumRx network pharmacy.
- See **Pharmacy options** earlier in this chapter for additional information.

Types of drugs

Generic: A lower-cost equivalent of a brand-name prescription drug. When a generic equivalent becomes available, the brand-name drug will no longer be covered unless the formulary states otherwise or TruDataRx approves coverage after a non-formulary clinical review. 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: A prescription drug sold under a proprietary or trademarked name assigned by its manufacturer, rather than under its generic name. A brand-name drug may have one or more generic drug equivalents containing the same active ingredient. A brand-name drug will not be covered when an equivalent generic is available unless the formulary states otherwise or TruDataRx approves coverage after a non-formulary clinical review.

Specialty: A prescription drug 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. See the following page for special rules for fertility specialty drugs.

Compound medications: Medications consisting of two or more ingredients that are measured, prepared, or mixed according to a prescription order. Any compounds exceeding $200 will require a prior authorization. Bulk ingredients, compound kits, and non-FDA approved medications will not be covered.

Medications that require prior authorization

Prior authorization is required before some medications will be covered by the AMP, including most specialty medications. TruDataRx will work with your provider to determine whether the medication is clinically necessary for your treatment and covered under the AMP.

Non-formulary clinical review requests are processed in the same manner as prior authorization requests.

After TruDataRx receives the required information, they will notify you and your provider, usually within two business days, to confirm whether coverage is authorized. If it is determined that the prescription is not a covered drug or you are not eligible for the drug under the AMP, the AMP will not pay a benefit for the drug. If the prescription drug requires prior authorization and the request is denied, 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, and amounts you pay will not be applied toward your deductible or out-of-pocket maximum.

For questions about prior authorizations, non-formulary clinical reviews, or appeals, call TruDataRx at **833-575-0755**. Providers may fax prior authorization requests to TruDataRx at **888-707-7324**. For pharmacy network questions, formulary lookup assistance, or other customer service questions, call OptumRx at **844-705-7493**.

Specialty medications

You must use Walmart Specialty Pharmacy for specialty medications. See the formulary for a list of specialty medications. You can use the OptumRx drug lookup tool or call OptumRx at **844-705-7493** for help checking whether a medication is treated as a specialty medication. All specialty medications must be filled through Walmart Specialty Pharmacy, except fertility medications filled through Kindbody's specialty pharmacy, and limited distribution drugs that are not available through Walmart Specialty Pharmacy. For questions concerning your specialty medication prescriptions, call Walmart Specialty Pharmacy at **800-284-9770**.

See below for special rules for fertility specialty medications. See also the **Medications that require prior authorization** section above for more information.

Fertility medication

The AMP medical benefit covers FDA-approved fertility medications, when prescribed by Kindbody, the family-building Centers of Excellence provider. These medications are unique to fertility treatment and will be filled through Kindbody's specialty pharmacy, Schraft's Pharmacy, and processed under the terms and conditions as described in **The medical plan** chapter.

Medications with quantity limits

Certain medications have limits on the quantity you can receive per prescription, based on FDA dosage guidelines, clinical review, or Plan design. Some brand medications and all specialty medications are generally limited to a 30-day supply, as shown in the **Pharmacy benefits** chart. A list of medications with quantity limits can be found through the OptumRx drug lookup tool.

Quantities greater than the approved quantity are not covered under the AMP unless an exception is required for an ACA Preventive Medication. If you choose to fill a quantity that is not covered, you must pay the full retail cost. See the **Preventive care exceptions process** later in this chapter.

Continuation of care

When there is a formulary change and a prescription drug you are currently taking changes formulary status, or your prior authorization expires, the AMP will provide assistance to you in transitioning your prescription to a covered formulary alternative or requesting review under the applicable prior authorization or non-formulary clinical review process.

Preventive care

Prescription medications that can keep you from developing a health condition are considered preventive medications. These include medications for certain health issues, such as high blood pressure, diabetes, and high cholesterol, as well as contraceptives and medications that prevent HIV infection. How much you pay for a preventive medication depends on which of two categories it falls in: ACA Preventive Medications, which the AMP covers at 100% under all AMP options, and Saver HSA Preventive Medications, which the Saver HSA Plan covers before you meet the network deductible at the applicable copay tier. A medication may fall in both categories, in which case it is covered at 100%.

The AMP will pay a benefit of 100% for ACA Preventive Medications, with no deductible or copay, under all AMP options, including the Saver HSA Plan. To be covered at 100%, a medication must fall under a recommendation by one of the agencies responsible for maintaining U.S. preventive care guidelines, as required under the ACA. Many of these guidelines are specific to gender, age, or risk factors. The AMP may use reasonable medical management procedures, as permitted by law, such as covering only generic drugs, requiring a prescription, or requiring that the medication be filled at a pharmacy described in this chapter.

Some preventive medications are available over the counter (OTC). The AMP will pay a benefit of 100%, with no deductible or copay, under all AMP options for an ACA Preventive Medication that is an OTC medication when it is prescribed by a physician or other health care provider.

Some common ACA Preventive Medications associated with the United States Preventive Services Task Force (USPSTF) recommendations or ACA implementation guidance are listed in the **Preventive medications** chart below. This chart is not a complete list, and each medication is covered only when the applicable recommendation-specific conditions are satisfied. For a current list of covered preventive medications, call OptumRx at **844-705-7493**.

Preventive medications Examples associated with USPSTF recommendations and ACA preventive services guidance	
Oral fluoride	By prescription when appropriate for children at least 6 months of age
Folic acid	By prescription of a daily supplement containing 0.4 to 0.8 mg (400 to 800 mcg) of folic acid for persons capable of becoming pregnant
Low-dose aspirin	By prescription at 81 mg/day after 12 weeks of gestation for pregnant persons at high risk for preeclampsia
Statin	By prescription for the primary prevention of cardiovascular disease for adults aged 40 to 75 years who have one or more cardiovascular disease risk factors and an estimated 10-year risk of a cardiovascular event of 10% or greater
Bowel prep agents	By prescription when appropriate for a screening colonoscopy for adults age 45 and over

If your provider believes that a different ACA Preventive Medication or a different quantity is medically necessary for you, you or your provider may request an exception. See **Preventive care exceptions process** later in this chapter. For the list of covered preventive care services, including preventive medications that require a prescription, see the **Preventive care** section of **The medical plan** chapter.

For preventive medications you must use a Walmart or Sam's Club pharmacy, Optum Home Delivery, or Walmart Specialty Pharmacy, unless a pharmacy network exception applies.

Vaccines

Some vaccines may be covered under the pharmacy benefit when received at a Walmart or Sam's Club pharmacy. To receive coverage for a vaccine through the pharmacy benefit, you must use a Walmart or Sam's Club pharmacy. For information about vaccines covered under the medical benefit, see the **Preventive care** section of **The medical plan** chapter.

Contraceptives for women

The AMP covers contraceptives for women as required by the ACA, including the full range of FDA-approved, -cleared, or -granted contraceptives and contraceptive care described in the HRSA-supported Women's Preventive Services Guidelines. Certain over-the-counter contraceptive products are covered without cost sharing when prescribed by a health care provider, as required by federal guidance. If your provider determines that a brand-name contraceptive is medically necessary, you or your provider may request coverage of the brand-name drug as described in the **Preventive care exceptions process** section of this chapter.

HIV prevention

The AMP covers ACA-required FDA-approved oral and injectable preexposure prophylaxis ("PrEP") for HIV prevention at 100%, with no deductible, copays, or other cost sharing, when prescribed for an eligible adolescent or adult at increased risk of acquiring HIV. The AMP also covers required PrEP-related baseline and monitoring services without copays or cost sharing when furnished as preventive services. Coverage is provided under the pharmacy benefit or medical benefit, as applicable, and is subject to applicable network, medical-management, and confidentiality rules, except that the AMP will not require use of one ACA-required PrEP formulation over another.

Preventive care exceptions process

As noted earlier in this chapter, the AMP covers generic contraceptive and preventive care medications as required by the ACA. With respect to those ACA Preventive Medications, if your provider believes that a brand-name medication, a different ACA Preventive Medication, or a different quantity or supply is medically necessary for you, the provider can prescribe that medication, quantity, or supply, and an exception will be granted. For more information, your provider may call TruDataRx at **833-575-0755**.

What is not covered by the pharmacy benefit

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

- Prescription drugs that are not included on the formulary, unless a non-formulary clinical review is approved by TruDataRx.
- Prescription drugs that are excluded under the terms of the AMP. Excluded drugs are not eligible for a non-formulary clinical review.
- Maintenance medications filled at a pharmacy other than a Walmart or Sam's Club pharmacy or Optum Home Delivery, unless a pharmacy network exception applies.
- Mail-order medications not filled through Optum Home Delivery.
- Specialty medications not filled through Walmart Specialty Pharmacy, except fertility medications filled through Kindbody's specialty pharmacy and limited distribution drugs that are not available through Walmart Specialty Pharmacy.
- Drugs for which prior authorization has not been secured, in cases where prior authorization is required.
- Over-the-counter medication, with the exception of insulin when a state does not require a prescription for it. Certain over-the-counter medications are covered as part of the preventive care benefit under the ACA when a prescription is provided. See **Preventive care** earlier in this chapter for more information.
- Prescription drugs with over-the-counter equivalents, other than medications that must be covered as ACA Preventive Medications.
- Prescription drug claims that are reduced, subsidized, or paid by another health plan or insurance provider. The AMP does not coordinate benefits for pharmacy claims.
- Prescription drugs that are dispensed, infused, or injected during an inpatient treatment or that are covered by the AMP as a medical benefit rather than a pharmacy benefit.

This list is not meant to be an all-inclusive list of excluded drugs and medications. For questions about whether a drug is on the formulary, non-formulary, or excluded, use the OptumRx drug lookup tool or call OptumRx at **844-705-7493**.

Filing a request for reimbursement or pharmacy benefit claim

When you fill a prescription at an eligible network pharmacy, you do not need to file a claim, except for medications that require prior authorization or a non-formulary clinical review. 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 pharmacy reimbursement request with OptumRx. Your reimbursement request must be submitted in writing within 12 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. You can find a reimbursement request form at **One.Walmart.com/Claims**.

If you disagree with OptumRx's decision because you believe the drug was incorrectly identified as a non-formulary or excluded drug, you may file a claim with TruDataRx.

Where the AMP requires prior authorization or a non-formulary clinical review, you must file a pre-service claim with TruDataRx before filling your prescription. Call TruDataRx at **833-575-0755** for the prior authorization or non-formulary clinical review.

Note: If the AMP does not pay a benefit for a medication because the medication is excluded under the terms of the AMP, the AMP cannot make an exception to cover that medication. You do have the legal right to file a claim for that medication and appeal the denial of any claim. However, a claim for a drug that is excluded under the terms of the AMP, and an appeal of such a claim, cannot overturn an AMP exclusion or create coverage where the AMP provides none. As a result, claims based solely on an AMP exclusion will be denied and appeals of such claims will be upheld unless you are able to clearly demonstrate that the medication is not excluded under the terms of the AMP. If you are able to demonstrate that a medication is not excluded under the terms of the AMP, that does not mean the AMP will provide a benefit for that medication. The medication must still satisfy all other terms and conditions for coverage.

Call OptumRx at **844-705-7493** for a claim form for card, network, or payment amount issues.

Call TruDataRx at **833-575-0755** for prior authorization, non-formulary clinical review, or pharmacy appeal questions. Claims and appeals are processed according to the terms described in the **Claims and appeals** chapter.

You can find a claim form at **One.Walmart.com/Claims**.

Privacy and security

When you purchase prescription drugs through a Walmart or Sam's Club pharmacy, Walmart Specialty Pharmacy, Optum Home Delivery, or if eligible, 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 consistent 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)

HSA advantages: tax breaks and Walmart contributions	148
HSA eligibility	148
Opening your HSA	149
Naming a beneficiary	150
Contributions to your HSA	150
Paying qualified medical expenses through your HSA	152
Investing your HSA	152
If you leave Walmart or are no longer enrolled in the Saver HSA Plan	152
Closing your HSA	152

Health savings account for Saver HSA Plan participants

If you are enrolled in the Saver HSA Plan and want to save money on qualified medical expenses, the HSA is a great option. Your HSA contributions are tax-free and Walmart 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**	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 "Register your account."	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** **IRS Publication 502**, *Medical and Dental Expenses* **IRS Publication 969**, *Health Savings Accounts and Other Tax-Favored Health Plans*	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 HSA Plan to open and contribute to an HSA through this program.
- Walmart will match pretax dollars you contribute through payroll deduction, dollar-for-dollar up to the matching limit.
- The HSA allows you to pay for qualified medical expenses (as defined by the IRS) with tax-free dollars.
- The HSA accepts rollover contributions from other eligible HSAs.
- You are not eligible to make HSA contributions for any month in which you travel on company business outside the U.S. and are covered under Blue Cross Blue Shield Global Solutions international business travel medical insurance, 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 are enrolled in the Saver HSA Plan, the HSA offers you:

- Company contributions to your HSA to match your pretax contributions, dollar-for-dollar up to the matching limit.
- The ability to contribute pretax dollars to your HSA through payroll deductions.
- The ability to roll over funds from prior HSAs.
- 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 from HealthEquity. 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 made through payroll deductions and matching contributions from Walmart. To receive company matching contributions to your HSA or make pretax contributions through payroll deductions, you must maintain an open account with HealthEquity and continue to be enrolled in the Saver HSA Plan. If you have an HSA with another custodian, Walmart will not allow you to make pretax contributions through payroll deductions for that HSA or make matching contributions to that HSA. You may move your funds to another HSA custodian at any time, but Walmart will support ongoing payroll deductions and provide company matching contributions only for HSAs established with HealthEquity.

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 will have the opportunity to invest 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 HealthEquity, 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, which do not exempt HSA contributions from state income tax. 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 enrolled in the Saver HSA Plan to contribute to an HSA through this program. The Saver HSA 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 HSA 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 Plan. Instead, the HSA is established by you during the benefits enrollment process and administered by HealthEquity.

Even if you are enrolled in the Saver HSA Plan, you are not eligible to make HSA contributions 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). This also includes a general purpose FSA or HRA of a spouse or other family member under which you have coverage. There are some exceptions for "limited purpose" FSAs/HRAs, which can be used for dental or vision or preventive care coverage only; "post-deductible" FSAs/HRAs, which provide coverage only after you satisfy the deductible under an HDHP; some disease-specific coverage; dental, vision, long-term care, and disability coverage; accident policies such as critical illness insurance and accident insurance, and others. However, if you are enrolled in the Saver HSA Plan and also enrolled in critical illness insurance offered under the Plan, you are not eligible for the major organ transplant rider under the critical illness insurance due to IRS guidance suggesting that such coverage would be viewed as non-high-deductible health plan coverage. For information, contact HealthEquity by phone at **866-296-2860** or online at **MyHealthEquity.com**.
- 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 dental, vision, or 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, other than services for dental, vision, or preventive care.
- You can be claimed as a dependent on another person's tax return.

You are also 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 Blue Cross Blue Shield Global Solutions international business travel medical insurance, which provides health coverage 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.

Other restrictions may apply. For further information, please call HealthEquity at **866-296-2860**. You are responsible for determining if you are eligible for an HSA.

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.

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.

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 HSA Plan, you choose the amount you want to contribute to your HSA 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 will receive a welcome kit at the home address that Walmart has in its records directly from HealthEquity, generally within the following time frames:

- By the end of December if you enroll during Annual Enrollment
- 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 pretax contributions or company matching contributions will be deposited to your HSA until it is open and your Saver HSA Plan coverage is effective. 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.

Once HealthEquity confirms that your account is open and you have completed your HSA election online, your pretax contributions and Walmart's matching contributions will begin the following pay period. If any pretax contributions or company matching contributions are made before your HSA is open, HealthEquity will hold those contributions and deposit them 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.

Your right to receive company matching contributions to your HSA is contingent upon your opening your HSA in a timely manner, and company matching contributions will not be earned or available unless you have opened your HSA in a timely manner. If you do not open your HSA by December 1 of the Plan year, you will forfeit your right to Walmart's matching contributions for that year, even if you are enrolled in the Saver HSA Plan during that year.

For questions about your account status, welcome kit, or debit card, call HealthEquity at **866-296-2860** or go online to **MyHealthEquity.com**.

To transfer funds from a prior HSA, contact HealthEquity at **866-296-2860**.

HSA fees

Walmart pays the monthly HSA maintenance fees if you are enrolled in the Saver HSA Plan and your HSA custodian is HealthEquity. However, if you are enrolled in COBRA, terminate employment with Walmart, otherwise become ineligible for AMP coverage, or are no longer enrolled in the Saver HSA Plan, you will be responsible for paying the monthly maintenance fees. 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.

Walmart does not pay overdraft fees, excess contribution fees, or lost card fees. Walmart also does not contribute funds or pay any fees associated with an HSA for your spouse or partner enrolled in the Saver HSA Plan through your family coverage.

HSA statements and information

Your right to receive a statement regarding your HealthEquity HSA balance and other information regarding your HealthEquity HSA is governed by the terms of the HealthEquity custodial agreement. To review information regarding your HSA, including the HealthEquity custodial agreement, please go to **MyHealthEquity.com.**

Naming a beneficiary

To ensure that your HSA is distributed according to your wishes in the event of your death, you may designate one or more beneficiaries. You may do this through the HealthEquity member portal in the HealthEquity app or at **MyHealthEquity.com**. For assistance and information call HealthEquity at **866-296-2860**.

If you do not name a beneficiary, your surviving spouse (if any) will be deemed the beneficiary. If your spouse is the designated or deemed beneficiary, your HSA account balance can be transferred upon your death to a new HSA in the name of your spouse. If you do not name a beneficiary and there is no surviving spouse, your account will be distributed to your estate, successor in interest, or other party with authority to act on the account.

Beneficiary designation requirements vary by state. For example, if you are married and living in a community property state and want to designate a primary beneficiary other than your spouse, your spouse must agree in writing to your designation.

Properly completed designations are effective upon receipt by HealthEquity and cancel all previous HSA beneficiary designations on file.

You should consult your tax or legal advisor when naming a beneficiary, as there may be tax or legal consequences to your designation.

Contributions to your HSA

Once you open your HSA, contributions to your HSA will be made under the following terms (as long as your account is open and you are enrolled in the Saver HSA Plan):

- You may make pretax contributions to your HSA through payroll deductions in any amount (of $5 or more each pay period) up to the legal limit, taking into account Walmart's contributions. Contributions are generally based annually on 26 pay periods.
- Walmart will match your pretax contributions dollar-for-dollar, up to the matching limit described in the chart on the following page.
- Pretax contributions and company matching contributions are deposited into your HSA shortly after each payroll deduction period ends.
- In addition to making pretax contributions by payroll deduction, you may 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 on the following page. These personal contributions are made on an after-tax basis and are not eligible for Walmart matching contribution. Although you may be able to claim an income tax deduction for contributions made directly to your HSA, there is no corresponding deduction for Social Security or Medicare taxes that may have been imposed on the funds used to make the direct contributions. (By comparison, pretax contributions made through payroll deductions are exempt from Social Security and Medicare taxes, as well as federal income tax and, in many cases, state income tax.) 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 pretax contribution or company match will be made to your HSA for that pay period.
- With respect to your final paycheck, your HSA pretax contributions and corresponding company 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 an election change event and switch from associate-only coverage to family coverage under the Saver HSA 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 Walmart made prior to the change will not be reduced. If this results in your having contributions in your account above the annual contribution limit, the excess contributions must be withdrawn by the tax-filing deadline to avoid additional taxes.

Annual contribution limits

By law, there is a maximum amount that may be contributed to your HSA during the year. The annual maximum contribution is the total contribution from all sources (pretax and after-tax contributions made by you and any company matching contributions). For 2027, the maximum annual contribution that can be made to your HSA is:

- $4,500 for individual coverage
- $9,000 for family coverage

These amounts are indexed annually by the federal government and are subject to change each year. You can consult IRS Publication 969 for the indexed amounts applicable to a particular year.

Your contributions and Walmart's contributions to the HSA		
Your Saver HSA Plan network annual deductible	**Company matching contribution: $1 for $1 up to**	**2027 maximum annual contribution (associate and company contributions combined)[1]**
$3,000 (associate-only coverage)	$350	$4,500
$6,000 (family coverage)	$700	$9,000
[1] If you are age 55 or over by December 31, 2027, you can contribute an additional $1,000 in 2027.		

Your maximum annual HSA contribution may be lower than the maximum set by law if there are any months during the year for which you are not HSA-eligible. You are HSA-eligible for a month if you have qualifying high-deductible health coverage on the first day of the month (such as coverage through the Saver HSA Plan) and you do not have any disqualifying health coverage on the first day of the month (such as coverage under Medicare or a "low deductible" health plan). If you are not HSA-eligible for one or more months during the year, your maximum annual HSA contribution is prorated for the number of months that you are HSA-eligible. For example, if you are only HSA-eligible for nine months of the year, your maximum annual HSA contribution is 9/12 (75%) of the annual maximum set by law. You are responsible for determining your maximum annual HSA contribution.

It is important to monitor contributions to your HSA—there are adverse tax consequences if your contributions exceed the annual limit. 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**.

If you are age 55 or older

If you are age 55 or older in 2027, you can make additional "catch up" contributions to your HSA by payroll deduction, just like your regular contribution. For 2027, the catch-up contribution limit is $1,000. Call HealthEquity at **866-296-2860** for information.

If you have family coverage

If you also cover your spouse under the Saver HSA Plan and you are legally married, you are both eligible to contribute to individual HSAs, but the contribution limit for 2027 for both accounts combined is based on the maximum amount that can be contributed for a family: $9,000. This limit can be shared between you and your spouse in any way you agree. If either you or your spouse is age 55 or older in 2027, the total combined contribution is increased by $1,000 for each participant age 55 or older. However, the extra $1,000 can only be contributed by each spouse to their own individual HSA. Walmart does not contribute funds or pay any fees associated with an HSA for your spouse.

If you cover an eligible partner under the Saver HSA Plan and you are not legally married, you and your partner are each eligible to contribute to individual HSAs up to the maximum family contribution limit of $9,000 (provided that neither you nor your partner can be claimed as a tax dependent on any individual's federal tax return). If either you or your partner is age 55 or older in 2027, the maximum contribution is increased by $1,000 for each participant age 55 or older, but this extra $1,000 can only be contributed by each partner to their own individual HSA. Walmart does not contribute funds or pay any fees associated with an HSA for your partner.

Call HealthEquity at **866-296-2860** for information on opening an HSA for your eligible spouse/partner.

Earning interest on your health savings account

The uninvested 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/Enroll**. Your current interest earned, along with the interest rate schedule, is available on your monthly statements.

Setting up or changing your contribution amount

You may change your contribution amount online at any time during the year on a prospective basis.

To set up or change your contribution amount, log on to **One.Walmart.com/Enroll**. 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 above), 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.

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 medical 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. Only medical expenses incurred after you have established an HSA are eligible for payment or reimbursement through an HSA. 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 medical 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 HSA 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." You are responsible for your own investment decisions. Amounts that are invested are not guaranteed or FDIC-insured and may lose value.

If you leave Walmart or are no longer enrolled in the Saver HSA 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 Walmart. 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. If you withdraw funds from your HSA upon closing the HSA, you may be subject to taxes on the withdrawn amounts.

The dental plan

Your dental plan	156
How the dental plan works	156
Filing a dental claim	158
What is covered under the dental plan	159
Limited benefits	161
What is not covered under the dental plan	161
Break in coverage	162
When your dental coverage ends	163
If you leave Walmart and are rehired	163

The information in this chapter describes dental benefits that may be available to you if:

- You are an eligible hourly, temporary, part-time OTR truck driver, or salaried (management) associate
- You have met all requirements for coverage to be effective, including actively-at-work requirements, and
- You have enrolled in a timely manner.

For questions about eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

The dental plan

The dental plan covers a wide range of services, with no deductible for preventive care 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	**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	**deltadentalar.com** Select "Login/Register" to create your account	Call Delta Dental at **800-462-5410**
Get a claim form if you use a nonparticipating dentist	**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, enrollment, and effective dates** chapter for information on eligibility.
- Delta Dental of Arkansas 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 consecutive 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 on record at Walmart.

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 hourly associates, temporary associates, and part-time OTR truck drivers. The dental plan is administered through Delta Dental.

The dental plan benefit is self-insured, which means benefits are not paid by an insurance company.

Delta Dental administers the dental plan and has been delegated the fiduciary authority to make determinations with respect to claims for benefits and the first-level appeal of a claim that has been denied.

Once you enroll in the dental plan, your coverage must remain in effect for two consecutive calendar years. You can add or remove a dependent during Annual Enrollment or due to an election change event, but you must maintain a minimum of associate-only coverage for two consecutive calendar years.

Choosing a coverage tier

When you enroll in the dental plan, you also select the eligible dependents you wish to cover:

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

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

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, nonsurgical 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 receiving orthodontia services 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
- Enrolled participants who have previously met their full waiting period

Coverage under the dental plan			
Annual deductible Waived for preventive and diagnostic care and orthodontia care	$75 per person/$225 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;[1] no annual deductible applies	80% of maximum plan allowance; no annual deductible
	[1] 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, nonsurgical 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 benefit

Lifetime maximum orthodontia benefit: The lifetime maximum orthodontia benefit will not reset, even if you:

- Terminate employment and are rehired, regardless of when you terminate or are rehired
- Are currently an eligible dependent enrolled in the dental plan and then become a Walmart associate who is directly eligible to enroll in the dental plan
- Are currently a Walmart associate enrolled in the dental plan and then become an eligible dependent of another associate
- Are currently an eligible dependent of one associate and then become an eligible dependent of another associate

Annual maximum benefit: The annual maximum benefit resets at the start of each calendar year. It will not reset during the year, even if you:

- Terminate employment and are rehired at any time during the calendar year
- Are currently an eligible dependent enrolled in the dental plan and, during the calendar year, you become a Walmart associate who is directly eligible to enroll in the dental plan
- Are currently a Walmart associate enrolled in the dental plan and, during the calendar year, you become an eligible dependent of another associate
- Are currently an eligible dependent of one associate and, during the calendar year, you become an eligible dependent of another associate

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 preventive and diagnostic care, basic care, and major care.

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 can differ by state and is derived from a variety of factors, including data from fees on claims and fee filings submitted by the dentist. If you see a non-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, however, when you use Delta Dental PPO and Premier dentists. Providers contracted with Delta Dental 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, you may save time when you use Delta Dental PPO or Premier dentists because they will 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 the **Resources** chart 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 on services covered by the dental plan for Delta Dental participants	Yes	No

Filing a dental claim

If you use a Delta Dental PPO or Premier dentist, your dentist will 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 PPO or Premier dentist. If you use a non-network dentist, the payment will be made to you. In some areas, payment may also be made to a non-network dentist if you expressly authorize such payment.

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 12 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 an eligible dependent 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.

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 dental plan 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 dental plan will be delayed or denied until an explanation of benefits is received showing a claim made with the primary plan.

How the dental plan coordinates with other plans			
	Example 1	Example 2	Example 3
If another plan pays primary at:	80%	80%	0%
And the dental plan's payment is:	80%	100%	80%
The dental plan's total benefit is:	0%	20%	80%

Determining which plan is primary

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

- The plan covering the participant for whom the claim is made, other than as a dependent, pays first and the other plan pays second.
- 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.

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: Covered every year as required by dentist. Combined with panoramic X-ray if done by same provider on same day and processed as a full-mouth series. Limited to two films per visit for children under age 10.

Cleaning (dental prophylaxis): Benefits are payable as follows:

- 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. Contact Delta Dental of Arkansas customer service to self-report your delivery date.
- Two additional cleanings are allowed for heart disease, diabetes, and periodontal disease. Additional periodontal maintenance (up to four per calendar year) allowed for periodontal disease. The additional benefit may not be combined for a patient with more than one of the above conditions.

Fluoride treatment: Covered once every calendar year for participants under age 19. One additional application per calendar year is covered for eligible dependents under age 19 who are identified at moderate or high risk (as defined by the American Dental Association's Dental Procedure Codes) for developing caries. Application of silver diamine fluoride is covered two times per calendar year per tooth. Restorations within two months of a silver diamine fluoride application are not covered. Sealants and preventive restorations are not covered if silver diamine fluoride has been applied to the tooth. Silver diamine fluoride is not covered on the same day as a restoration of the same tooth.

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. If the total amount charged for separately billed intraoral images (i.e., bitewings and periapicals) equals or exceeds the benefit payable for a full-mouth series, the charges for the images will be combined and deemed to comprise a full-mouth series. A benefit will be paid only if no other full-mouth series or panoramic radiographic image has been paid for the patient 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 evaluations are payable subject to the routine oral evaluations 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.

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 18.

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 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.

- 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.

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.
- Full or partial or removable dentures or fixed bridges 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 six months 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.

Surgical periodontics: Treatment of the gums—osseous surgery/soft tissue graft, provided in the same area once in any consecutive 36-month period.

Orthodontia

To be eligible for orthodontia assistance, you must be enrolled in the dental plan for at least 12 months. The 12-month waiting period applies to you and, separately, to each of your covered dependents. The 12-month waiting period is waived for localized associates and their covered dependents. If you were previously enrolled in the dental plan and coverage terminated for any reason after you or your covered dependent had met the 12-month waiting period (e.g., you terminated employment and were rehired or you voluntarily dropped coverage), you or your covered dependent's prior period of enrollment in the dental plan will count toward your 12-month waiting period. However, if you or your covered dependent had not met the 12-month waiting period prior to termination of coverage, prior time enrolled in the dental plan will not count toward the 12-month waiting period, and you or your covered dependent must meet a new 12-month waiting period following your reenrollment.

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 monthly based on the estimated period for treatment and on continued eligibility
- 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
- The date on which the active bands or appliances are removed

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** below.

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 of bridgework during the first six-month post-delivery period, and such services are received more often than once every 60-consecutive-month period. Recementation of bridgework during the first six-month post-delivery period, or such services received more than once every 12-consecutive-month period.

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 are received more often than once every five years for repairs and once every three years for relines and rebases. Immediate denture relining during the first three-month post-delivery period.

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
- 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
- Charges incurred as a result of war

Break in coverage

There may be occasions in which you must make special arrangements to pay your share of the cost of dental coverage 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). Failure to pay the required amount by the due date may result in an interruption in the payment of any benefit claims and/or cancellation of your coverage effective back to the date for which payment is current.

For details on the impact a break in coverage may have, and on how to make payments to continue your coverage, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** 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 share of the cost of coverage before or during the leave. For information about making payments while on a leave of absence, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter.

When your 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, enrollment, and effective dates** 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 Budget Reconciliation Act of 1985, as amended (COBRA). See the **COBRA** chapter for information regarding COBRA continuation coverage.

If your coverage is canceled due to your failure to pay for the coverage in a timely manner, coverage ends on the last day for which payment was made. See **Paying for your benefits** in the **Eligibility, enrollment, and effective dates** chapter for information. There is no right to continue coverage under COBRA when coverage is canceled due to nonpayment.

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

If you voluntarily drop coverage after an election change event or at Annual Enrollment (after completing two consecutive calendar years of coverage), coverage ends as follows:

- **After an election change event:** coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave Walmart and are rehired

If you are a part-time hourly associate or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work. For details regarding the impact to your required minimum enrollment period, deductible, and waiting period for orthodontia assistance, see below.

If you are a full-time hourly, management, or OTR truck driver associate, see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work. For details regarding the impact to your required minimum enrollment period, deductible, and waiting period for orthodontia assistance, see below.

Impact to required minimum enrollment period, deductible, and waiting period for orthodontia assistance:

- If you terminate and then return to work within 30 days of your termination date, your deductible will not reset unless you terminate in one calendar year and return to work in the following calendar year. Your waiting period for orthodontia assistance will also not reset.
- If you terminate and then return to work more than 30 days but less than 13 weeks from your termination date, your deductible will not reset when you return to work in the same calendar year in which you terminated. Your deductible will reset when you terminate in one calendar year and return to work in the following calendar year. You or your covered dependent's waiting period for orthodontia assistance will reset unless the 12-month waiting period has already been met. If you have already maintained the required minimum enrollment period of two years, you may drop dental coverage within 60 days after returning.
- If you terminate and then return to work 13 weeks or more from your termination date, you will be considered a new associate and will be required to complete any applicable eligibility waiting period or other requirements. You or your covered dependent's waiting period for orthodontia assistance will reset unless the 12-month waiting period has already been met. See the **Eligibility, enrollment, and effective dates** chapter for details.

The vision plan

The vision plan	166
How the vision plan works	166
How to use the plan	167
What is not covered	167
Breakage and loss of eyewear	168
Filing a vision claim	168
Break in coverage	168
When your vision coverage ends	168
If you leave Walmart and are rehired	169

The information in this chapter describes vision benefits that may be available to you if:

- You are an eligible hourly, temporary, part-time OTR truck driver, or salaried (management) associate
- You have met all requirements for coverage to be effective, including actively-at-work requirements, and
- You have enrolled in a timely manner.

For questions about eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

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	**One.Walmart.com**	
For detailed information about vision plan coverage or to locate a VSP network provider	**Walmart.VSPforme.com** Enter your member number	Call VSP at **866-240-8390**
Get the cost for vision plan coverage	**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. Note: There may be rare instances where a provider at a Walmart Vision Center or Sam's Club Optical facility is not a VSP provider. You should verify that a provider is a VSP network provider before receiving services.
- You may purchase contact lenses online at **SamsClubContacts.com** or from a VSP network provider. VSP coordinates the amount of your purchase eligible for coverage. Go to **Walmart.VSPforme.com** or call VSP at **866-240-8390** for details about the contact lens benefit.
- 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, 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 hourly associates, temporary associates, and part-time OTR truck drivers. **Note:** There may be rare instances where a provider at a Walmart Vision Center or Sam's Club Optical facility is not a VSP provider. You should always verify that a provider is a VSP network provider before receiving services.

Choosing a coverage tier

When you enroll in the vision plan, you also select the eligible dependents you wish to cover:

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

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

Vision plan benefits			
	Walmart Vision Center	**Sam's Club Optical**	**VSP network providers**
Routine exam copay Once every calendar year	$4 *Low-vision services, such as supplemental testing and supplemental aids for visual problems not correctable with regular lenses, are a plan benefit when specific criteria are met and when prescribed by a VSP network provider. Low-vision services may be available less frequently than once every calendar year. Call VSP for more information on eligibility criteria.*		
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	$45		
Lenses • Single vision • Lined bifocal • Lined trifocal • Lenticular	100% covered after copay The following options are also covered at 100%: • Scratch coating • Polycarbonate lenses • UV (ultraviolet) protected *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.*		
Elective contact lenses Once every calendar year in lieu of all other lenses and frame benefits	$130 contact lens allowance *Charges above the contact lens allowance are your responsibility.* *You may be charged an additional fee of up to $60 for fitting and evaluation.*		
Necessary contact lenses Once every calendar year in lieu of all other lenses and frame benefits	100% covered after copay once every calendar year. Includes professional fees and materials. *Non-elective contact lenses are a Plan benefit when specific criteria are met and when prescribed by a VSP network provider. Call VSP for more information on eligibility criteria.*		
Note: Sales taxes may apply and will reduce the vision benefit.			

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. Benefits will be paid only for covered services provided through any Walmart Vision Center, Sam's Club Optical, or VSP network provider. No benefits are available if you see a non-network provider.
Note: There may be rare instances where a provider at a Walmart Vision Center or Sam's Club Optical facility is not a VSP provider. You should always verify that a provider is a VSP network provider before receiving services.

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
- Anti-reflective coating
- Color coating
- Mirror coating
- Optional cosmetic processes
- Low vision care
- Cosmetic lenses
- 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 **Walmart.VSPforme.com** and enter your member number. **Note:** There may be rare instances where a provider at a Walmart Vision Center or Sam's Club Optical facility is not a VSP provider. You should always verify that a provider is a VSP network provider before receiving services.
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)
  - 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
- Two pairs of glasses instead of bifocals
- Contact lens modification, polishing, or cleaning
- Refitting of contact lenses after the initial (90-day) fitting period
- Local, state, or federal taxes, except where VSP is required by law to pay

Breakage and loss of eyewear

If you damage your eyewear within one year of purchase, you may be eligible for replacement or repair. Check with your provider for warranty details. Warranties may vary depending on the product and manufacturer.

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 an eligible dependent 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 for your vision coverage 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 cover the amounts owed for coverage (such as after a reduction in hours). Failure to make your coverage 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 how to make payments to continue your coverage, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** 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 the amounts owed for coverage before or during the leave. For information about making payments while on a leave of absence, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** 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 your 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, enrollment, and effective dates** chapter). You and/or your enrolled dependents may be eligible for continued coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). See the **COBRA** chapter for information regarding COBRA continuation coverage.

If your coverage is canceled due to your failure to pay for the coverage in a timely manner, coverage ends on the last day for which payment was made. See **Paying for your benefits** in the **Eligibility, enrollment, and effective dates** chapter for information. There is no right to continue coverage under COBRA when coverage is canceled due to nonpayment.

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

If you voluntarily drop coverage after an election change event or at Annual Enrollment, coverage ends as follows:

- **After an election change event:** coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave Walmart and are rehired

If you are a part-time hourly associate or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

If you are a full-time hourly, management, or truck driver associate, see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

Associate assistance resources

What is Help Now?

Using Help Now 172

Help Now support services by Humankind 172

When Help Now benefits end 172

What is My Mental Health Resources?

Using My Mental Health Resources 172

Mental health coaching and therapy services 173

Neuropsychological support 173

Work-life services 174

Learning resources 174

Contacting My Mental Health Resources 174

When My Mental Health Resources benefits end 174

Filing a claim for My Mental Health Resources benefits 175

What is the nicotine cessation program?

Enrolling in the program 175

How it works 175

When participation in the nicotine cessation program benefit ends 175

Filing a claim for nicotine cessation program benefits 175

Help Now is not a benefit offered under the Walmart Inc. Associates' Health and Welfare Plan and is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Associate assistance resources

Walmart offers a variety of associate assistance services to help you address a wide range of issues you and your eligible dependents may face. **Help Now** services are provided by Humankind. **My Mental Health Resources** services and the **nicotine cessation program** are provided by Lyra.

My Mental Health Resources and the **nicotine cessation program** are separate programs providing distinct services. Although the programs are separate, each program may refer you to the other program for additional support. You do not have to use one program to receive services under the other. You may choose the support that is right for you.

Resources		
Find what you need	**Online**	**Other resources**
Help Now		
Access a Help Now resource specialist (Monday-Friday, 7 a.m.-7 p.m. CT)	**helpnow.humankindforall.com**	Call **855-4HLPNOW (855-445-7669)**
Access more information about how you can get Help Now	**One.Walmart.com/HelpNow**	
My Mental Health Resources		
Quickly match with a mental health therapist or coach for up to 20 free sessions each year	**Walmart.LyraHealth.com**	Call **800-825-3555**
Speak with a Lyra Care Navigator to access Lyra resources, find a mental health provider, and get immediate support in times of crisis, self-harm, or suicidal thoughts	Chat with a Care Navigator at: **Walmart.LyraHealth.com**	Call **800-825-3555**
Tap into Lyra Essentials to access articles, activities, self-guided tools, and resources across a wide range of mental health topics	**Walmart.LyraHealth.com**	
Explore on-demand work-related mental health knowledge courses, live monthly workshops, and small-group facilitated Gatherings	**Walmart.LyraHealth.com**	
Nicotine cessation program		
Get help for you and your eligible dependents to quit smoking, chewing tobacco, vaping, or using any nicotine products	**Walmart.LyraHealth.com**	Call **800-825-3555**

What you need to know about associate assistance resources

Help Now

- Help Now services are provided by Humankind, whose resource specialists are ready to assist you with your well-being needs.
- Help Now services are confidential, except as required by law.
- This service is optional.
- There is no cost to you for Help Now services. You are automatically enrolled in Help Now as of your date of hire.

My Mental Health Resources

- My Mental Health Resources is available 24 hours a day, seven days a week, 365 days a year.
- You and your eligible dependents can find mental health therapy and coaching, self-guided tools, and work-life assistance.
- There is no cost to you for My Mental Health Resources benefits. You and your eligible dependents are automatically enrolled in the program as of your date of hire, regardless of whether you enroll in a Walmart medical plan. Eligible dependents can utilize My Mental Health Resources benefits even if you are enrolled in a Walmart medical plan and your dependents are not. You will need to set up a free account with Lyra to access on-demand courses or start care with a provider.

Nicotine cessation program

- There is no cost to use the nicotine cessation program.
- You will need to set up a free account with Lyra to enroll in the nicotine cessation program.
- Eligible dependents can sign up for the nicotine cessation program even if you are enrolled in a Walmart medical plan and your dependents are not.

What is Help Now?

Help Now provides associates and their eligible dependents with on-demand support for a variety of life challenges. Whether you need assistance navigating your Walmart benefits, paying bills, finding food or housing, or taking care of a sick family member, help is just a phone call (or email) away. Help Now services are provided by Humankind, whose resource specialists understand Walmart well-being benefits and community resources. From your date of hire, it's available at no cost to you and your eligible dependents.

Using Help Now

If you are an associate in the United States or Puerto Rico, you and your eligible dependents are automatically enrolled in Help Now through Humankind as of your first day of employment. Eligible dependents include your spouse/partner and children up to age 26. You do not need to take any steps to enroll. You can contact Help Now by calling **855-4HLPNOW** (**855-445-7669**) during the hours of 7 a.m. to 7 p.m. CT or visiting **helpnow.humankindforall.com**. See **Dependent eligibility** in the **Eligibility, enrollment, and effective dates** chapter.

Help Now support services by Humankind

Humankind provides personalized support by phone.

Humankind can help you navigate to resources to support the following areas, which may be updated or modified from time to time:[1]

- Financial concerns
- Food/meals
- Veteran assistance
- Community support groups
- Foreclosure/eviction prevention resources
- Repair services
- Housing
- Education
- Transportation
- Childcare/eldercare
- And others

[1] Humankind's services are limited to helping you find and navigate available resources. Humankind does not provide direct financial assistance, including monetary distributions or loans.

Help Now resource specialists educate you on the well-being programs available to you through the Plan and help you access those programs. If the Plan does not have a well-being program to support your individual need, the Help Now resource specialist will research, identify, vet, and connect you to resources available to you in your community. The resource specialist will notify you of any fees charged by the community resources, if known.

For more information on support categories, go to **One.Walmart.com/HelpNow**.

If you would like support, you can call **855-4HLPNOW** (**855-445-7669**). Calls are confidential, except as required by law.

When Help Now benefits end

Benefits end on your last day of employment, or when you are no longer eligible under the terms of the Plan.

Help Now is a resource navigation benefit that does not provide medical care. Help Now support services are exempt from ERISA and are not COBRA-eligible.

What is My Mental Health Resources?

My Mental Health Resources is one of Walmart's employee assistance programs. Provided by Lyra, this program provides confidential emotional wellness and mental health support. Mental health coaching and therapy services and learning resources are available at no cost to you and your eligible dependents from your date of hire. Initial consultations for work-life services are available at no cost to you. Additional work-life services are available at a discounted fee. You can call Lyra's Care Navigator Team or visit Lyra's online platform to connect with therapists and mental health coaches, access digital wellness tools for managing stress, sleep, and relationships, and tap into work-life services.

Using My Mental Health Resources

If you are an associate in the United States, you and your eligible dependents are automatically enrolled in My Mental Health Resources as of your first day of employment. You will need to register with Lyra to access on-demand resources or start care with a provider. Eligible dependents include your spouse/domestic partner, and your children, stepchildren, or foster children under the age of 26. See **Dependent eligibility** in the **Eligibility, enrollment, and effective dates**

chapter. You and your eligible dependents are required to provide your WIN and your date of birth to confirm eligibility for services. All services provided are confidential, except as required by law.

Associates of any age (minors included) can set up their own accounts with Lyra. Dependents can set up accounts starting at age 13. Parental consent is not required to set up an account with Lyra.

Depending on state law, associates and dependents aged 13-17 may need parental consent for care. For those in Lyra's teen program, Lyra Care for Teens, parental consent, when required, will be obtained verbally during the first session, along with a completed "consent for care" form for virtual sessions and digital engagement.

Dependents under 13 can receive care through their parent's account. Parents can register and find care for their children age 12 and younger. If a minor who is 12 years old lives in a state that allows them to seek mental health care without parental consent, the minor can contact Lyra's Care Navigator Team for assistance in finding a provider and scheduling an appointment without involving their parents/guardians.

You can access My Mental Health Resources any time at **Walmart.LyraHealth.com** or call Lyra any time at **800-825-3555** to find tools for:

- Identifying a mental health provider
- Building strong mental health and resiliency
- Stress management
- Improving sleep
- Strengthening relationships at home and in the workplace

Many Lyra resources are accessible online and by telephone. Lyra's counseling services are available as face-to-face or live video sessions.

Mental health coaching and therapy services

You and your eligible dependents may receive up to 20 mental health coaching or therapy sessions, per person, per year, at no cost, as long as you access therapy or coaching through a Lyra network provider. If you are both an associate and a dependent of another associate, such as your spouse/partner or parent, you are not eligible for additional sessions as a dependent of another associate. You are eligible for a maximum of 20 sessions per year through My Mental Health Resources.

You can find your Lyra provider at **Walmart.LyraHealth.com** or by calling **800-825-3555** where a Lyra Care Navigator can help you register and search for care.

If you are enrolled in the Premier PPO, Contribution HRA, Saver HSA, or Personalized Wellbeing Copay Plan under the Associates' Medical Plan (AMP), the AMP will cover mental health therapy and medication management visits with a Lyra network provider, subject to other AMP terms. Your Lyra network provider may also be in your TPA network under the AMP. You can see the negotiated rate for your Lyra provider at **Walmart.LyraHealth.com**. If your provider is also in your TPA network, you can see the negotiated rate for your provider at **IncludedHealth.com/Walmart**.

Refer to **The medical plan** chapter for information about provider networks.

Through Lyra coaching, you can work with a coach through regularly scheduled sessions to better understand what's challenging you, decide what you want to work on, and plan a path forward. Choose to connect with your coach via live messaging through your mobile device or from your computer or meet "face-to-face" over live video on a recurring basis. You can also select a more hands-off experience through Lyra's Guided Self-Care program.

Lyra therapy offers access to mental health providers that only use evidence-based treatments, with appointments generally available within two weeks. Lyra's therapists can diagnose mental health conditions and identify thoughts, behaviors, and strong emotions that may be symptoms of depression, anxiety, PTSD, or other conditions. During your sessions, your therapist will introduce new skills and may assign exercises for you to practice between sessions. Therapy sessions are available through both virtual and in-person appointments, depending on individual provider availability.

Areas you can address with a mental health provider include:

- Managing stress and burnout
- Coping with depression, anxiety, or substance use
- Building healthy relationships with family, friends, and co-workers
- Parent-child conflict
- Balancing the demands of work and home life
- Grief and loss
- Working through emotionally difficult situations

Neuropsychological support

Lyra offers confidential neurodiversity resources including specialized caregiver coaching support and a range of neuroinclusive resources for individuals and families

navigating neurodiverse needs such as ADHD, ASD, and learning differences. Call Lyra at **800-825-3555** for more information about these services, including eligibility criteria.

If you are enrolled in the Premier PPO, Contribution HRA, Saver HSA, or Personalized Wellbeing Copay Plan under the Associates' Medical Plan (AMP), the AMP will cover neuropsychological assessment services through Lyra, subject to other AMP terms.

Work-life services

Lyra, through its third-party partner, makes available access to legal and identity-theft support. Initial consultations are at no cost to you. Additional services are available at a discounted fee.

Work-life services include helping you:

- Explore your options related to legal issues
- Access a library of legal forms and documents for a variety of needs
- Recover from identity theft

You can receive a half-hour consultation for each legal 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. If you need more legal or identity-theft support beyond the initial consultation, you can continue for an additional discounted fee. Resources, documents, and self-help tools are all available 24/7 online at **Walmart.LyraHealth.com/Worklife**.

Learning resources

Lyra's learning resources can help you build strategies to help improve your well-being at work and home through on-demand courses and live events like webinars and discussion groups created and facilitated by Lyra.

On-demand courses

Explore unlimited on-demand courses taught by mental health professionals at your own pace. While some courses feature five to eight chapters of in-depth content, others take less than 15 minutes to complete.

Live events: webinars and discussion groups

Each month, Lyra offers webinars and virtual discussion groups on topics related to mental health, led by a clinical expert. The webinars offer an opportunity for attendees to watch, listen, and learn, whereas the discussion groups provide a supportive space for participants to share their experiences in a small-group setting. Advance registration is required for both webinars and discussion groups.

To explore on-demand courses or register for a live event, visit **Walmart.LyraHealth.com** and navigate to the "Library" tab once you've logged into your Lyra account. You must be 18 years or older to register for and attend live events including workshops and Gatherings sessions.

Contacting My Mental Health Resources

Lyra on the web

Visit **Walmart.LyraHealth.com** to start care with a mental health care provider, and access self-guided mental health essentials tools. You may also download the Lyra Health app from the App Store or Google Play to access many of Lyra's services. Registering as a new user will require you to use your WIN and date of birth to confirm eligibility.

You can also access more information at **One.Walmart.com/MyMentalHealthResources**.

Calling Lyra

Call **800-825-3555** for personalized support at any time from a Care Navigator. Services are available in English and Spanish (other languages available upon request). Calls are confidential, except as required by law.

When My Mental Health Resources benefits end

If you experience a qualifying event and become eligible for COBRA benefits, My Mental Health Resources will remain available to you and your eligible dependents for 18 months after your last day of employment (or the maximum duration for which you would be eligible for COBRA coverage) at no cost to you. If you enroll for COBRA coverage under the medical, vision, or dental plan, the benefit will be available throughout the COBRA period. However, you do not have to enroll in COBRA coverage under the medical, vision, or dental plan to continue your My Mental Health Resources benefits.

If one or more of your dependents experiences a qualifying event other than your termination of employment and becomes eligible for COBRA benefits, My Mental Health Resources will remain available to those dependents for the maximum duration for which they would be eligible for COBRA coverage at no cost to them. If they enroll for COBRA coverage under the medical, vision, or dental plan, the benefit will be available throughout the COBRA period. However, they do not have to enroll in COBRA coverage under the medical, vision, or dental plan to continue their My Mental Health Resources benefits.

Filing a claim for My Mental Health Resources benefits

You do not have to file a claim for My Mental Health Resources benefits. As long as you remain eligible, you may access the Lyra website or contact Lyra 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:

Walmart Benefits Total Rewards Team
Attn: Custodian of Records
Mail Stop 3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

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.

What is the nicotine cessation program?

The nicotine cessation program is one of Walmart's employee assistance programs and is available at no cost to you and your eligible dependents from your date of hire. Provided by Lyra, this program provides access to Lyra's Nicotine Quitline program to help you quit smoking, chewing tobacco, or vaping.

You may participate in the nicotine cessation program two times in any calendar year.

Enrolling in the program

If you are an associate in the United States who is at least age 18, you and your eligible dependents can enroll in the nicotine cessation program as of your first day of employment. You will need to register with Lyra to start the program.

Eligible dependents include your spouse/domestic partner and your children, stepchildren, or foster children who are age 18 or older and under the age of 26. See **Dependent eligibility** in the **Eligibility, enrollment, and effective dates** chapter. You and your eligible dependents are required to provide your WIN and your date of birth to confirm eligibility for services.

The Nicotine Quitline is available Monday through Friday, 6 a.m.–6 p.m. Pacific Time.

How it works

You work with a trained Nicotine Quitline advocate to build a quit plan based on your nicotine use, past quit attempts, reasons for quitting, and your goals. The plan is developed using proven tools, like the Fagerström Test for Nicotine Dependence.

You can expect your first call to last about 30–45 minutes. You can schedule weekly follow-up calls of about 15–20 minutes. You can have up to six calls in total, including your initial call. Between scheduled calls, you have access to real-time phone support when you need it.

The program also includes up to two $50 digital payment cards issued by IQPay to purchase nicotine replacement therapy (patches, gum, or lozenges) at Walmart or Walmart.com.

The program moves at your readiness to quit. Most people finish in about six weeks.

If you need extra mental health support while you quit, your advocate can refer you to My Mental Health Resources.

When participation in the nicotine cessation program benefit ends

If you experience a qualifying event and become eligible for COBRA benefits, the nicotine cessation program will remain available to you and your eligible dependents for 18 months after your last day of employment (or the maximum duration for which you would be eligible for COBRA coverage) at no cost to you. If you enroll for COBRA coverage under the medical, vision, or dental plan, the benefit will be available throughout the COBRA period. However, you do not have to enroll in COBRA coverage under the medical, vision, or dental plan to continue the nicotine cessation program benefit.

Filing a claim for nicotine cessation program benefits

You do not have to file a claim for the nicotine cessation program benefit. As long as you remain eligible, you may access the Lyra website or contact Lyra 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:

Walmart Benefits Total Rewards Team
Attn: Custodian of Records
Mail Stop 3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

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.

COBRA

COBRA continuation coverage	178
COBRA qualifying events	178
Paying for COBRA coverage	180
How long COBRA coverage may last	181
When your COBRA coverage ends	183

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** **805 Moberly Lane** **Bentonville, Arkansas 72716-3501**
Contact WageWorks (a HealthEquity company), the COBRA administrator, for questions regarding eligibility, enrollment, premiums, or notification of a second qualifying event	**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 access to My Mental Health Resources and the nicotine cessation program, provided by Lyra, automatically continues 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 access to My Mental Health Resources or the nicotine cessation program.
- If one or more of your dependents experiences a qualifying event other than your termination of employment and becomes eligible for COBRA benefits, My Mental Health Resources will remain available to those dependents for the maximum duration for which they would be eligible for COBRA coverage at no cost to them. If they enroll for COBRA coverage under the medical, vision, or dental plan, the benefit will be available throughout the COBRA period. However, they do not have to enroll in COBRA coverage under the medical, vision, or dental plan to continue their My Mental Health Resources 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 COBRA. COBRA continuation coverage applies to medical, dental, and vision coverage; it does not apply to other benefits described in this 2027 *Associate Benefits Book*.

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 tier or select an alternate medical plan, if applicable.

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 information on state continuation rights, contact your HMO provider.

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, enrollment, and effective dates** 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)
- 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, as described in the **Eligibility, enrollment, and effective dates** chapter (e.g., the end of the month in which a dependent turns age 26)
- 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, a reduction in hours of employment that makes you ineligible for coverage under the Plan, or you enroll in Medicare Part D. You or your dependent must notify People Services if you enroll in Medicare Part D. Walmart will make this notification to the COBRA administrator generally 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's loss of dependent status. You will need to notify People Services, even if you made changes online to modify your coverage as a result of one of these life events. 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 your behalf or on behalf of 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
805 Moberly Lane
Bentonville, Arkansas 72716-3501

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
- 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, your covered dependent will lose their right to elect COBRA continuation coverage. To protect your covered dependent's rights, let People Services know about any changes in addresses of covered dependents. 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 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 form to the address on the election form 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 dependents who lose coverage because of the qualifying event. A parent or legal guardian may elect COBRA coverage

on behalf of a minor eligible dependent. 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, Medicare, 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**.

Election 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 an election change event outside Annual Enrollment or a subsequent qualifying event. For information about election change events, see **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter. If an election 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 an election change event while on COBRA, each person must individually meet any applicable benefit waiting period (for example, for weight loss surgery) and is subject to any applicable Plan limitations. If you change medical plans due to an election 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 HRA Plan to another plan, your HRA balance under the Contribution HRA 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 applicable waiting periods.

In the event of an election change event, 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 election 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

The COBRA premium is the amount you were paying before the qualifying event, plus the amount Walmart was paying, 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 premium payment is due 45 days after you elect COBRA and must cover the period from the time your coverage was lost because of a qualifying event up to the end of the month in which your election is made. (For example, assume your employment terminates on September 30, and you lose coverage on September 30. You elect COBRA on November 15. Your initial premium payment should equal the premiums for October and November and is due on or before December 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 December 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. To eliminate any possible delay in the updating of your eligibility information, it is recommended that you pay your premiums 7-10 days in advance of the due date.

You are allowed a 30-day grace period from the premium due date before coverage is canceled. However, if you make your payment on the first day of the month or later, 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. To avoid interruption or cancellation of coverage, it is recommended that you pay your premiums 7-10 days in advance of the due date. Using the ACH debit through the COBRA administrator can cause eligibility delays since these drafts are taken on the first business day of the month. 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.

COBRA is month-to-month coverage, and if you do not want to continue coverage, it can be terminated in the following ways:

- Simply stop paying premiums, and your COBRA coverage will be terminated for nonpayment.
- Enter a support request in the WageWorks online message center.
- Send a letter to WageWorks requesting termination of your COBRA coverage, mailed to:

  WageWorks
  P.O. Box 14390
  Lexington, Kentucky 40512-4390

If you choose to cancel coverage, it cannot be reinstated. Coverage will be automatically canceled if your payment is not postmarked on or before the deadline date of the month your premium is due.

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 Walmart 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 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 you enrolled in Medicare
You enroll in Medicare Part D	Not applicable	36 months from the date you 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

In general, if you are eligible for Medicare Parts A and/or B and terminate employment with Walmart (or lose coverage under the Plan), you have an eight-month special enrollment period in which to enroll in Medicare Part A and/or B that runs from the date you are no longer employed by Walmart (or lose coverage under the Plan, whichever occurs first), even if you elect COBRA continuation coverage. You should 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 to enroll in Medicare Parts A and/or B (i.e., until the next Medicare annual enrollment period) and may have to pay a higher Medicare premium when you do enroll. 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 covered dependents may be eligible for extended COBRA coverage for up to 36 months from the date you became entitled to Medicare.

If you are entitled to Medicare prior to your COBRA election date, you or your covered dependents must notify the COBRA administrator at **800-570-1863** of your Medicare entitlement date in order to ensure that maximum coverage eligibility for your dependents is properly calculated.

If you or an eligible dependent is disabled

If you are a qualified beneficiary who has COBRA coverage because of termination of employment or reduction in hours, you and each covered dependent may be entitled to an extra 11 months of COBRA coverage if you or your covered dependents 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 the 18-month period of COBRA continuation coverage
- 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

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 Walmart 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 dependent is not enrolled in COBRA coverage, the COBRA premium for the covered dependents 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.

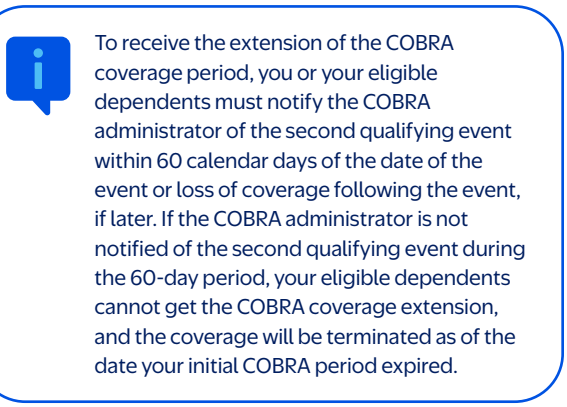
If you have a second qualifying event while on COBRA

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)
- 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 your 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:

- Walmart 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)
- 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.

Full-time hourly short-term disability

Your short-term disability benefit	186
How short-term disability benefits are funded	186
How full-time hourly short-term disability is administered	186
When you qualify for benefits	186
When benefits are not paid	188
When benefits begin	188
Calculating your benefit	189
Filing a short-term disability claim	191
When short-term disability benefit payments end	193
Returning to work following a leave	193
If you are on a leave of absence or experience a temporary layoff	194
When your short-term disability coverage ends	194
If you pass away while receiving short-term disability benefits	194
If you leave Walmart and are rehired	194

The information in this chapter describes short-term disability benefits that may be available to you if:

- You are an eligible full-time hourly associate
- You have met all requirements for coverage to be effective, including actively-at-work requirements, and
- You have enrolled in a timely manner (if applicable).

For questions about eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

Full-time hourly short-term disability

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 replace part of your pay. Options include the short-term disability basic plan and short-term disability enhanced plan.

Resources		
Find what you need	**Online**	**Other resources**
To request a leave or to file a claim for basic or enhanced benefits or maternity benefits, or to get more information	**One.Walmart.com/TimeAndSupport > Leave of Absence**	Call Sedgwick at **800-492-5678**
If you work in one of the states listed below, file a claim with Sedgwick, which will manage your leave and notify Lincoln of the claim. Delaware Hawaii New Jersey New York	**One.Walmart.com/TimeAndSupport > Leave of Absence**	Call Sedgwick/Lincoln at **800-492-5678**
If you work in one of the states or localities listed below, file a claim with Sedgwick in addition to filing with your state or locality. For maternity benefit information, see the **Maternity benefit** section later in this chapter.		
California	**edd.ca.gov**	Call **800-480-3287**
Colorado	**famli.colorado.gov**	Call **866-263-2654**
Connecticut	**ctpaidleave.org**	Call **877-499-8606**
Maine	**maine.gov/paidleave**	Call **207-621-5024**
Massachusetts	**paidleave.mass.gov**	Call **833-344-7365**
Minnesota	**paidleave.mn.gov**	Call **844-556-0444**
Oregon	**paidleave.oregon.gov**	Call **833-854-0166**
Rhode Island	**dlt.ri.gov/tdi**	Call **401-462-8420**
Washington, D.C.	**dcpaidfamilyleave.dc.gov**	Call **202-899-3700**
Washington state	**paidleave.wa.gov**	Call **833-717-2273**

What you need to know about full-time hourly short-term disability

- This chapter describes disability benefits available to you under two options: the short-term disability basic plan and the short-term disability enhanced plan.
  - **The short-term disability basic plan**
    - The *short-term disability basic benefit* replaces 50% of your average weekly wage for up to 25 weeks after a waiting period of seven calendar days, with no weekly maximum (however, if you work in New York there is a maximum of $6,000 per week).
    - The *short-term disability maternity benefit* replaces 100% of your average weekly wage for up to nine weeks after a waiting period of seven calendar days.
  - **The short-term disability enhanced plan** replaces 60% of your average weekly wage for up to 25 weeks after a waiting period of seven calendar days, with no weekly maximum (however, the New York short-term disability enhanced plan has a maximum of $6,000 per week).
- Some states and localities provide legally mandated benefits. Variations in laws and administrative procedures may affect your eligibility to participate in a Walmart short-term disability plan, as well as the amount of any disability benefit, as described in the chart titled **Legally mandated benefits**.
  - If you work in California, Hawaii, New Jersey, or Rhode Island, you are not eligible for the Walmart short-term disability enhanced plan or the basic benefit under the short-term disability basic plan because the states in which you work provide legally mandated benefits. However, you are eligible for the maternity benefit under the Walmart short-term disability basic plan to supplement any legally mandated maternity benefits offered by the state.
  - If you work in Colorado, Connecticut, Delaware, Maine, Massachusetts, Minnesota, New York, Oregon, Washington, D.C., or Washington state, you are eligible to participate in one of Walmart's short-term disability plans, but it will only supplement your state or locally mandated benefit.
  - Legally mandated benefits are not offered under the Associates' Health and Welfare Plan, and benefits paid under those legally mandated programs are not provided under a Walmart short-term disability plan. Legally mandated benefits are not discussed in detail in this chapter, except where relevant to help you understand benefits under a Walmart short-term disability plan.

Your short-term disability benefit

If the short-term disability plan is available at your location and you become disabled as defined in the **When you qualify for benefits** section later in this chapter, and you are eligible to receive short-term disability benefits, the short-term disability basic plan provides a basic weekly benefit of 50% of your average weekly wage for up to 25 weeks of an approved disability, after a waiting period of seven calendar days, with no maximum weekly benefit (however, if you work in New York there is a maximum weekly benefit of $6,000). For more information about your average weekly wage, see **Calculating your benefit** later in this chapter.

If the short-term disability plan is available at your location and you become disabled as defined in the **When you qualify for benefits** section later in this chapter, and you are eligible to receive short-term disability benefits, the short-term disability enhanced plan provides a weekly benefit of 60% of your average weekly wage for up to 25 weeks of an approved disability, after a waiting period of seven calendar days, with no maximum weekly benefit (however, if you work in New York, the New York short-term disability enhanced plan has a maximum weekly benefit of $6,000).

If your disability is due to pregnancy, the short-term disability basic plan provides 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. If you are eligible for legally mandated short-term disability benefits, the maternity benefit supplements your state benefits. The combined total of the maternity benefit available to you under the short-term disability basic plan and the maternity benefit available to you under any state or locally mandated program will not exceed 100% of your average weekly wage for nine weeks. If you remain disabled and are eligible for benefits after the first nine weeks of short-term disability benefits, and Walmart's short-term disability basic and enhanced plans are available at your work location, the short-term disability plan will pay the basic benefit or the benefit under the enhanced plan, depending on the plan in which you are enrolled, for up to 16 additional weeks (for a total of up to 25 weeks of benefit payments). See **Maternity benefit** later in this chapter for more information.

How short-term disability benefits are funded

The short-term disability basic plan is provided by Walmart at no cost to you. However, if you enroll in the short-term disability enhanced plan, you and Walmart share the cost. If you participate in the short-term disability enhanced plan, your cost is based on your eligible earnings and your age. Your contributions are intended to cover the costs of benefits.

Except for associates who work in New York, the short-term disability plans are self-insured. This means no insurance company collects premiums and pays benefits. However, the maternity benefit is self-insured for all associates, including those who work in New York. Walmart currently funds benefits under the self-insured short-term disability plan from Walmart's general assets.

For associates who work in New York, benefits provided under the short-term disability basic plan and the New York short-term disability enhanced plan are insured by Lincoln.

How full-time hourly short-term disability is administered

Except as otherwise provided, the short-term disability plans are administered by Sedgwick Claims Management Services, Inc. (Sedgwick). With respect to any benefit payments made under a short-term disability plan that is administered by Sedgwick, the Plan Administrator has delegated the fiduciary authority for determining claims for benefits and related appeals to Sedgwick.

See the **Legally mandated benefits** chart on the following page for details regarding the administration of non-maternity disability coverage available for associates in states and localities with legally mandated benefits. For details regarding the administration of short-term disability plan maternity benefit, see **Maternity benefit** later in this chapter.

When you qualify for benefits

To be eligible to receive short-term disability benefits under either short-term disability plan, you must meet the following requirements:

- The short-term disability plan must be available at your location.
- Your coverage must be effective.
- Your disability must have occurred on or after the effective date of your coverage.
- You must be on active status on the date of your disability unless:
  - You are on leave of absence or layoff as described later in this chapter under **If you are on a leave of absence or experience a temporary layoff**, or
  - You are unable to work because you have experienced medical complications during pregnancy or postpartum and have exhausted the nine-week short-term disability maternity benefit, as described later in this chapter under **Maternity benefit**

Legally mandated benefits	
If you work in a state or locality with a legally mandated benefit, differences in laws and administrative procedures affect your eligibility to participate in a Walmart short-term disability plan, as well as the amount of your disability benefit. See below for general information. Call the number listed in the **Resources** chart for details about benefits in these states or localities. See **Maternity benefit** for information about the maternity benefit, including information about administration.	
Legally mandated benefits administered by your state	If you work in **California** or **Rhode Island**, you are not eligible to participate in a Walmart short-term disability plan. Your disability benefit is administered by the state. You may still be eligible for the maternity benefit[1] under the Walmart short-term disability basic plan.
Legally mandated benefits administered by Lincoln	If you work in **Hawaii** or **New Jersey**, you are not eligible to participate in a Walmart short-term disability plan. Your disability benefit is provided in accordance with the state program and is insured and administered by Lincoln. You may still be eligible for the maternity benefit[1] under the Walmart short-term disability basic plan. If you work in **Delaware** or **New York**, you are eligible to participate in the Walmart short-term disability basic plan and the short-term disability enhanced plan to supplement your state benefit. Your benefits under these plans are insured and administered by Lincoln.
Legally mandated benefits administered by Sedgwick	If you work in **Colorado**, **Connecticut**, **Maine**, **Massachusetts**, **Minnesota**, **Oregon, Washington, D.C.**, or **Washington state**, you are eligible to participate in a Walmart short-term disability plan to supplement your legally mandated benefits, which are administered by Sedgwick.[1]
[1] The amount of any non-maternity or maternity benefit paid under a Walmart short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates you are eligible to receive from the state or locality, regardless of whether you apply for that legally mandated benefit. If the benefit available to you under any state or locally mandated program is less than the benefit available to you under a Walmart short-term disability plan, the combined total of the benefit available to you under a Walmart short-term disability plan and the benefit available to you under any state or locally mandated program will not exceed the benefits that would have been available under the Walmart short-term disability plan you are enrolled in, if you had not worked in a state with a legally mandated program. You will be required to provide your determination letter from the state or locality to Sedgwick. If Sedgwick overestimated what your legally mandated benefit would be, meaning that you were paid less under the short-term disability plan than you were entitled to, you will be paid the difference in a lump sum payment. If Sedgwick underestimated what your legally mandated benefit would be, meaning that you were paid more under the short-term disability plan than you were entitled to, you must repay any amount overpaid to you. See the **Right to recover overpayment** section later in this chapter.	

- Except as otherwise provided in the **Maternity benefit** section, you must submit objective medical evidence provided by a qualified doctor that you are disabled as defined below (for purposes of this chapter, the term "doctor" includes 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 would be eligible for reimbursement if submitted for reimbursement under the Associates' Medical Plan).
- You must receive approval by Sedgwick or Lincoln (as applicable) of your claim.

These conditions apply whether you are enrolled in the short-term disability basic or enhanced plan or the New York short-term disability enhanced plan. Sedgwick or Lincoln may require written proof of your disability, as described below, or additional information before making a decision on your claim. A statement by your doctor that you are unable to work does not by itself prove that you are disabled. Approval of a leave of absence also does not constitute approval for short-term disability benefits.

Except as otherwise provided in the **Maternity benefit** section, for purposes of benefits provided under a short-term disability plan, as described in this chapter, "disabled" or "disability" means that (i) 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, and (ii) you are under the continuous care of a qualified doctor and are following the course of treatment prescribed by your doctor. This includes taking medication as prescribed, and/or a series of ongoing services or appointments provided by your doctor over a period of time. A single appointment where no medication is prescribed or no follow-up appointments or actions are recommended is not a course of treatment.

Disability 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. Loss of license by itself is not sufficient for meeting the definition of disability.

If you are employed as a pilot, copilot, or crewmember of an aircraft, "disability" or "disabled" means that, as a result of a mental or physical illness or injury, you are unable to perform the material and substantial duties of your own occupation under the applicable Federal Aviation Administration fitness standards.

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 but not limited to X-rays, laboratory reports, tests, consulting physician reports, as well as reports and chart notes from your doctor.

If your disability is caused by a mental illness or substance use disorder, you are encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, licensed counselor, drug and alcohol counselor, or clinical social worker who specializes in mental health and/or substance use disorders, and is licensed pursuant to state law. See the **Associate assistance resources** chapter for information on resources that are available if you are experiencing the effects of a mental illness or substance use disorder.

If Sedgwick or Lincoln requests that you be examined by an independent doctor, you must attend the exam to be considered for benefits. Walmart will pay the cost of any such examination.

The maximum length of any one period of disability during which disability benefits are paid, even if the disability is the result of more than one cause, is 25 weeks, after the initial waiting period of seven calendar days. See also **If you return to work and become disabled again**.

See the **Maternity benefit** section for additional details regarding the maternity benefit.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that:

- Arose before your coverage became effective
- Is not under continuous care of and being treated by a qualified doctor
- Is caused by taking part in an insurrection, rebellion, riot, or civil disorder
- Resulted from your commission of or attempt to commit a crime (e.g., assault, battery, felony, or any illegal occupation or activity)
- Resulted from doing any work for pay or profit (for example, an illness or injury that is related to work outside of Walmart or related to your Walmart work for which workers' compensation benefits are paid, or may be paid, if properly claimed)

When benefits begin

If your short-term disability claim is approved, the benefits will begin after a waiting period of seven calendar days, on the eighth calendar day after your disability begins. If your claim for short-term disability benefits is retroactively approved, any benefit payments that would have otherwise been paid to you while your claim decision was pending will be made to you in a lump sum payment when approved. Short-term disability benefits administered by Sedgwick are paid only through Walmart payroll in the same way in which your regular wages are paid to you. Other forms or methods of payment are not permitted.

For your pay to continue during the initial waiting period of seven calendar days, you may use paid time off. You should not use paid time off beyond the initial seven-day waiting period while a claim decision is pending or for any period during which short-term disability benefits are approved, unless allowed by state law. If you are later found to be ineligible for short-term disability benefits, you may go back and use paid time off for any time that was unpaid, subject to terms of the paid time off policy. You may be required to repay any paid time off used for days when disability benefits were approved. Upon repayment, any paid time off balance will be restored.

The paid time off policy is not a benefit offered under, or administered as part of, the Plan. For specific details about the paid time off policy, refer to **One.Walmart.com/TimeAndSupport**.

Calculating your benefit

The amount of your weekly short-term disability benefit is based on:

- Your average weekly wage, as defined below
- The duration of your disability
- Whether you are enrolled in the short-term disability basic plan or enhanced plan

Your average weekly wage is defined as follows:

Average weekly wage	
Length of employment	**How average weekly wage is determined**
Employed 12 months or more	Your eligible earnings for the 26 pay periods[1] immediately preceding your last day worked ÷ 52 weeks For example, the average weekly wage for an associate with eligible earnings of $36,400 for the prior 26 pay periods is $700 ($36,400 ÷ 52)
Employed less than 12 months	Eligible earnings since date of hire ÷ number of weeks worked For example, the average weekly wage for an associate with eligible earnings of $8,400 for 12 weeks of work is $700 ($8,400 ÷ 12)
[1] Any pay periods in which you have no eligible earnings are excluded, decreasing the number of pay periods used for the calculation. To the extent your eligible earnings were paid on a weekly basis during the 12-month period, the number of pay periods used to calculate your average weekly wage will be adjusted accordingly. Your short-term disability benefits are paid through Walmart payroll on a pay-period basis. If your disability benefit is payable for less than a week, your disability benefit for each day that you are disabled during that week will be 1/7 of the weekly benefit.	
Eligible earnings used to determine average weekly wage include: • Regular earnings for the 26 pay periods prior to your last day worked • Overtime • Regularly scheduled target incentive bonuses that you and associates in similarly situated job types or job levels are eligible to earn • Paid time off and similar pay that replaces regular earnings (e.g., bereavement leave, jury duty leave, and sick time) Eligible earnings used to determine average weekly wage exclude: • Any previously paid disability benefits • Commissions or any other extra compensation or fringe benefits not listed above	

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 Average weekly wage: $700 50% of $700: $350
Short-term disability enhanced plan coverage	60% of your average weekly wage Average weekly wage: $700 60% of $700: $420 weekly benefit Benefits are paid through Walmart payroll on a pay-period basis.
Note: If you are eligible for legally mandated benefits as well as benefits under a Walmart short-term disability plan, the amount of the benefit under the Walmart short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates that you will receive. See **Legally mandated benefits** earlier in this chapter.	

Maternity benefit

See the **When you qualify for benefits** section for general requirements applicable to all disability benefits under a short-term disability plan, including the maternity benefit. There are some exceptions to those general rules that apply to the maternity benefit. Those exceptions are discussed in this section. Also see the **Legally mandated benefits** chart earlier in this section.

The maternity benefit is 100% of your average weekly wage for up to the first nine weeks of leave, after an initial waiting period of seven calendar days. Disability benefits begin on the eighth calendar day after your disability begins.

If your disability is due to pregnancy, the date of your disability is generally on or up to two weeks prior to your expected date of delivery. If you begin your short-term disability leave during this time frame, you will be deemed to meet the definition of disability for purposes of the maternity benefit. If you begin your leave more than two weeks prior to your expected delivery date, you will be required to provide objective medical evidence to demonstrate you are disabled, as defined in the **When you qualify for benefits** section. If you are disabled, as defined in that section, you will begin your short-term disability maternity benefit on the date you are determined to be disabled. In no event will the maternity benefit exceed nine weeks.

If you begin your short-term disability leave after your delivery date, you must meet the Plan's definition of disabled, as defined in the **When you qualify for benefits** section. In that case, any disability benefit will be subject to rules applicable to non-maternity disability benefits

and depend on whether you are eligible for the short-term disability basic or enhanced benefit. You will not be eligible for the maternity benefit described in this section.

If you return to work before receiving your full maternity benefit and then go on leave again, you will not be able to resume your maternity benefit unless you provide objective medical evidence to Sedgwick to support a determination that you meet the definition of disability. If no medical evidence is provided, the remainder of the maternity benefit is forfeited.

The maternity benefit is summarized below. See the **Legally mandated benefits** chart earlier in this section for additional information about legally mandated benefits.

Maternity benefit		
Your work location (state or locality)[1]	**Up to 9 weeks[2]**	**Beyond 9 weeks[2] (up to 25 total 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 postpartum, benefits may be payable under the short-term disability basic or enhanced plan, as described above.
If (i) you work in a state or locality with a legally mandated benefit, (ii) *you are eligible* to receive the state benefit due to your pregnancy, and (iii) you work in a location eligible for the Walmart short-term disability basic or enhanced plan	100% of your average weekly wage, reduced by any legally mandated benefits that are payable at the applicable state or local government rate, after an initial waiting period of 7 calendar days.	Additional benefits may be available through your state or local government and benefits may be payable under the short-term disability basic or enhanced plan, as described above.
If (i) you work in a state or locality with a legally mandated benefit, (ii) *you are eligible* to receive the state benefit due to your pregnancy, and (iii) you do not work in a location eligible for the Walmart short-term disability basic or enhanced plan	100% of your average weekly wage, reduced by any legally mandated benefits that are payable at the applicable state or local government rate, after an initial waiting period of 7 calendar days.	Additional benefits may be available through your state or local government.
If (i) you work in a state or locality with a legally mandated benefit, (ii) *you are not eligible* to receive the state or local government benefit due to your pregnancy, and (iii) you work in a location eligible for the Walmart short-term disability basic or enhanced plan	100% of your average weekly wage after an initial waiting period of 7 calendar days.	If you experience medical complications during pregnancy or postpartum, benefits may be payable under the short-term disability basic or enhanced plan, as described above.
If (i) you work in a state or locality with a legally mandated benefit, (ii) *you are not eligible* to receive the state or local government benefit due to your pregnancy, and (iii) you do not work in a location eligible for the Walmart short-term disability basic or enhanced plan	100% of your average weekly wage after an initial waiting period of 7 calendar days.	The Walmart short-term disability basic and enhanced plans are not available; maternity benefits end after the first 9 weeks of benefit payments.
Benefits are typically paid through Walmart payroll on a pay-period basis. However, there may be some instances during the claim process where payments could be issued outside the normal payroll cycle.		

[1] If you work in California, Colorado, Connecticut, Delaware, Hawaii, Maine, Massachusetts, Minnesota, New Jersey, New York, Oregon, Rhode Island, Washington, D.C., or Washington state, Sedgwick will estimate the legally mandated benefit available to you under the state-mandated programs, regardless of whether you have applied for the legally mandated benefits.

[2] You may be eligible for certain company-paid leave benefits, equal to 100% of your average weekly wage, following the birth, adoption, or foster-care placement of a child. You cannot receive these paid leave benefits while receiving short-term disability maternity benefits. For more information, refer to the corresponding paid leave policy on **One.Walmart.com/TimeAndSupport**.

Taxes and your short-term disability benefit

The taxation of benefits payable to you depends on whether you are enrolled in the short-term disability basic plan or enhanced plan. If you are enrolled in the short-term disability basic plan, benefits payable to you are subject to taxes. This is because you do not make contributions to the short-term disability basic plan, and you do not pay any tax on the coverage that Walmart provides. If you are enrolled in the short-term disability enhanced plan, 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's contribution and associate after-tax contributions. Walmart generally withholds federal, state, local, and Social Security taxes from the portion of your benefit that is taxable.

If you work in New York, please contact Lincoln for information regarding the taxation of your short-term disability plan basic or enhanced benefits. Associates in other states or localities with legally mandated benefits who are not eligible to participate in the short-term disability basic or enhanced plans should either contact Lincoln (if you work in Delaware, Hawaii or New Jersey) or the state or locality in which you are located for information about the tax status of state or local benefits.

The Plan Administrator cannot guarantee the specific tax consequences that will result from your receipt of benefits under a Walmart short-term disability plan. The Plan Administrator does not provide legal or tax advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Right to recover overpayment

The Plan has the right to recover from you, and you must repay, any amount overpaid to you for short-term disability benefits under a Walmart short-term disability plan. 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, Walmart will first deduct these amounts from future disability payments (if any). If there is a remaining amount due after any deductions from future disability payments, then Walmart may, in its discretion, deduct overpaid amounts from your pay, to the extent permitted by law. If you are enrolled in the short-term disability enhanced plan, your entire benefit may also become subject to taxes if you do not repay overpaid amounts in a timely manner.

Filing a short-term disability claim

If you become disabled, you should file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption in your wages, or the denial of your claim. The timing and the process you need to follow when filing a claim for short-term disability benefits depend on whether the short-term disability plan is available at your location (i.e., whether you are in a state or locality that provides legally mandated benefits). See the **Claim filing instructions** on the following page for information about filing your claim.

STEP 1: Contact Sedgwick to apply for a leave of absence. Regardless of the process you follow to file a short-term disability claim with the Plan, you will need to contact Sedgwick by going to **One.Walmart.com/TimeAndSupport > Leave of Absence** or by calling **800-492-5678** to apply for a leave of absence 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.

The leave of absence policy is not a benefit offered under, or administered as part of, the Plan and is not discussed here in detail. For specific details about the leave of absence policy, refer to **One.Walmart.com/TimeAndSupport**.

Note: The approval of a leave of absence under Walmart's leave of absence policy does not automatically mean your short-term disability claim is approved. See **When benefits begin** for details.

STEP 2: File a claim for short-term disability or legally mandated benefits. Your claim for short-term disability benefits cannot be fully processed until you have stopped working. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated.

Note: Your claim filing date is the date on which you submit your disability claim to Sedgwick. In order for Sedgwick to begin their review of your claim, you must have fully stopped working. If you file your claim prior to your first date of absence, Sedgwick will begin processing your claim as of your first date of absence. If you file your claim on or after your first date of absence, Sedgwick will begin their review as of your reported date.

See the chart on the following page for details on where and when to file your claim.

Claim filing instructions

Your state or locality may have unique filing periods, which could potentially exclude benefits for periods prior to the date of your benefits application. It is strongly advised that you promptly apply to your state or locality for any benefits that are mandated by law.

State or locality	Eligibility	Claim administrator	Filing instructions
California **Rhode Island**	Not eligible for Walmart short-term disability basic or enhanced Eligible for maternity, as a supplement to legally mandated benefits	State for legally mandated benefit Sedgwick for maternity	**California:** Go to **edd.ca.gov** or call **800-480-3287** for instructions **Rhode Island:** Go to **dlt.ri.gov/tdi** or call **401-462-8420** for instructions For maternity benefit, file a claim with Sedgwick within 90 days of the date your disability begins; you will need to provide the determination letter from the state with benefit details. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
Hawaii **New Jersey**	Not eligible for Walmart short-term disability basic or enhanced Eligible for maternity, as a supplement to legally mandated benefits	Lincoln Sedgwick for maternity	**Hawaii:** File a claim with Sedgwick within 90 days of the date your disability begins, and Sedgwick will forward to Lincoln. **New Jersey:** File a claim with Sedgwick within 30 days of the date your disability begins, and Sedgwick will forward to Lincoln. For maternity benefit, file a claim with 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.
Colorado **Connecticut** **Maine** **Massachusetts** **Minnesota** **Oregon** **Washington, D.C.** **Washington state**	Eligible for Walmart short-term disability plan as a supplement to legally mandated benefits	State or district for legally mandated benefit Sedgwick for supplemental benefits and maternity	**Colorado:** Go to **famli.colorado.gov** or call **866-263-2654** for instructions **Connecticut:** Go to **ctpaidleave.org** or call **877-499-8606** for instructions **Maine:** Go to **maine.gov/paidleave** or call **207-621-5024** for instructions **Massachusetts:** Go to **paidleave.mass.gov** or call **833-344-7365** for instructions **Minnesota:** Go to **paidleave.mn.gov** or call **844-556-0444** for instructions **Oregon:** Go to **paidleave.oregon.gov** or call **833-854-0166** for instructions **Washington, D.C.:** Go to **dcpaidfamilyleave.dc.gov** or call **202-899-3700** for instructions **Washington state:** Go to **paidleave.wa.gov** or call **833-717-2273** for instructions **Sedgwick:** File a claim with Sedgwick within 90 days of the date your disability begins; you will need to provide the determination letter from the state or district with state or district benefit details. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
Delaware **New York**	Eligible for Walmart short-term disability plan as a supplement to legally mandated benefits	Lincoln Sedgwick for supplemental benefits and maternity	File a claim with Sedgwick within 30 days of the date your disability begins and Sedgwick will forward to Lincoln. For maternity benefit, file a claim with 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.
All others	Eligible for Walmart short-term disability plan	Sedgwick	File a claim with 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 3: Let your doctor's office know it will be contacted for information. Tell your doctor's office that it will be contacted and asked to complete an attending physician's statement and provide objective 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
- Doctor visit notes

You must sign a form authorizing your doctor to release this information. (This release will be included in the initial packet that you receive from Sedgwick; however, if you are filing your claim online, an electronic signature is accepted.)

STEP 4: Follow up with your doctor to ensure that the requested information is forwarded to Sedgwick. Any delay in sending information to Sedgwick could result in a delay, or denial, in the processing of your claim and the payment of benefits.

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 claim is approved.

When short-term disability benefit payments end

If you are receiving short-term disability benefits under a Walmart short-term disability plan, your benefit payments will end on the earliest of:

- The date you no longer meet the short-term disability plan's definition of disabled
- The date you fail to furnish the 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 you to be examined
- The last day of the maximum period for which benefits are payable
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart
- The date of your death

If your short-term disability benefits end and you do not return to work for any reason, you must request an extension of your leave of absence (refer to the **Resources** chart at the beginning of the chapter for contact information). Failure to do so may result in your employment being terminated.

Benefits provided under a state or locally mandated program may have different end dates from Walmart's short-term disability plan.

Returning to work following a leave

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.

To ensure a smooth transition back to work and avoid a potential impact to your pay, you will need to contact Sedgwick **up to seven days prior to your actual return-to-work date**. If your return-to-work date changes, you should notify Sedgwick immediately. 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 your 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 and you are classified as a full-time associate on active status (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 as a full-time associate and are on active status for more than 30 calendar days and then become disabled from the same or a related condition, it will be considered a new disability, and you may be able to receive up to 25 weeks of benefits following your completion of a new seven-calendar-day benefit waiting period.

If you return as a full-time associate and are on active status for any number of calendar days and then become disabled from a new and unrelated condition, it will be considered a new disability, and you may qualify for up to 25 weeks of short-term disability benefits. A new benefit waiting period of seven calendar days will apply.

If you are on a leave of absence or experience a temporary layoff

If you are not on active status due to a leave of absence or temporary layoff, your eligibility for short-term disability benefits will continue for 90 days from the beginning of your leave or temporary layoff. Your eligibility for short-term disability coverage ends on the 91st day after the beginning of your leave of absence or temporary layoff but is reinstated to your prior coverage if you return to active work status within one year (you will not be required to satisfy the 12-month waiting period again). See **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter for more information, including details on paying for benefits while on leave.

Note: If your eligibility for short-term disability coverage ends because your leave of absence or temporary layoff exceeds 90 days, you remain eligible for short-term disability benefits for any illness or injury that occurred before the date your coverage ends.

When your short-term disability coverage ends

Your short-term disability basic plan and enhanced plan coverage ends on the earliest of:

- The date your employment terminates
- The last day of the pay period in which your job status changes from an eligible job status
- The date of your death
- The 91st day of a leave of absence or layoff (unless you return to work)
- The date the short-term disability benefit is no longer offered by Walmart

In addition, coverage under the short-term disability enhanced plan will end if you voluntarily drop your coverage. See the **Eligibility, enrollment, and effective dates** chapter for information.

If you pass away while receiving short-term disability benefits

Any short-term disability benefits that have accrued but remain unpaid as of the date of your death will be paid to the beneficiary designated under your company-paid life insurance. For details on how to designate a beneficiary and the rules that apply if you do not name a beneficiary, please refer to the **Naming a beneficiary** section of the **Company-paid life insurance** chapter.

If you leave Walmart and are rehired

If you are a full-time hourly associate, see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

Salaried short-term disability

Your short-term disability benefit	198
How salaried short-term disability is administered	198
When you qualify for benefits	198
When benefits are not paid	199
When benefits begin	200
Calculating your benefit	200
Filing a salaried short-term disability claim	202
Your pay after filing a claim	204
When short-term disability benefit payments end	204
Returning to work following a leave	204
If you are on a leave of absence or experience a temporary layoff	205
When your salaried short-term disability coverage ends	205
If you pass away while receiving short-term disability benefits	205
If you leave Walmart and are rehired	205

The information in this chapter describes short-term disability benefits that may be available to you if:

- You are an eligible salaried (management) associate (full-time OTR truck drivers: see next chapter), and
- You have met all requirements for coverage to be effective, including actively-at-work requirements.

For questions about eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

Salaried short-term disability

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 replace part of your pay.

Resources		
Find what you need	**Online**	**Other resources**
To request a leave, file a claim for benefits, or get more information	**One.Walmart.com/TimeAndSupport > Leave of Absence**	Call Sedgwick at **800-492-5678**
If you work in one of the states or localities listed below, file a claim with Sedgwick in addition to filing with your state or locality.		
Colorado	**famli.colorado.gov**	Call **866-263-2654**
Connecticut	**ctpaidleave.org**	Call **877-499-8606**
Maine	**maine.gov/paidleave**	Call **207-621-5024**
Massachusetts	**paidleave.mass.gov**	Call **833-344-7365**
Minnesota	**paidleave.mn.gov**	Call **844-556-0444**
Oregon	**paidleave.oregon.gov**	Call **833-854-0166**
Washington, D.C.	**dcpaidfamilyleave.dc.gov**	Call **202-899-3700**
Washington state	**paidleave.wa.gov**	Call **833-717-2273**
If you work in Delaware, file a claim with Sedgwick, which will manage your leave and notify Lincoln of your claim.		

What you need to know about salaried short-term disability

- This chapter describes disability benefits available to you under the short-term disability plan.
- For maternity benefit information, see the **Maternity benefit** section later in this chapter.
- The salaried short-term disability plan replaces 100% of your base pay for up to six weeks after a waiting period of seven calendar days and 75% of your base pay for up to 19 additional weeks. (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 your disability is due to pregnancy, the short-term disability plan replaces 100% of your base pay for up to nine weeks after a waiting period of seven calendar days. Additional benefits may be payable after the first nine weeks of benefits if you experience medical complications during pregnancy or postpartum. For details, see **Maternity benefit** later in this chapter.
- Some states and localities provide legally mandated benefits. Variations in laws and administrative procedures may affect your eligibility to participate in a Walmart short-term disability plan, as well as the amount of any disability benefits as described in the **Legally mandated benefits** chart in this chapter.

Your short-term disability benefit

If you become disabled as defined in the **When you qualify for benefits** section later in this chapter and are 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 benefits, 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, the salaried short-term disability plan pays a maternity benefit of 100% of your base pay for up to the first nine weeks, after an initial waiting period of seven calendar days. If you are eligible for legally mandated short-term disability benefits, the maternity benefit supplements your state benefits. The combined total of the maternity benefit available to you under the short-term disability plan and the maternity benefit available to you under any state or locally mandated program will not exceed 100% of your average weekly wage for nine weeks. If you remain disabled and eligible for benefits after the first nine weeks of short-term disability benefits, the salaried short-term disability plan will pay 75% of your base pay for up to an additional 16 weeks (for a total of up to 25 weeks). See **Maternity benefit** later in this chapter for more information.

How salaried short-term disability is administered

The salaried short-term disability plan is provided by Walmart at no cost to you. The salaried short-term disability plan is self-insured. This means no insurance company collects premiums and pays benefits. Walmart currently funds benefits under the salaried short-term disability plan from Walmart's general assets.

The salaried short-term disability plan is administered by Sedgwick Claims Management Services, Inc. (Sedgwick). The Plan Administrator has delegated the fiduciary authority for determining claims for benefits and related appeals to Sedgwick.

Legally mandated benefits

Short-term disability benefits provided by individual states and local governments generally have no impact on your eligibility for the salaried short-term disability plan, unless you work in Colorado, Connecticut, Delaware, Maine, Massachusetts, Minnesota, New Jersey, Oregon, Washington, D.C., or Washington state. Rules applicable to these state and local programs can be found in the chart below.

When you qualify for benefits

To be eligible to receive short-term disability benefits, you must meet the following requirements:

- Your coverage must be effective.
- Your disability must have occurred on or after the effective date of your coverage.
- You must be on active status on the date of your disability unless:
  - You are on leave of absence or layoff as described later in this chapter under **If you are on a leave of absence or experience a temporary layoff**, or
  - You are unable to work because you have experienced medical complications during pregnancy or postpartum and have exhausted the nine-week short-term disability plan maternity benefit, as described later in this chapter under **Maternity benefit**

Legally mandated benefits	
If you are a salaried associate who works in Colorado, Connecticut, Delaware, Maine, Massachusetts, Minnesota, New Jersey, Oregon, Washington, D.C., or Washington state	You are eligible to participate in the Walmart salaried short-term disability plan to supplement your state benefits. The amount of the benefit under the 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. If the benefit available to you under any state or locally mandated program is less than the benefit available to you under the Walmart short-term disability plan, the combined total of the benefit available to you under the Walmart short-term disability plan and the benefit available to you under any state or locally mandated program will not exceed the benefits that would have been available under the Walmart short-term disability plan if you had not worked in a state or locality with a legally mandated plan. You will be required to provide your determination 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 salaried short-term disability plan than you were entitled to, you will be paid the difference in a lump sum payment. If Sedgwick underestimated what your mandated benefit would be, meaning that you were paid more under the salaried short-term disability plan than you were entitled to, you must repay any amount overpaid to you. See the **Right to recover overpayment** section later in this chapter.

- Except as otherwise provided in the **Maternity benefit** section in this chapter, you must submit objective medical evidence provided by a qualified doctor that you are disabled as defined on this page (for purposes of this chapter, the term "doctor" includes 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 would be eligible for reimbursement if submitted for reimbursement under the Associates' Medical Plan).
- You must receive approval by Sedgwick of your claim.

Disability 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. Loss of license by itself is not sufficient for meeting the definition of disability.

If you are employed as a pilot, copilot, or crewmember of an aircraft, "disability" or "disabled" means that, as a result of a mental or physical illness or injury, you are unable to perform the material and substantial duties of your own occupation under the applicable Federal Aviation Administration fitness standards.

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.

If your disability is caused by a mental illness or substance use disorder, you are encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, licensed counselor, drug and alcohol counselor, or clinical social worker who specializes in mental health and/or substance use disorders and is licensed pursuant to state law. See the **Associate assistance resources** chapter for information on resources that are available if you are experiencing the effects of a mental illness or substance use disorder.

Sedgwick may require written proof of your disability, as described later in this chapter, or additional information before making a decision on your claim. A statement by your doctor that you are unable to work does not by itself prove that you are disabled.

Approval of a leave of absence also does not constitute approval for short-term disability benefits.

Except as otherwise provided in the **Maternity benefit** section, for purposes of benefits provided under the short-term disability plan, "disabled" or "disability" means that (i) 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, and (ii) you are under the continuous care of a qualified doctor and are following the course of treatment prescribed by your doctor. This includes taking medication as prescribed, and/or a series of ongoing services or appointments provided by your doctor over a period of time. A single appointment where no medication is prescribed or no follow-up appointments or actions are recommended is not a course of treatment.

If Sedgwick requests that you be examined by an independent doctor, you must attend the exam to be considered for benefits. Walmart will pay the cost of any such examination.

The maximum length of any one period of disability during which disability benefits are paid, even if the disability is the result of more than one cause, is 25 weeks, after the initial waiting period of seven calendar days. See also **If you return to work and become disabled again**.

See the **Maternity benefit** section of this chapter for additional details regarding the maternity benefit.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that:

- Arose before your coverage became effective
- Is not under the continuous care of and being treated by a qualified doctor
- Is caused by taking part in an insurrection, rebellion, riot, or civil disorder
- Resulted from your commission of or attempt to commit a crime (e.g., assault, battery, felony, or any illegal occupation or activity)
- Resulted from doing any work for pay or profit that is related to work outside of Walmart

When benefits begin

If your short-term disability claim is approved, the benefit will begin after a waiting period of seven calendar days, on the eighth calendar day after your disability begins. If your claim for short-term disability benefits is retroactively approved, any benefit payments that would have otherwise been paid to you while your claim decision was pending will be made to you in a lump sum payment when approved. Short-term disability benefits are only paid through Walmart payroll in the same way that your base pay is paid to you; other forms or methods of payment are not permitted.

For your pay to continue during the initial waiting period of seven calendar days, you may use paid time off. Short-term disability benefits begin on the eighth calendar day after your eligible disability begins. You should not use paid time off beyond the initial seven-day waiting period, unless allowed by state law, while a claim decision is pending or for any period during which short-term disability benefits are approved (see **Your pay after filing a claim** later in this chapter for information regarding provisional pay that may apply after your initial waiting period of seven calendar days). If you are later found to be ineligible for short-term disability benefits, you may go back and use paid time off for any time that was unpaid, subject to the terms of the paid time off policy. You may be required to repay any paid time off used for days when disability benefits were received. Upon repayment, any paid time off balance will be restored.

The paid time off policy is not a benefit offered under, or administered as part of, the Plan. For specific details about the paid time off policy, refer to **One.Walmart.com/TimeAndSupport**.

Calculating your benefit

The amount of your short-term disability benefit is based on:

- Your base pay, as defined below, as of your last day worked
- 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 salary
Non-exempt associates	Hourly rate multiplied by normal hours scheduled per 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 per pay period. Disability benefits begin on the 8th calendar day. You may use paid time off during your first 7 calendar days of continuous disability.	After an initial waiting period of 7 calendar days, 100% of your base pay per pay period. Workers' compensation benefits are payable at the applicable state rate; short-term disability benefits make up the difference up to 100% of your base pay per pay period. Example: If your base pay per pay period is $1,000 and workers' compensation pays 66% for your disability, or $660, short-term disability will pay an additional $340, for a total benefit of $1,000.
More than 7 weeks, up to 26 weeks	75% of your base pay per pay period. For example, if your base pay per pay period (as defined above) is $1,000, 75% of $1,000 is a $750 benefit. Short-term benefits are paid through Walmart payroll on a pay-period basis.	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 per pay period. Example: If your base pay per pay period 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.)
If a benefit is payable for less than a week, your disability benefit will be based on your base pay divided by your regular work schedule for each day you are disabled. 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 paid time off for the absences.		
Note: For associates who are eligible for legally mandated benefits (as noted in **Legally mandated benefits** 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 Sedgwick estimates that you will receive.		

Workers' compensation and your short-term disability benefits

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 salaried short-term disability plan are as described here:

<table>
<tr><th colspan="3">Maternity benefit</th></tr>
<tr><th>Duration of benefit</th><th>Your benefit is:</th><th>If you are eligible for legally mandated benefits in Colorado; Connecticut; Delaware; Maine; Massachusetts; Minnesota; New Jersey; Oregon; Washington, D.C.; and Washington state:</th></tr>
<tr><td rowspan="2">Up to 9 weeks[1]</td><td>100% of your base pay after an initial waiting period of 7 calendar days.</td><td>Legally mandated benefits are payable at the applicable state or local government rate; the Walmart salaried short-term disability maternity benefit will be reduced by any legally mandated benefits that you are eligible for.</td></tr>
<tr><td colspan="2">Maternity benefits under the salaried short-term disability plan begin on the 8th calendar day after your eligible disability begins. You may use paid time off during your first 7 calendar days of continuous disability. Benefits are paid through Walmart payroll on a pay-period basis.</td></tr>
<tr><td colspan="3">[1] You may be eligible for certain company-paid leave benefits, equal to 100% of your base pay, following the birth, adoption, or foster-care placement of a child. You cannot receive these paid leave benefits while receiving short-term disability maternity benefits. For more information, refer to the corresponding paid leave policy on One.Walmart.com/TimeAndSupport.</td></tr>
<tr><td colspan="3">Note: For associates who are eligible for legally mandated benefits (as noted in Legally mandated benefits earlier in this chapter) as well as benefits under the salaried short-term disability plan, the amount of the benefit under the salaried short-term disability plan will be reduced by the amount of the legally mandated benefit, regardless of whether you have applied for the legally mandated benefit.</td></tr>
</table>

See the **When you qualify for benefits** section for general requirements applicable to all disability benefits under the short-term disability plan, including the maternity benefit. There are some exceptions to those general rules that apply to the maternity benefit. Those exceptions are discussed in this section. See also the **Legally mandated benefits** chart earlier in this section.

The maternity benefit is 100% of your base pay for up to the first nine weeks of leave, after an initial waiting period of seven calendar days. Disability benefits begin on the eighth calendar day after your disability begins.

If your disability is due to pregnancy, the date of your disability is generally on or up to two weeks prior to your expected date of delivery. If you begin your short-term disability leave during this time frame, you will be deemed to meet the definition of disability for purposes of the maternity benefit. If you begin your leave more than two weeks prior to your expected delivery date, you will be required to provide objective medical evidence to demonstrate you are disabled, as defined in the **When you qualify for benefits** section. If you are disabled, as defined in that section, you will begin your short-term disability maternity benefit on the date you are determined to be disabled. In no event will the maternity benefit exceed nine weeks.

If you begin your short-term disability leave after your delivery date, you must meet the salaried short-term disability plan's definition of disabled, as stated in the **When you qualify for benefits** section. In that case, any disability benefit will be subject to rules applicable to non-maternity disability benefits. To the extent you are eligible for a disability benefit, that benefit would be determined under the rules applicable to non-maternity short-term disability. You will not be eligible for the maternity benefit described in this section.

If you experience medical complications during pregnancy or postpartum and continue to meet the definition of disabled after an initial unpaid waiting period of seven calendar days and the first nine weeks of paid benefits, the salaried short-term disability plan will provide disability benefits of 75% of your base pay starting with week 10, up to 25 weeks of benefit payments.

If you return to work before receiving your full maternity benefit and then go on leave again, you will not be able to resume your maternity benefit unless you provide objective medical evidence to Sedgwick to support a determination that you meet the definition of disability. If no medical evidence is provided, the remainder of the maternity benefit is forfeited.

Note: For associates in states or localities with legally mandated benefits, please refer to the **Legally mandated benefits** chart earlier in this chapter for information about coordination of benefits.

Taxes and your short-term disability benefit

Benefits payable to you under the 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 and you do not pay any tax on the coverage that Walmart provides, 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 Plan Administrator cannot guarantee the specific tax consequences that will result from your receipt of benefits under Walmart's short-term disability plan. The Plan Administrator is not providing legal or tax advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Right to recover overpayment

The Plan has the right to recover from you, and you must repay, any amount overpaid to you for short-term disability benefits under the salaried short-term disability plan. 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, Walmart will first deduct such amounts from future disability payments (if any). If there is a remaining amount due after any deductions from future disability payments, then Walmart may, in its discretion, deduct overpaid amounts from your pay, to the extent permitted by law.

Filing a salaried short-term disability claim

If you become disabled, you should file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption in your wages, or the denial of your claim. The timing and the process you need to follow when filing a claim for short-term disability benefits depend on whether the short-term disability plan is available at your location (i.e., whether you are in a state or locality that provides legally mandated benefits). See the **Claim filing instructions** chart on the next page for information about filing your claim.

STEP 1: Contact Sedgwick to apply for a leave of absence. Regardless of the process you follow to file a short-term disability claim with the Plan, you will need to contact Sedgwick by going to **One.Walmart.com/TimeAndSupport > Leave of Absence** or by calling **800-492-5678** to apply for a leave of absence 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.

The leave of absence policy is not a benefit offered under, or administered as part of, the Plan and is not discussed here in detail. For specific details about the leave of absence policy refer to **One.Walmart.com/TimeAndSupport**.

Note: The approval of a leave of absence under Walmart's leave of absence policy does not automatically mean your short-term disability claim is approved. See **When benefits begin** for details.

STEP 2: File a claim for short-term disability or legally mandated benefits. Your claim for short-term disability benefits cannot be fully processed until you have stopped working. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated.

Note: Your claim filing date is the date on which you submit your disability claim to Sedgwick. In order for Sedgwick to begin their review of your claim, you must have fully stopped working. If you file your claim prior to your first date of absence, Sedgwick will begin processing your claim as of your first date of absence. If you file your claim on or after your first date of absence, Sedgwick will begin their review as of your reported date.

See the chart on the next page for details on where and when to file your claim.

Claim filing instructions			
Your state or locality may have unique filing periods, which could potentially exclude benefits for periods prior to the date of your benefits application. It is strongly advised that you promptly apply to your state or locality for any benefits that are mandated by law.			
State or locality	**Eligibility**	**Claim administrator**	**Filing instructions**
Colorado **Connecticut** **Delaware** **Maine** **Massachusetts** **Minnesota** **New Jersey** **Oregon** **Washington, D.C.** **Washington state**	Eligible for Walmart short-term disability plan as a supplement to legally mandated benefits	State or district for legally mandated benefit Sedgwick for supplemental benefits and maternity	**Colorado:** Go to **famli.colorado.gov** or call **866-263-2654** for instructions **Connecticut:** Go to **ctpaidleave.org** or call **877-499-8606** for instructions **Delaware:** File a claim with Sedgwick, which will file a state claim on your behalf **Maine:** Go to **maine.gov/paidleave** or call **207-621-5024** for instructions **Massachusetts:** Go to **paidleave.mass.gov** or call **833-344-7365** for instructions **Minnesota:** Go to **paidleave.mn.gov** or call **844-536-0444** for instructions **New Jersey:** File a claim with Sedgwick, which will file a state claim on your behalf **Oregon:** Go to **paidleave.oregon.gov** or call **833-854-0166** for instructions **Washington, D.C.:** Go to **dcpaidfamilyleave.dc.gov** or call **202-899-3700** for instructions **Washington state:** Go to **paidleave.wa.gov** or call **833-717-2273** for instructions **Sedgwick:** File a claim with Sedgwick within 90 days of the date your disability begins; you will need to provide the determination letter from the state or district with state or district benefit details. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
All others	Eligible for Walmart short-term disability plan	Sedgwick	File a claim with 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 3: Let your doctor's office know it will be contacted for information. Tell your doctor's office that it will be contacted and asked to complete an attending physician's statement and provide objective 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
- Doctor visit notes

You must sign a form authorizing your doctor to release this information. (This release will be included in the initial packet that you receive from Sedgwick; however, if you are filing your claim online, an electronic signature is accepted.)

STEP 4: Follow up with your doctor to ensure that the requested information is forwarded to Sedgwick. Any delay in sending information to Sedgwick could result in a delay, or denial, in the processing of your claim and the payment of benefits.

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 claim is approved.

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. In order for your pay to continue during the initial waiting period of seven calendar days, you may use paid time off. Following your initial waiting period of seven calendar days, 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 received and/or your claim has not been approved.

If your claim is approved, the approval will be effective as of the date of your disability, and the provisional pay you received after your seven-day waiting period and while your claim was pending will count toward your disability benefit.

If your claim is denied before the Medical Due Date because you are not disabled, as defined by the salaried short-term disability plan, your provisional pay will be stopped and Walmart will commence efforts to recover the provisional pay that was paid to you while your claim was pending.

You will not receive provisional pay during any period when a determination is being made regarding a relapse/recurrent claim (see **If you return to work and become disabled again** on this page).

For specific details about the paid time off policy, refer to **One.Walmart.com**.

When short-term disability benefit payments end

If you are receiving short-term disability benefit payments from the salaried short-term disability plan, your benefit payments will end on the earliest of:

- The date you no longer meet the short-term disability plan's definition of disabled
- The date you fail to furnish the 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 you to be examined
- The last day of the maximum period for which benefits are payable
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart
- The date of your death

If your short-term disability benefits end and you do not return to work for any reason, you must request an extension of your leave (refer to the **Resources** chart at the beginning of the chapter for contact information). Failure to do so may result in your employment being terminated.

Benefits provided under a state or locally mandated program may have different end dates from the salaried short-term disability plan.

Returning to work following a leave

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.

To ensure a smooth transition back to work and avoid a potential impact to your pay, you will need to contact Sedgwick **up to seven days prior to your actual return-to-work date.** If your return-to-work date changes, you should notify Sedgwick immediately. 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 your 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 and you are classified as a management associate on active status (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 of seven calendar days. The combined benefit duration for both periods of disability will not exceed 25 weeks.

If you have returned as a management associate and are on active status 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, following your completion of a new seven-calendar-day waiting period.

If you return as a management associate and are on active status for any number of calendar days and then become disabled from a new and unrelated condition, it will be considered a new disability, and you may qualify for up to 25 weeks of short-term disability 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 paid time off for the absences.

If you are on a leave of absence or experience a temporary layoff

If you are not on active status due to a leave of absence or temporary layoff, your eligibility for short-term disability benefits will continue for 90 days from the beginning of your leave or temporary layoff. Your eligibility for short-term disability coverage ends on the 91st day after the beginning of your leave of absence or temporary layoff but is reinstated if you return to work within one year. See **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter for more information, including details on paying for benefits while on leave.

Note: If your eligibility for short-term disability coverage ends because your leave of absence or temporary layoff exceeds 90 days, you remain eligible for short-term disability benefits for any illness or injury that occurred before the date your coverage ends.

When your salaried short-term disability coverage ends

Your short-term disability coverage ends on the earliest of:

- The date your employment terminates
- The last day of the pay period in which your job status changes from an eligible job status
- The date of your death
- The 91st day of a leave of absence or layoff (unless you return to work)
- The date the benefit is no longer offered by Walmart

If you pass away while receiving short-term disability benefits

Any short-term disability benefits that have accrued but remain unpaid as of the date of your death will be paid to the beneficiary designated under your company-paid life insurance. For details on how to designate a beneficiary and the rules that apply if you do not name a beneficiary, please refer to the **Naming a beneficiary** section of the **Company-paid life insurance** chapter.

If you leave Walmart and are rehired

If you leave Walmart and return to work for Walmart as a salaried associate, you will automatically be reenrolled in the salaried short-term disability plan.

Truck driver short-term disability

Your short-term disability benefit	208
How truck driver short-term disability is administered	208
When you qualify for benefits	209
When benefits are not paid	209
When benefits begin	210
Calculating your benefit	210
Filing a truck driver short-term disability claim	212
Your pay after filing a claim	213
When short-term disability benefit payments end	214
Returning to work following a leave	214
If you are on a leave of absence or experience a temporary layoff	215
When your truck driver short-term disability coverage ends	215
If you pass away while receiving short-term disability benefits	215
If you leave Walmart and are rehired	215

The information in this chapter describes short-term disability benefits that may be available to you if:

- You are a full-time OTR truck driver associate, and
- You have met all requirements for coverage to be effective, including actively-at-work requirements.

For questions about eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

Truck driver short-term disability

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 OTR truck drivers can replace part of your pay.

Resources		
Find what you need	**Online**	**Other resources**
To request a leave, file a claim for benefits, or get more information	**One.Walmart.com/TimeAndSupport > Leave of Absence**	Call Sedgwick at **800-492-5678**
If you work in one of the states or localities listed below, file a claim with Sedgwick in addition to filing with your state or locality.		
Colorado	**famli.colorado.gov**	Call **866-263-2654**
Connecticut	**ctpaidleave.org**	Call **877-499-8606**
Maine	**maine.gov/paidleave**	Call **207-621-5024**
Massachusetts	**paidleave.mass.gov**	Call **833-344-7365**
Minnesota	**paidleave.mn.gov**	Call **844-556-0444**
Oregon	**paidleave.oregon.gov**	Call **833-854-0166**
Washington, D.C.	**dcpaidfamilyleave.dc.gov**	Call **202-899-3700**
Washington state	**paidleave.wa.gov**	Call **833-717-2273**
If you work in Delaware, file a claim with Sedgwick, which will file a state claim on your behalf.		

What you need to know about truck driver short-term disability

- This chapter describes disability benefits available to you under the short-term disability plan.
- For maternity benefit information, see the **Maternity benefit** section.
- 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. (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, the short-term disability plan replaces 100% of your average day's pay for up to nine weeks. Additional benefits may be payable after the first nine weeks of benefits if you experience medical complications during pregnancy or postpartum. For details, see **Maternity benefit** later in this chapter.
- Some states and localities provide legally mandated benefits. Variations in laws and administrative procedures may affect your eligibility to participate in a Walmart short-term disability plan, as well as the amount of any disability benefits as described in the **Legally mandated benefits** chart in this chapter.

Your short-term disability benefit

If you become disabled as defined in the **When you qualify for benefits** section later in this chapter, and are 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 workday after your 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, the truck driver short-term disability plan pays a maternity benefit of 100% of your average day's pay for up to the first nine weeks, after an initial waiting period of seven calendar days. The waiting period begins on your next scheduled workday after your disability begins. If you are eligible for legally mandated short-term disability benefits, the maternity benefit supplements your state benefits. The combined total of the maternity benefit available to you under the short-term disability plan and the maternity benefit available to you under any state or locally mandated program will not exceed 75% of your base pay for nine weeks. If you remain disabled and eligible for benefits after the first nine weeks of short-term disability benefits, the truck driver short-term disability plan will pay 75% of your base pay for up to an additional 16 weeks (for a total of up to 25 weeks of benefit payments). See **Maternity benefit** later in this chapter for more information.

How truck driver short-term disability is administered

The truck driver short-term disability plan is provided by Walmart at no cost to you. The truck driver short-term disability plan is self-insured. This means no insurance company collects premiums and pays benefits. Walmart currently funds benefits under the truck driver short-term disability plan from Walmart's general assets.

The truck driver short-term disability plan is administered by Sedgwick Claims Management Services, Inc. (Sedgwick). The Plan Administrator has delegated the fiduciary authority for determining claims for benefits and related appeals to Sedgwick.

Legally mandated benefits

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, unless you are an associate who works in Colorado, Connecticut, Delaware, Maine, Massachusetts, Minnesota, New Jersey, Oregon, Washington, D.C., or Washington state. Rules applicable to these state and local plans can be found in the following chart.

Legally mandated benefits	
If you are an associate who works in Colorado, Connecticut, Delaware, Maine, Massachusetts, Minnesota, New Jersey, Oregon, Washington, D.C., or Washington state	You are eligible to participate in the truck driver short-term disability plan to supplement your state benefits. The amount of the benefit under the truck driver 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. If the benefit available to you under any state or locally mandated program is less than the benefit available to you under a Walmart short-term disability plan, the combined total of the benefit available to you under a Walmart short-term disability plan and the benefit available to you under any state or locally mandated program will not exceed the benefits that would have been available under the short-term disability plan if you had not worked in a state with a legally mandated program. You are responsible for providing your determination 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 truck driver short-term disability plan than you were entitled to, you will be paid the difference in a lump sum payment. If Sedgwick underestimated what your mandated benefit would be, meaning that you were paid more under the truck driver short-term disability plan than you were entitled to, you must repay any amount overpaid to you. See the **Right to recover overpayment** section later in this chapter.

When you qualify for benefits

To be eligible to receive short-term disability benefits, you must meet the following requirements:

- Your coverage must be effective.
- Your disability must have occurred on or after the effective date of your coverage.
- You must be on active status on the date of your disability unless:
  - You are on leave of absence or layoff as described later in this chapter under **If you are on a leave of absence or experience a temporary layoff**, or
  - You are unable to work because you have experienced medical complications during pregnancy or postpartum and have exhausted the nine-week short-term disability plan maternity benefit, as described later in this chapter under **Maternity benefit**
- Except as otherwise provided in the **Maternity benefit** section, you must submit objective medical evidence provided by a qualified doctor that you are disabled as defined below (for purposes of this chapter, the term "doctor" includes 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 would be eligible for reimbursement under the Associates' Medical Plan).
- You must receive approval by Sedgwick of your claim.

Sedgwick may require written proof of your disability, as defined later in this chapter, or additional information before making a decision on your claim. A statement by your doctor that you are unable to work does not by itself prove that you are disabled. Approval of a leave of absence also does not constitute approval for short-term disability benefits.

Except as otherwise provided in the **Maternity benefit** section, for purposes of benefits provided under the truck driver short-term disability plan, "disabled" or "disability" means that (i) 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, in accordance with the Federal Motor Carrier Safety Administration regulations, or pregnancy, and (ii) you are under the continuous care of a qualified doctor and are following the course of treatment prescribed by your doctor. This includes taking medication as prescribed, and/or a series of ongoing services or appointments provided by your doctor over a period of time. A single appointment where no medication is prescribed or no follow-up appointments or actions are recommended is not a course of treatment.



Disability 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. Loss of license by itself is not sufficient for meeting the definition of disability. 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.

If your disability is caused by a mental illness or substance use disorder, you are encouraged to seek treatment within 30 days from the first date of absence from a psychologist, psychiatrist, licensed counselor, drug and alcohol counselor, or clinical social worker who specializes in mental health and/or substance use disorders and is licensed pursuant to state law. See the **Associate assistance resources** chapter for information on resources that are available if you are experiencing the effects of a mental illness or substance use disorder.

If Sedgwick requests that you be examined by an independent doctor, you must attend the exam to be considered for benefits. Walmart will pay the cost of any such examination.

The maximum length of any one period of disability during which disability benefits are paid, even if the disability is the result of more than one cause, is 25 weeks, after the initial waiting period of seven calendar days. See also **If you return to work and become disabled again**.

See the **Maternity benefit** section for additional details regarding the maternity benefit.

When benefits are not paid

Short-term disability benefits will not be paid for an illness or injury that:

- Arose before your coverage became effective
- Is not under the continuous care of and being treated by a qualified doctor
- Is caused by taking part in an insurrection, rebellion, riot, or civil disorder

- Resulted from your commission of or attempt to commit a crime (e.g., assault, battery, felony, or any illegal occupation or activity)
- Resulted from doing any work for pay or profit that is related to work outside of Walmart

When benefits begin

If your short-term disability claim is approved, the benefit will begin after a waiting period of seven calendar days. The waiting period begins on your next scheduled workday after your disability begins. If your claim for short-term disability benefits is retroactively approved, any benefit payments that would have otherwise been paid to you while your claim decision was pending will be made to you in a lump sum payment when approved. Short-term disability benefits are only paid through Walmart payroll in the same way that your average daily pay is paid to you; other forms or methods of payment are not permitted.

For your pay to continue during the initial waiting period of seven calendar days, you may use paid time off. Short-term disability benefits begin on the eighth calendar day after your eligible disability begins. You should not use paid time off beyond the initial seven-day waiting period while a claim decision is pending or for any period during which short-term disability benefits are approved, unless allowed by state law (see **Your pay after filing a claim** later in this chapter for information regarding provisional pay that may apply after your initial waiting period of seven calendar days). If you are later found to be ineligible for short-term disability benefits, you may go back and use paid time off for any time that was unpaid, subject to the terms of the paid time off policy. You may be required to repay any paid time off used for days when disability benefits were received. Upon repayment, any paid time off balance will be restored.

The paid time off policy is not a benefit offered under, or administered as part of, the Plan. For specific details about the paid time off policy, refer to **One.Walmart.com**.

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
- The duration of your disability

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 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.

If you become disabled and are eligible to receive short-term disability benefits, the truck driver short-term disability plan pays benefits as described below.

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 paid time off 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. Short-term benefits are paid through Walmart payroll on a pay-period basis.	After an initial waiting period of 7 calendar days, up to 75% of your average day's pay per pay period. Workers' compensation benefits are payable at the applicable state rate; short-term disability benefits make up the difference up to 75% of your average day's pay. Example: If your average day's 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.) Short-term disability benefits are paid through Walmart payroll on a pay-period basis, while workers' compensation is paid through a separate check except in the states of Texas and Wyoming, where the entire benefit is included in the payment you receive from Walmart.
If a benefit is payable for less than a week, your disability benefit will be based on 75% of your average day's pay multiplied by your regular workdays scheduled for each day you are disabled. 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.		
Note: For associates who are eligible for legally mandated benefits (as noted in **Legally mandated benefits** earlier in this chapter) as well as benefits under the truck driver short-term disability plan, the amount of the benefit under the truck driver short-term disability plan will be reduced by the amount of the legally mandated benefit Sedgwick estimates that they will receive.		

Workers' compensation and your short-term disability benefits

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 Colorado; Connecticut; Delaware; Maine; Massachusetts; Minnesota; New Jersey; Oregon; Washington, D.C.; and Washington state:**
Up to 9 weeks[1]	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 be reduced by any legally mandated benefits that you are eligible for.
	Maternity benefits under the truck driver short-term disability plan begin on the 8th calendar day after your eligible disability begins. You may use paid time off during your first 7 calendar days of continuous disability. Benefits are paid through Walmart payroll on a pay-period basis.	
[1] You may be eligible for certain company-paid leave benefits, equal to 100% of your average day's pay, following the birth, adoption, or foster-care placement of a child. You cannot receive these paid leave benefits while receiving short-term disability maternity benefits. For more information, refer to the corresponding paid leave policy on **One.Walmart.com**.		
Note: For associates who are eligible for legally mandated benefits (as noted in **Legally mandated benefits** earlier in this chapter) as well as benefits under the truck driver short-term disability plan, the amount of the benefit under the truck driver short-term disability plan will be reduced by the amount of the legally mandated benefit, regardless of whether you have applied for the legally mandated benefits.		

See the **When you qualify for benefits** section for general requirements applicable to all disability benefits under the truck driver short-term disability plan, including the maternity benefit. There are some exceptions to those general rules that apply to the maternity benefit. Those exceptions are discussed in this section. See also the **Legally mandated benefits** chart earlier in this section.

The maternity benefit is 100% of your average day's pay for up to the first nine weeks of leave, after an initial waiting period of seven calendar days. Disability benefits begin on the eighth calendar day after your disability begins.

If your disability is due to pregnancy, the date of your disability is generally on or up to two weeks prior to your expected date of delivery. If you begin your short-term disability leave during this time frame, you will be deemed to meet the definition of disability for purposes of the maternity benefit. If you begin your leave more than two weeks prior to your expected delivery date, you will be required to provide objective medical evidence to demonstrate you are disabled, as defined in the **When you qualify for benefits** section. If you are disabled, as defined in that section, you will begin your short-term disability maternity benefit on the date you are determined to be disabled. In no event will the maternity benefit exceed nine weeks.

If you begin your short-term disability leave after your delivery date, you must meet the truck driver short-term disability plan's definition of disabled, as stated in the **When you qualify for benefits** section. In that case, any disability benefit will be subject to rules applicable to non-maternity disability benefits.

If you experience medical complications during pregnancy or postpartum and continue to meet the definition of disabled after an initial unpaid waiting period of seven calendar days and the first nine weeks of paid benefits, the truck driver short-term disability plan will provide disability benefits of 75% of your average day's pay, starting with week 10, up to 25 weeks of benefit payments.

If you return to work before receiving your full maternity benefit and then go on leave again, you will not be able to resume your maternity benefit unless you provide objective medical evidence to Sedgwick to support a determination that you meet the definition of disability. If no medical evidence is provided, the remainder of the maternity benefit is forfeited.

Note: For associates in states or localities with legally mandated benefits, please refer to the **Legally mandated benefits** chart earlier in this chapter for coordination of benefits.

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, and you do not pay any tax on the coverage that Walmart provides, 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 Plan Administrator cannot guarantee the specific tax consequences that will result from your receipt of benefits under the truck driver short-term disability plan. The Plan Administrator is not providing legal or tax advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Right to recover overpayment

Walmart has the right to recover from you, and you must repay, any amount overpaid to you for short-term disability benefits under the truck driver short-term disability plan. 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, Walmart will first deduct such amounts from future disability payments (if any). If there is a remaining amount due after any deductions from future disability payments, then Walmart may, in its discretion, deduct overpaid amounts from your pay, to the extent permitted by law.

Filing a truck driver short-term disability claim

If you become disabled, you should file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption in your wages, or the denial of your claim. The timing and the process you need to follow when filing a claim for short-term disability benefits depend on whether the short-term disability plan is available at your location (i.e., whether you are in a state or locality that provides legally mandated benefits). See **Claim filing instructions** below for information about filing your claim.

STEP 1: Contact Sedgwick to apply for a leave of absence. Regardless of the process you follow to file a short-term disability claim with the Plan, you will need to contact Sedgwick by going to **One.Walmart.com/TimeAndSupport > Leave of Absence** or by calling **800-492-5678** to apply for a leave of absence 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.

The leave of absence policy is not a benefit offered under, or administered as part of, the Plan and is not discussed here in detail. For specific details about the leave of absence policy, refer to **One.Walmart.com**.

Note: The approval of a leave of absence under Walmart's leave of absence policy does not automatically mean your short-term disability claim is approved. See **When benefits begin** for details.

STEP 2: File a claim for short-term disability or legally mandated benefits. Your claim for short-term disability benefits cannot be fully processed until you have stopped working. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated.

Note: Your claim filing date is the date on which you submit your disability claim to Sedgwick. In order for Sedgwick to begin their review of your claim, you must have fully stopped working. If you file your claim prior to your first date of absence, Sedgwick will begin processing your claim as of your first date of absence. If you file your claim on or after your first date of absence, Sedgwick will begin their review as of your reported date.

See the chart below for details on where and when to file your claim.

Claim filing instructions			
Your state or locality may have unique filing periods, which could potentially exclude benefits for periods prior to the date of your benefits application. It is strongly advised that you promptly apply to your state or locality for any benefits that are mandated by law.			
State or locality	**Eligibility**	**Claim administrator**	**Filing instructions**
Colorado **Connecticut** **Delaware** **Maine** **Massachusetts** **Minnesota** **New Jersey** **Oregon** **Washington, D.C.** **Washington state**	Eligible for Walmart short-term disability plan as a supplement to legally mandated benefits	State or district for legally mandated benefit Sedgwick for supplemental benefits and maternity	**Colorado:** Go to **famli.colorado.gov** or call **866-263-2654** for instructions **Connecticut:** Go to **ctpaidleave.org** or call **877-499-8606** for instructions **Delaware:** File a claim with Sedgwick, which will file a state claim on your behalf **Maine:** Go to **maine.gov/paidleave** or call **207-621-5024** **Massachusetts:** Go to **paidleave.mass.gov** or call **833-344-7365** for instructions **Minnesota:** Go to **paidleave.mn.gov** or call **844-536-0444** **New Jersey:** File a claim with Sedgwick, which will file a state claim on your behalf **Oregon:** Go to **paidleave.oregon.gov** or call **833-854-0166** for instructions **Washington, D.C.:** Go to **dcpaidfamilyleave.dc.gov** or call **202-899-3700** for instructions **Washington state:** Go to **paidleave.wa.gov** or call **833-717-2273** for instructions **Sedgwick:** File a claim with Sedgwick within 90 days of the date your disability begins; you will need to provide the determination letter from the state or district with state or district benefit details. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
All others	Eligible for Walmart short-term disability plan	Sedgwick	File a claim with 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 3: Let your doctor's office know it will be contacted for information. Tell your doctor's office that it will be contacted and asked to complete an attending physician's statement and provide objective 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
- Doctor visit notes

You must sign a form authorizing your doctor to release this information. This release will be included in the initial packet that you receive from Sedgwick; however, if you are filing your claim online, an electronic signature is accepted.

STEP 4: Follow up with your doctor to ensure that the requested information is forwarded to Sedgwick. Any delay in sending information to Sedgwick could result in a delay, or denial, in the processing of your claim and the payment of benefits.

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 claim is approved.

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. In order for your pay to continue during the initial waiting period of seven calendar days, you may use paid time off. Following your initial waiting period of seven calendar days, your pay will continue until your Medical Due Date; this pay is known as "provisional pay." Your pay will be suspended after your original Medical Due Date if the required medical documentation has not been received and/or your claim has not been approved.

If your claim is approved, the approval will be effective as of the date of your disability, and the provisional pay you received after your seven-day waiting period and while your claim was pending will count toward your disability benefit.

If your claim is denied before the Medical Due Date because you are not disabled, as defined by the truck driver short-term disability plan, your provisional pay will be stopped and Walmart will commence efforts to recover the provisional pay that was paid to you while your claim was pending.

You will not receive provisional pay during any period when a determination is being made regarding a relapse/recurrent claim (see **If you return to work and become disabled again** later in this chapter).

For specific details about the paid time off policy, refer to **One.Walmart.com**.

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 short-term disability plan's definition of disabled
- The date you fail to furnish the 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 you to be examined
- The last day of the maximum period for which benefits are payable
- The date you are medically able and qualified to work in a similar full-time position offered to you by Walmart
- The date of your death

If your short-term disability benefits end and you do not return to work for any reason, you must request an extension of your leave (refer to the **Resources** chart at the beginning of the chapter for contact information). Failure to do so may result in your employment being terminated.

Benefits provided under a state or locally mandated program may have different end dates from the truck driver short-term disability plan.

Returning to work following a leave

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.

To ensure a smooth transition back to work and avoid a potential impact to your pay, you will need to contact Sedgwick **up to seven days prior to your actual return-to-work date.** If your return-to-work date changes, you should notify Sedgwick immediately. 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 your 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 and you are classified as a full-time OTR truck driver on active status (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 of seven calendar days. The combined benefit duration for both periods of disability will not exceed 25 weeks.

If you have returned as a full-time OTR truck driver and are on active status for more than 30 calendar days and then become disabled from the same or a related condition, it will be considered a new disability, and you may be able to receive up to 25 weeks of short-term disability benefits, following your completion of a new seven-calendar-day waiting period.

If you return as a full-time OTR truck driver and are on active status 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 short-term disability 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 paid time off for the absences.

If you are on a leave of absence or experience a temporary layoff

If you are not on active status due to a leave of absence or temporary layoff, your eligibility for short-term disability benefits will continue for 90 days from the beginning of your leave or temporary layoff. Your eligibility for short-term disability coverage ends on the 91st day after the beginning of your leave of absence or temporary layoff but is reinstated if you return to work within one year. See **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter for more information, including details on paying for benefits while on leave.

Note: If your eligibility for short-term disability coverage ends because your leave of absence or temporary layoff exceeds 90 days, you remain eligible for short-term disability benefits for any illness or injury that occurred before the date your coverage ends.

When your truck driver short-term disability coverage ends

Your short-term disability coverage ends on the earliest of:

- The date your employment terminates
- The last day of the pay period in which your job status changes from an eligible job status
- The date of your death
- The 91st day of a leave of absence or layoff (unless you return to work)
- The date the short-term disability benefit is no longer offered by Walmart

If you pass away while receiving short-term disability benefits

Any short-term disability benefits that have accrued but remain unpaid as of the date of your death will be paid to the beneficiary designated under your company-paid life insurance. For details on how to designate a beneficiary and the rules that apply if you do not name a beneficiary, please refer to the **Naming a beneficiary** section of the **Company-paid life insurance** chapter.

If you leave Walmart and are rehired

If you leave Walmart and return to work for Walmart as a full-time OTR truck driver, you will automatically be reenrolled in the truck driver short-term disability plan.

Full-time hourly and salaried long-term disability

The long-term disability plans	218
When you qualify for long-term disability benefits	218
Filing a long-term disability claim	219
When benefits are not paid	219
When long-term disability benefits begin	219
Calculating your benefit	219
If you are disabled and working	221
When long-term disability benefit payments end	222
If you return to work and become disabled again	223
If you go on a leave of absence or experience a temporary layoff	223
When your long-term disability coverage ends	223
If you leave Walmart and are rehired	223

The information in this chapter describes long-term disability benefits that may be available to you if:

- You are an eligible full-time hourly or salaried (management) associate (truck drivers: see next chapter)
- You have met all requirements for coverage to be effective, including actively-at-work requirements, and
- You have enrolled in a timely manner.

For questions about eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

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 The Lincoln National Life Insurance Company (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.

Full-time hourly and salaried long-term disability

If you become disabled and can't work, Walmart'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	**One.Walmart.com/TimeAndSupport > Leave of Absence**	Call Lincoln at **877-353-6404**

What you need to know about full-time hourly and salaried long-term disability

This chapter describes long-term disability benefits available to you under one of two plan options:

- **The long-term disability plan** replaces 50% of your average monthly wage.
- **The long-term disability enhanced plan** replaces 60% of your average monthly wage.

The long-term disability plans

If you become disabled, as defined in the **When you qualify for long-term disability benefits** section, the long-term disability plan provides a benefit of 50% of your average monthly wage up to a maximum monthly benefit of $15,000, minus the amount of certain other benefits or income you are eligible to receive, after your benefit waiting period.

If you become disabled, as defined in the **When you qualify for long-term disability benefits** section, the long-term disability enhanced plan provides a benefit of 60% of your average monthly wage up to a maximum monthly benefit of $18,000, minus the amount of certain other benefits or income you are eligible to receive, after your benefit waiting period.

Both plans are insured by Lincoln. For information about your benefit waiting period, see **When long-term disability benefits begin** later in this chapter. For information about your average monthly wage or other income or benefits that may reduce your benefit, see **Calculating your benefit** and **Other benefits or income that reduce long-term disability benefits** later in this chapter.

The cost of long-term disability coverage

Your cost for long-term disability coverage is based on your eligible earnings, your age, and whether you select the long-term disability plan or the long-term disability enhanced plan. Premiums are deducted from all wages, including bonuses. If you have no eligible earnings in a pay period, no premiums are due for that pay period. If while receiving long-term disability benefits you receive any other eligible earnings, including bonuses, through Walmart's payroll systems, your premiums for all benefits, including long-term disability, will be withheld from those payments. To review how to maintain coverage for other benefits while receiving long-term disability benefits, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter.

When you qualify for long-term disability benefits

Under the terms of the long-term disability plan and long-term disability enhanced plan, "disability" or "disabled" generally 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, with reasonable continuity, the material and substantial duties of any occupation for which you are reasonably fitted by training, education, experience, age, and physical or mental capacity. However, if you are employed as a pilot, copilot, or crewmember of an aircraft, "disability" or "disabled" 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.

In determining whether you are disabled, for persons other than pilots or copilots, 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 long-term disability 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.
- You must be actively at work at the time of your disability. You will be considered actively at work if you are performing services at Walmart's usual place of business or a location designated by Walmart or if you were actually at work on the day immediately preceding:
  - A weekend or holiday (except where one or both of these days are scheduled workdays)
  - Paid time off
  - Any nonscheduled workday
  - An approved leave of absence

Preexisting condition exclusion

You will not receive long-term disability benefits for any disability or partial disability which begins in your first 12 months after your coverage effective date if such disability or partial disability is caused, partially or entirely, or results from a preexisting condition. A "preexisting condition" means any condition resulting from an injury or sickness for which you were diagnosed or received treatment during the three-month period prior to your coverage effective date. Under the terms of the preexisting 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 long-term disability plan (50% benefit) to the long-term disability enhanced plan (60% benefit), the preexisting condition exclusion will apply to the additional coverage amount. If you had satisfied the preexisting condition requirement of the long-term disability plan (50% benefit) and then suffer a disability before you satisfy the preexisting condition exclusion of the long-term disability enhanced plan (60% benefit), you will only receive benefits under the long-term disability plan (50% benefit).

Filing a long-term disability claim

If you are on an approved short-term disability claim and are enrolled in long-term disability benefits, your claim will be automatically transitioned from Sedgwick to Lincoln. You may also call Lincoln at **877-353-6404** as soon as you know you will need to use your long-term disability benefit. Lincoln will provide you with additional information on how to complete your claim.

Associates receiving workers' compensation benefits and enrolled in the long-term disability plan or long-term disability enhanced plan may be eligible for disability benefits after their benefit waiting period has expired. Call Lincoln at **877-353-6404** to report your long-term disability 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 long-term disability 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
- 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 long-term disability benefits begin

If you are approved by Lincoln for long-term disability benefits, they will begin after your benefit waiting period: 26 weeks or the end of your short-term disability benefits, whichever is longer.

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 the specified number of calendar days (as defined below) or less during a benefit 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 the specified number of 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 long-term disability benefits. The "specified number of calendar days" means (i) 60 days for hourly associates and hourly pharmacists (other than hourly pharmacists working in California), and (ii) 180 days for salaried associates, salaried pharmacists, hourly pharmacists working in California, management, and pilots. The specified number of calendar days need not be consecutive.

Calculating your benefit

The amount of your long-term disability benefit is based on:

- Your average monthly wage, as defined below
- If you are enrolled in the long-term disability plan or the long-term disability enhanced plan

Average monthly wage	
Length of employment	**How average monthly wage is determined**
Employed 12 months or more	Your eligible earnings for the 26 pay periods[1] immediately prior to your last day worked ÷ 12 For example, the average monthly wage for an associate with pre-disability eligible earnings of $36,000 for the prior 26 pay periods is $3,000 ($36,000 ÷ 12). [1]If your eligible earnings were paid on a weekly basis during the 12-month period, the number of pay periods used to calculate your average monthly wage will be adjusted accordingly.
Employed less than 12 months	Your eligible earnings since date of hire ÷ number of months worked For example, the average monthly wage for an associate with eligible earnings of $21,000 for seven months of work is $3,000 ($21,000 ÷ 7).

Eligible earnings used to determine average monthly wage include:

- Regular earnings for the 26 pay periods prior to your last day worked (if your regular earnings were paid on a weekly basis, the number of pay periods used will be adjusted accordingly)
- Overtime
- Regularly scheduled target incentive bonuses that you and associates in similarly situated job types or job levels are eligible to earn
- Paid time off and similar pay that replaces regular earnings (e.g., bereavement, jury duty, and sick time)

Any pay periods in which you have no eligible earnings are excluded, decreasing the number of pay periods used for the calculation.

Eligible earnings used to determine average monthly wage exclude any previously paid disability benefits, commissions, or any other extra compensation or fringe benefits not listed above.

If you have been employed less than 12 months, an annualized average of eligible earnings will be used.

Your long-term disability benefit is shown below:

Your long-term disability benefit	
If you are enrolled	**Your coverage is**
In the long-term disability plan	50% of your average monthly wage up to a maximum monthly benefit of $15,000, minus the amount of certain other benefits or income you are eligible to receive (for example, Social Security disability benefits)[1]
In the long-term disability enhanced plan	60% of your average monthly wage up to a maximum monthly benefit of $18,000, minus the amount of certain other benefits or income you are eligible to receive (for example, Social Security disability benefits)[1]
[1] See **Other benefits or income that reduce long-term disability benefits** for more information.	

Your benefit will be no less than $50 for any month that you are eligible to receive long-term disability benefits.

Long-term disability benefits are paid as long as you continue to be disabled as defined by the long-term disability plans.

Lincoln has the right to recover, and you must repay, any amount overpaid to you for long-term disability benefits under the long-term disability plan or long-term disability enhanced plan.

Other benefits or income that reduce long-term disability benefits

Your long-term disability benefit amount is reduced, or offset, by the gross amount of other benefits or income you receive or are eligible to receive. “Other income” includes any earnings from any form of employment, including under any formal or informal sick leave or salary continuation plans. Except with respect to retirement benefits, “other benefits” only includes amounts you (or, under certain circumstances, your family) are entitled to as the result of the same disability for which your long-term disability benefit is paid. Examples of other benefits include amounts from the following:

- Social Security disability insurance (including amounts your family receives or is eligible to receive due to your disability)
- Social Security retirement benefits granted after the date of disability (including benefits your family receives or is eligible to receive due to your eligibility for retirement benefits)
- Workers’ compensation
- Company-related group insurance plans providing disability benefits
- Company-paid or partially paid individual policies providing disability benefits to the extent such benefits, plus your long-term disability benefit, exceed your average monthly wage
- No-fault automobile insurance
- Any ongoing short-term disability benefits payable under Walmart short-term disability coverage (i.e., relapse-related benefits)
- State disability payments
- Unemployment benefits, or benefits under any other governmental benefit act or law
- Settlement or judgment, less associated costs of a lawsuit that represents or compensates for your loss of earnings or bodily function

If any of the other benefits that reduce your long-term disability benefits are subsequently adjusted by cost-of-living increases, your long-term disability benefit will not be further reduced. Refer to the policy for a complete list of offsets. You may obtain a copy of the long-term disability policy by calling Lincoln at **877-353-6404**.

Reduction of long-term disability benefit example		
Annual salary: $36,000	**Long-term disability plan (50%)**	**Long-term disability 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
Long-term disability 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 long-term disability 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.

If you are required to pursue Social Security disability benefits and you do not apply, or you do not provide proof of application or appeal, your long-term disability benefits will be reduced by the amount you and any eligible dependents are estimated to receive from Social Security disability.

If you qualify for Social Security disability or retirement benefits while you are receiving benefits under the long-term disability plan and your Social Security disability claim is approved retroactively, you must reimburse Lincoln for any long-term disability 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 or any occupation on a part-time basis, and
- Earn between 20% and 80% of your indexed average monthly wage

If you accept a new position and perform all of the material and substantial duties on a full-time basis, you are not partially disabled.

Lincoln offers a work incentive benefit for the first six pay periods (12 pay periods if paid weekly) that you are partially disabled and working. You will continue to receive the full amount of your monthly benefit for the first six or 12 pay periods, as applicable, if you are partially disabled, unless your benefit and current monthly earnings from work while partially disabled exceed your average monthly wage. If this occurs, your monthly benefit will be reduced by the excess amount so that the monthly benefit plus your eligible earnings do not exceed 100% of your average monthly wage.

After the first six or 12 pay periods, as applicable, 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	
[(A - B) ÷ A] x C = D	
A	Your indexed average monthly wage[1]
B	Your current partial monthly eligible earnings
C	The monthly long-term disability benefit payable if you were totally disabled, less other benefits or income that reduce long-term disability benefits
D	The disabled and working benefit payable

[1] "Indexed average monthly wage" means your average monthly wage increased annually by 7% or the percentage change in the Consumer Price Index, whichever is less.

If you pass away while receiving long-term disability benefits

Coverage under the long-term disability plan ends upon your death. However, if you pass away while receiving long-term disability benefits, a lump-sum payment of $5,000 or three times your last monthly long-term disability 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 long-term disability benefit payments end

Long-term disability benefit payments end on the earliest of:

- The date you fail to furnish proof of continued disability or partial 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 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 average monthly wage
- 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 this page)
- The date of your death

Note: Your employment is not a condition of the continuation of long-term disability benefits.

Maximum duration of long-term disability benefits

Age when you become disabled	Benefits duration
Prior to age 62	Until Social Security 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 long-term disability 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
- 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/successive claim," the successive disability will be part of the same disability.

Your long-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 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.

If you go on a leave of absence or experience a temporary layoff

Once your long-term disability coverage is effective, if you are not actively at work due to a leave of absence or temporary layoff, your long-term disability coverage continues for 90 days from the beginning of your leave or temporary layoff. Your long-term disability coverage ends on the 91st day after your leave of absence or temporary layoff begins but is reinstated if you return to active work status within one year. See **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter for more information, including details on paying for benefits coverage while on leave.

Note: If your long-term disability coverage ends because your leave of absence or temporary layoff exceeds 90 days, you remain eligible for long-term disability benefits for any illness or injury that occurred before the date your coverage ends.

When your long-term disability coverage ends

Your long-term disability coverage ends:

- The day you voluntarily drop coverage (as described below)
- 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 immediately preceding the pay period in which your job status changes from an eligible job status
- 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 you lose eligibility
- If you do not return to work after the last day of a leave of absence
- When the benefit is no longer offered by Walmart
- On the date of your death

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

If you voluntarily drop coverage after an election change event or at Annual Enrollment, coverage ends as follows:

- **After an election change event:** coverage ends the day you request the election change. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave Walmart and are rehired

If you are a full-time hourly or management associate (excluding full-time OTR truck drivers), see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

Truck driver long-term disability

The truck driver long-term disability plans	226
When you qualify for truck driver long-term disability benefits	226
Filing a truck driver long-term disability claim	227
When benefits are not paid	227
When truck driver long-term disability benefits begin	228
Calculating your benefit	228
If you are disabled and working	229
When truck driver long-term disability benefit payments end	230
If you return to work and become disabled again	231
If you go on a leave of absence or experience a temporary layoff	231
When your long-term disability coverage ends	231
If you leave Walmart and are rehired	231

The information in this chapter describes long-term disability benefits that may be available to you if:

- You are a full-time OTR truck driver
- You have met all requirements for coverage to be effective, including actively-at-work requirements, and
- You have enrolled in a timely manner.

For questions about a recent transfer to a full-time OTR truck driver job classification, eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

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 The Lincoln National Life Insurance Company (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, Walmart's long-term disability plans work with other benefits you get to replace part of your paycheck. There are two long-term disability plans for truck drivers that pay different levels of benefits.

Resources		
Find what you need	**Online**	**Other resources**
Get more details or file a claim	**One.Walmart.com/TimeAndSupport > Leave of Absence**	Call Lincoln at **877-353-6404**

What you need to know about truck driver long-term disability

- Walmart offers truck drivers a long-term disability plan and also a long-term disability enhanced plan. Each plan offers a choice of five-year coverage or full-duration coverage.
- The truck driver long-term disability plans work with certain other benefits you receive while disabled to replace 50% of your average monthly wage if you select the truck driver long-term disability plan or 60% of your average monthly wage if you select the truck driver long-term disability enhanced plan.
- If you enroll in either plan after your initial enrollment period, your coverage is subject to Lincoln's approval. You will have to submit Proof of Good Health, and you may be required to undergo a medical exam at your own expense before you can be approved for coverage.

The truck driver long-term disability plans

You are eligible to enroll in truck driver long-term disability coverage if you are a full-time OTR truck driver. You can choose between two coverage plans, each of which is available in two options:

- **Long-term disability plan**
  - Five-year coverage
  - Full-duration coverage
- **Long-term disability enhanced plan**
  - Five-year coverage
  - Full-duration coverage

The options under the truck driver long-term disability plan and long-term disability enhanced plan pay benefits as described in the following chart.

Truck driver long-term disability		
	Long-term disability plan	**Long-term disability enhanced plan**
Five-year coverage	Pays 50% of average monthly wage up to a maximum monthly benefit of $15,000, minus the amount of certain other benefits or income you are eligible to receive[1]	Pays 60% of average monthly wage up to a maximum monthly benefit of $18,000, minus the amount of certain other benefits or income you are eligible to receive[1]
	Both plans pay benefits for 60 months, unless the amount of time shown in the **Maximum duration of truck driver long-term disability benefits** chart (later in this chapter) will result in a benefits duration of less than 60 months, in which case the monthly benefit will be payable for the lesser period.	
	Long-term disability plan	**Long-term disability enhanced plan**
Full-duration coverage	Pays 50% of average monthly wage up to a maximum monthly benefit of $15,000, minus the amount of certain other benefits or income you are eligible to receive[1]	Pays 60% of average monthly wage up to a maximum monthly benefit of $18,000, minus the amount of certain other benefits or income you are eligible to receive[1]
	Both plan options pay benefits for the amount of time shown in the **Maximum duration of truck driver long-term disability benefits** chart (later in this chapter).	
[1] See **Calculating your benefit** and **Other benefits or income that reduces truck driver long-term disability benefits** (later in this chapter) for more information.		

Both plans are insured by Lincoln. For information about your benefit waiting period, see **When truck driver long-term disability benefits begin** later in this chapter. For information about your average monthly wage or other income or benefits that may reduce your benefit, see **Calculating your benefit** and **Other benefits or income that reduces truck driver long-term disability benefits** later in this chapter.

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 and required to submit Proof of Good Health. You may be required to undergo a medical exam at your own expense before you can be approved for coverage.

If you enroll in the five-year coverage option and subsequently decide to enroll in the full-duration coverage option, or if you enroll in the truck driver long-term disability plan and subsequently decide to enroll in the truck driver long-term disability enhanced plan, you will be considered a late enrollee and required to provide Proof of Good Health before you can be approved for coverage.

See the **Eligibility, enrollment, and effective dates** chapter for more details about when coverage is effective.

The cost of truck driver long-term disability coverage

Your cost for truck driver long-term disability coverage is based on your eligible earnings, your age, and your choice of coverage under either the long-term disability plan or the long-term disability enhanced plan. Premiums are deducted from all wages, including bonuses. If you have no earnings in a pay period, no premiums are due for that pay period. If while receiving long-term disability benefits you receive any other earnings, including bonuses, through Walmart's payroll systems, your premiums for all benefits, including long-term disability, will be withheld from those payments. To review how to maintain coverage for other benefits while receiving long-term disability benefits, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter.

When you qualify for truck driver long-term disability benefits

Under the terms of the truck driver long-term disability plans, "disability" or "disabled" generally 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, or you lose medical certification in accordance with the Federal Motor Carrier Safety

Administration regulations. After 24 months of benefit payments, "disability" or "disabled" generally means that you are unable to perform, with reasonable continuity, the material and substantial duties of any occupation for which you are reasonably fitted by training, education, experience, age, and physical or mental capacity.

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 long-term disability 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.
- You must be actively at work at the time of your disability. You will be considered actively at work if you are performing services at Walmart's usual place of business or a location designated by Walmart or if you were actually at work on the day immediately preceding:
  - A weekend or holiday (except where one or both of these days are scheduled workdays)
  - Paid time off
  - Any nonscheduled workday
  - An approved leave of absence

If your long-term disability coverage was subject to Proof of Good Health and approved by Lincoln, Lincoln has the right to reexamine your Proof of Good Health questionnaire within the first two years from the date long-term disability coverage became effective. 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.

Preexisting condition exclusion

You will not receive truck driver long-term disability benefits for any disability or partial disability which begins in your first 12 months after your coverage effective date if such disability or partial disability is caused, partially or entirely, or results from a preexisting condition. A "preexisting condition" means any condition resulting from an injury or sickness for which you were diagnosed or received treatment during the three-month period prior to your effective date. Under the terms of the preexisting 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 long-term disability plans, or if you change from the truck driver long-term disability plan to the truck driver long-term disability enhanced plan, the preexisting condition exclusion will apply to the additional duration or level of benefits, as applicable. In this scenario, if you had satisfied the preexisting condition requirement of the five-year duration coverage option or the truck driver long-term disability plan and then suffer a disability before you satisfy the preexisting condition exclusion of the full-duration coverage option or truck driver long-term disability enhanced plan, you will only receive benefits under the five-year duration coverage plan or truck driver long-term disability plan, as applicable.

Filing a truck driver long-term disability claim

If you are on an approved short-term disability claim and are enrolled in long-term disability benefits, your claim will be automatically transitioned from Sedgwick to Lincoln. You may also call Lincoln at **877-353-6404** as soon as you know you will need to use your truck driver long-term disability 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 long-term disability 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
- 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 truck driver long-term disability benefits begin

If you are approved by Lincoln for truck driver long-term disability benefits, they will begin after your benefit waiting period: 26 weeks or the end of your short-term disability benefits, whichever is longer.

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 long-term disability benefits. The specified number of calendar days need not be consecutive.

Calculating your benefit

The amount of your truck driver long-term disability is based on:

- Your average monthly wage
- Which truck driver long-term disability 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
Employed less than 12 months	Your activity pay, mileage rate, and bonuses since date of hire ÷ the number of months worked

Note that any pay periods in which you have no eligible 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 long-term disability plan or the truck driver full-duration coverage long-term disability plan	50% of your average monthly wage up to a maximum monthly benefit of $15,000, minus the amount of certain other benefits or income you are eligible to receive (for example, Social Security disability benefits)[1]
In the truck driver five-year coverage long-term disability enhanced plan or the truck driver full-duration coverage long-term disability enhanced plan	60% of your average monthly wage up to a maximum monthly benefit of $18,000, minus the amount of certain other benefits or income you are eligible to receive (for example, Social Security disability benefits)[1]
[1] See **Other benefits or income that reduces truck driver long-term disability benefits** for more information.	

Your benefit will be no less than $50 for any month that you are eligible to receive long-term disability benefits.

Truck driver long-term disability benefits are paid as long as you continue to be disabled as defined by the truck driver long-term disability plans.

Lincoln has the right to recover, and you must repay, any amount that is overpaid to you for truck driver long-term disability benefits under the truck driver long-term disability plan or the truck driver long-term disability enhanced plan.

Other benefits or income that reduces truck driver long-term disability benefits

Your truck driver long-term disability benefit amount is reduced, or offset, by other benefits or income you receive or are eligible to receive. "Other income" includes any earnings from any form of employment, including under any formal or informal sick leave or salary continuation plans. Except with respect to retirement benefits, "other benefits" only includes amounts you (or, under certain circumstances, your family) are entitled to as the result of the same disability for which your truck driver long-term disability benefit is paid. Examples of other benefits include amounts from the following:

- Social Security disability insurance (including amounts your family receives or is eligible to receive due to your disability)
- Social Security retirement benefits that are granted after the date of disability (including benefits your family receives or is eligible to receive due to your eligibility for retirement benefits)
- Workers' compensation

- Company-related group insurance plans providing disability benefits
- Company-paid or partially paid individual policies providing disability benefits to the extent such benefits, plus your truck driver long-term disability benefit, exceed your average monthly wage
- No-fault automobile insurance
- Any ongoing short-term disability benefits payable under Walmart short-term disability coverage (i.e., relapse-related benefits)
- State disability payments
- Unemployment benefits, or benefits under any other governmental benefit act or law
- Settlement or judgment, less associated costs of a lawsuit, that represents or compensates for your loss of earnings or bodily function

If any of the other benefits that reduce your long-term disability benefits are subsequently adjusted by cost-of-living increases, your long-term disability 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 long-term disability policy by calling Lincoln at **877-353-6404**.

Example: reduction of truck driver long-term disability benefit

	Long-term disability plan (50%)	Long-term disability 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
Long-term disability 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 long-term disability 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.

If you are required to pursue Social Security disability benefits and you do not apply, or you do not provide proof of application or appeal, your long-term disability benefits will be reduced by the amount you are estimated to receive from Social Security disability.

If you qualify for Social Security disability or retirement benefits while you are receiving benefits under any of the truck driver long-term disability plan options and your Social Security disability claim is approved retroactively, you must reimburse Lincoln for any long-term disability 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 long-term disability 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 or any occupation on a part-time basis, and
- Earn between 20% and 80% of your indexed average monthly wage

If you accept a new position and perform all of the material and substantial duties on a full-time basis, you are not partially disabled.

Lincoln offers a work incentive benefit for the first six pay periods that you are partially disabled and working. You will continue to receive the full amount of your monthly benefit for the first six pay periods if you are partially disabled, unless your benefit and current earnings received while partially disabled exceed your pre-disability average monthly wage. Your monthly benefit will be reduced by the excess amount so that the monthly benefit plus your earnings do not exceed 100% of your average monthly wage.

After the first six pay periods 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	
[(A - B) ÷ A] x C = D	
A	Your indexed average monthly wage[1]
B	Your current partial monthly earnings
C	The monthly benefit payable if you were totally disabled, less other benefits or income that reduces truck driver long-term disability benefits
D	The disabled and working benefit payable

[1] "Indexed average monthly wage" means your pre-disability monthly earnings increased annually by 7% or the percentage increase in the Consumer Price Index, whichever is less.

If you pass away while receiving truck driver long-term disability benefits

Coverage under the truck driver long-term disability plans ends upon your death. However, if you pass away while receiving truck driver long-term disability benefits, a lump sum payment of $5,000 or three times your gross last monthly long-term disability 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 long-term disability benefit payments end

Truck driver long-term disability 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 average monthly wage
- 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 below)
- The date of your death

Note: Your employment is not a condition of the continuation of long-term disability benefits.

Five-year coverage

Five-year coverage pays benefits for 60 months unless the amount of time shown in the **Maximum duration of truck driver long-term disability benefits** chart below will result in a benefits duration of less than 60 months, in which case the monthly benefit will be payable for the lesser period.

Full-duration coverage

Full-duration coverage pays benefits for the amount of time shown in the **Maximum duration of truck driver long-term disability benefits** chart below.

Maximum duration of truck driver long-term disability benefits

Age when you become disabled	Benefits duration
Prior to age 62	Until Social Security 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 long-term disability 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
- Nonmedical 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/successive claim," the successive disability will be part of the same disability. Your long-term disability 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 consecutive months or more, any recurrence of a disability will be treated as a new disability. A new benefit waiting period must be completed.

If you go on a leave of absence or experience a temporary layoff

Once your truck driver long-term disability coverage is effective, if you are not actively at work due to a leave of absence or temporary layoff, your truck driver long-term disability coverage continues for 90 days from the beginning of your leave or temporary layoff. Your truck driver long-term disability coverage ends on the 91st day after your leave of absence or temporary layoff begins but is reinstated if you return to active work status within one year. See **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter for more information, including details on paying for benefits coverage while on leave.

Note: If your long-term disability coverage ends because your leave of absence or temporary layoff exceeds 90 days, you remain eligible for long-term disability benefits for any illness or injury that occurred before the date your coverage ends.

When your long-term disability coverage ends

Your truck driver long-term disability coverage ends:

- The day you voluntarily drop coverage (as described below)
- On the last day of the pay period immediately preceding the pay period in which your job status changes from an eligible job status
- The last day of coverage for which payment was made, if you fail to pay the amount due for your coverage within 30 days of the date your premium is due
- On the date you lose eligibility
- If you do not return to work after the last day of a leave of absence
- When the benefit is no longer offered by Walmart
- On the date of your death

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

If you voluntarily drop coverage after an election change event or at Annual Enrollment, coverage ends as follows:

- **After an election change event:** coverage ends the day you request the election change. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave Walmart and are rehired

If you are a full-time OTR truck driver, see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

Company-paid life insurance

Company-paid life insurance	234
Naming a beneficiary	234
Early payout due to terminal illness	235
Filing a company-paid life insurance claim	235
When benefits are not paid	235
When your company-paid life insurance coverage ends	235
EstateGuidance®	236
Continuing your company-paid life insurance after you leave Walmart or lose coverage	236
If you leave Walmart and are rehired	237

The information in this chapter describes company-paid life insurance benefits that may be available to you if:

- You are a full-time hourly or salaried (management) associate, and
- You have met all requirements for coverage to be effective, including actively-at-work requirements.

For questions about eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

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	**One.Walmart.com/Beneficiary**	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 an eligible associate, Walmart provides life insurance coverage at no cost to you. 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 last day worked, 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.
- The Certificate of Insurance is available online at **One.Walmart.com** or at **Prudential.com/Walmart**. The certificate provides detailed information about company-paid life insurance, in addition to the highlights available in this chapter.

Company-paid life insurance

Your company-paid coverage amount is equal to your annualized rate of pay, including overtime and bonuses, based on the previous 26 pay periods of active status (if paid biweekly) or 52 weeks (if paid weekly) prior to your last day worked, rounded to the nearest $1,000, to a maximum of $50,000. Commissions and all other benefits are not included in your annualized rate of pay.

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, coffin, and transportation of your remains. The benefit is the lesser of the cost to return your remains or $20,000.

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 name your beneficiaries by using Walmart's beneficiary management tool, which can be accessed at **One.Walmart.com/Beneficiary** or at **MyWalmart**, **Me@Sams**, or **Me@Campus**.

To be valid, your beneficiary designation must be on file with the Plan before your death. The most recent beneficiary designation on file with the Plan will prevail, regardless of the method you used to complete the designation.

If you are unable to access the beneficiary management tool for any reason, for example if you are on a leave of absence, call Prudential at **877-740-2116**.

You can name anyone you wish as your beneficiary(ies). If the beneficiary(ies) listed in your most recent beneficiary designation on file with the Plan differs from the beneficiary(ies) named in your will, the beneficiary designation on file with the Plan prevails. If you have not named 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** on this page.

The following information is required for each beneficiary:

- Name
- Relationship to you
- Date of birth
- The percentage you wish to designate per beneficiary, up to 100%

You can also provide the following optional information for each beneficiary, which may help Prudential pay the benefit faster:

- Current address and phone number
- Social Security number

If two or more beneficiaries are named, they will share the insurance benefit equally. The beneficiary management tool will automatically calculate their percentage shares. You will have the opportunity to change these percentages, but note that your assigned percentages must add up to 100%. If they do not, you will receive an error message and be prompted to try again.

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 may change your beneficiaries at any time by using Walmart's beneficiary management tool, which can be accessed at **One.Walmart.com/Beneficiary** or at **MyWalmart**, **Me@Sams**, or **Me@Campus**. To be valid, any change in beneficiary must be on file with the Plan before your death, and the most recent beneficiary designation on file with the Plan will prevail, regardless of the method you used to complete the designation.

If you are unable to access the beneficiary management tool for any reason, for example if you are on a leave of absence, call Prudential at **877-740-2116**.

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:

- Spouse or partner of the deceased; if not surviving, then
- Children in equal shares; if not surviving, then
- Parents in equal shares; if not surviving, then
- Siblings in equal shares; if not surviving, then
- Your estate.

Be sure to keep your beneficiary information up to date. Proceeds will go to whoever is listed in your beneficiary designation on file with the Plan, regardless of your current relationship with that person, unless applicable law says otherwise. You can check your beneficiaries on file with the Plan and/or change your beneficiary(ies) at any time at **One.Walmart.com/Beneficiary** and **MyWalmart**, **Me@Sams**, or **Me@Campus**. If you are unable to access the beneficiary management tool, call Prudential at **877-740-2116**.

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 (measured on the date you provide proof of your terminal illness). Payment is made to you in a lump sum. Upon your death, your beneficiary(ies) receives the amount of life insurance coverage in effect on the date of your death, reduced by the amount of early payouts you received before your death.

If you terminate from Walmart 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 or lose coverage** 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 company-paid life insurance claim

The following information must be provided to Prudential regarding the deceased associate:

- Name
- Social Security number
- Date of death
- Cause of death (if known)

An original or certified copy of the death certificate may be 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 70182
Philadelphia, Pennsylvania 19176

If a death certificate is required, 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**.

When benefits are not paid

No benefits are paid if you die before your coverage effective date.

When your company-paid life insurance coverage ends

Your company-paid life insurance coverage ends:

- At termination of your employment
- On the last day of the pay period in which 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
- When the benefit is no longer offered by Walmart

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**, promotional code: **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 in your beneficiary designation on file with the Plan differs from the beneficiary(ies) named in your will, the beneficiary designation on file with the Plan prevails.

Walmart makes EstateGuidance available to you as a convenience and does not specifically recommend or endorse EstateGuidance for preparation of your will. You should choose a will preparation service or service provider that best suits your personal needs and objectives. EstateGuidance does not provide tax or legal advice.

Continuing your company-paid life insurance after you leave Walmart or lose coverage

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.



You will not be able to continue your coverage unless you contact Prudential within 31 days of the date your coverage ends.

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 below.

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 Walmart 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 a conversion notification was mailed to you and 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 a conversion notification was not mailed to you and your death occurs during the 91-day period immediately following the termination date of your coverage, 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 Walmart and are rehired

If you are a full-time hourly or management associate (including full-time OTR truck drivers but not part-time OTR truck drivers), see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

Optional associate life insurance

Optional associate life insurance	240
Naming a beneficiary	240
Early payout due to terminal illness	241
Filing an optional associate life insurance claim	241
When benefits are not paid	242
Break in coverage	242
When your optional associate life insurance coverage ends	242
Continuing your optional associate life insurance after you leave Walmart or lose coverage	242
If you leave Walmart and are rehired	243

The information in this chapter describes optional associate life insurance benefits that may be available to you if:

- You are an hourly, temporary, part-time OTR truck driver, or salaried (management) associate
- You have met all requirements for coverage to be effective, including actively-at-work requirements, and
- You have enrolled in a timely manner.

For questions about eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

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	**One.Walmart.com/Beneficiary**	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

- Depending on the amount of coverage you choose and when you enroll, you may be required 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.
- The Certificate of Insurance is available online at **One.Walmart.com** or at **Prudential.com/Walmart**. The certificate provides detailed information about company-paid life insurance, in addition to the highlights available in this chapter.

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.

Your coverage choices for optional associate life insurance depend on your job classification, as reflected in Walmart's payroll system. The coverage amounts you can choose are shown in the chart below.

Hourly associates and part-time OTR 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 effective dates by job classification** section in the **Eligibility, enrollment, and effective dates** 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.

Proof of Good Health

Proof of Good Health is not required if you enroll in the $25,000 guaranteed amount:

- During your initial enrollment period, or
- Due to an election change event as described in the **Permitted election changes outside Annual Enrollment** section of the **Eligibility, enrollment, and effective dates** chapter

Proof of Good Health is required if:

- You select a coverage amount above the $25,000 guaranteed amount, or
- You enroll in any amount after your initial enrollment period for any reason other than an election change event

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.

If Proof of Good Health is required, coverage will not be effective until Prudential approves your coverage. See the **Eligibility, enrollment, and effective dates** chapter for details.

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 name your beneficiaries by using Walmart's beneficiary management tool, which can be accessed at **One.Walmart.com/Beneficiary** or at **MyWalmart**, **Me@Sams**, or **Me@Campus**.

To be valid, your beneficiary designation must be on file with the Plan before your death. The most recent beneficiary designation on file with the Plan will prevail, regardless of the method you used to complete the designation.

If you are unable to access the beneficiary management tool for any reason, for example if you are on a leave of absence, call Prudential at **877-740-2116**.

You can name anyone you wish as your beneficiary(ies). If the beneficiary(ies) listed in your most recent beneficiary designation on file with the Plan differs from the beneficiary(ies) named in your will, the beneficiary designation on file with the Plan prevails. If you have not named 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 required for each beneficiary:

- Name
- Relationship to you
- Date of birth
- The percentage you wish to designate per beneficiary, up to 100%

You can also provide the following optional information for each beneficiary, which may help Prudential pay the benefit faster:

- Current address and phone number
- Social Security number

If two or more beneficiaries are named, they will share the insurance benefit equally. The beneficiary management tool will automatically calculate their percentage shares. You will have the opportunity to change these percentages but note that your assigned percentages must add up to 100%. If they do not, you will receive an error message and be prompted to try again.

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 beneficiaries at any time by using Walmart's beneficiary management tool, which can be accessed at **One.Walmart.com/Beneficiary** or at **MyWalmart**, **Me@Sams**, or **Me@Campus**.

To be valid, any change in beneficiary must be on file with the Plan before your death, and the most recent beneficiary designation on file with the Plan will prevail, regardless of the method you used to complete the designation.

If you are unable to access the beneficiary management tool for any reason, for example if you are on a leave of absence, call Prudential at **877-740-2116**.

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:

- Spouse or partner of the deceased; if not surviving, then
- Children in equal shares; if not surviving, then
- Parents in equal shares; if not surviving, then
- Siblings in equal shares; if not surviving, then
- Your estate

Be sure to keep your beneficiary information up to date. Proceeds will go to whoever is listed in your beneficiary designation on file with the Plan, regardless of your current relationship with that person, unless applicable law says otherwise. You can check your beneficiaries on file with the Plan and/or change your beneficiary(ies) at any time at **One.Walmart.com/Beneficiary** and **MyWalmart**, **Me@Sams**, or **Me@Campus**. If you are unable to access the beneficiary management tool, call Prudential at **877-740-2116**.

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 is made to you in a lump sum. Upon your death, your beneficiary(ies) receives 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 Walmart 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 or lose coverage** 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 an optional associate life insurance claim

The following information must be provided to Prudential regarding the deceased associate:

- Name
- Social Security number
- Date of death
- Cause of death (if known)

An original or certified copy of the death certificate may be 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 70182
Philadelphia, Pennsylvania 19176

If a death certificate is required, 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 reexamine 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
- Payroll deductions may be refunded

If you die before your coverage effective date, no benefits will be paid.

Break in coverage

There may be occasions in which you must make special arrangements to pay for your optional associate life insurance coverage 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). Failure to pay amounts owed for coverage within 30 days of the due date will result in cancellation of coverage.

For details on how to make payments to continue your coverage, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** 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 **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter.

When your optional associate life insurance coverage ends

Your optional associate life insurance coverage ends:

- On the date you voluntarily drop coverage (as described below)
- At termination of your employment
- On the last day of coverage for which payment was made, if you fail to pay the amount owed for your coverage within 30 days of the date your payment was due
- On the date of your 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 Walmart

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

If you voluntarily drop coverage after an election change event or at Annual Enrollment, coverage ends as follows:

- **After an election change event:** coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

This policy is term life insurance. It has no cash value.

Continuing your optional associate life insurance after you leave Walmart or lose coverage

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.

You will not be able to continue your coverage unless you contact Prudential within 31 days of the date your coverage ends.

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 Walmart 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 be no more than the lesser of the amount of coverage you elected under the plan or not more than five times your annual earnings; provided, however, the amount 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 must apply for the individual contract and pay the first premium by the later of:

- the 31st day after you cease to be insured, or
- the 15th day after you have been given written notice of the conversion privilege

If a conversion notice was mailed to you and 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 a conversion notice was not mailed to you and your death occurs during the 91-day period immediately following the termination date of your coverage, 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 Walmart and are rehired

If you are a part-time hourly associate or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

If you are a full-time hourly, management, or truck driver associate, see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

Optional dependent life insurance

Optional dependent life insurance	246
Additional benefits	246
Filing an optional dependent life insurance claim	247
When benefits are not paid	247
Break in coverage	247
When your optional dependent life insurance coverage ends	247
Continuing spouse/partner coverage after you leave Walmart or lose coverage	248
If you leave Walmart and are rehired	249

The information in this chapter describes optional dependent life insurance benefits that may be available to you if:

- You are an hourly, temporary, part-time OTR truck driver, or salaried (management) associate
- You have met all requirements for coverage to be effective, including actively-at-work requirements, and
- You have enrolled in a timely manner.

For questions about eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

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	**One.Walmart.com**	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

- Full-time hourly and management associates can enroll their spouse/partner and/or their children; part-time hourly associates and part-time OTR truck drivers can enroll their children but not their spouse/partner.
- 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 after your initial enrollment period for a reason other than an election change event. Proof of Good Health is not required for your children.
- Your dependent is not eligible for coverage while on active duty in the armed forces of any country.
- Coverage is provided through the Prudential Insurance Company of America (Prudential).
- This policy is term life insurance. It has no cash value.
- The Certificate of Insurance is available online at **One.Walmart.com** or at **Prudential.com/Walmart**. The certificate provides detailed information about company-paid life insurance, in addition to the highlights available in this chapter.

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.

When you enroll in optional dependent life insurance, if your covered spouse/partner and/or covered 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[1]		Child coverage
$5,000	$75,000	$5,000
$15,000	$100,000	$10,000
$25,000	$150,000	$20,000
$50,000	$200,000	

[1] Not available for part-time hourly associates, temporary associates, or part-time OTR 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. Payroll deductions from optional dependent life coverage do not subsidize coverage under company-paid life insurance.

Your dependent is not eligible for coverage while on active duty in the armed forces of any country.

If your spouse/partner or dependent child is confined for medical treatment (at home or elsewhere), the coverage effective date is delayed until the spouse/partner or child has a medical release (does not apply to a newborn child).

This policy is term life insurance. It has no cash value.

Proof of Good Health

Proof of Good Health is required for your spouse/partner's optional dependent life insurance coverage if:

- You select a coverage amount above the $5,000 guaranteed amount during your initial enrollment period or when you enroll due to an election change event
- You enroll after your initial enrollment period for any amount for a reason other than an election change event, or
- You increase your coverage after your initial enrollment period

Proof of Good Health is not required for children.

Within 60 days of an election change event, you may elect to cover your spouse/partner or change the amount of insurance for your spouse/partner. In this instance, even though you are outside your initial enrollment period, your spouse/partner 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.

If Proof of Good Health is required, coverage will not be effective until Prudential approves your coverage. See the **Eligibility, enrollment, and effective dates** 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, enrollment, and effective dates** 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 an optional dependent life insurance claim

The following information must be provided to Prudential regarding the deceased dependent:

- Name
- Social Security number
- Date of death
- Cause of death (if known)

An original or certified copy of the death certificate may be required as proof of death. Mail the death certificate to:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 70182
Philadelphia, Pennsylvania 19176

If a death certificate is required, 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 reexamine 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
- Payroll deductions paid may be refunded

Except as otherwise provided, if your dependent dies before the coverage effective date, no benefits will be paid.

Break in coverage

There may be occasions in which you must make special arrangements to pay for your optional dependent life insurance coverage 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). Failure to pay amounts owed for coverage within 30 days of the due date will result in cancellation of coverage.

For details on how to make payments to continue your coverage, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter.

If you go on a leave of absence

You may continue optional dependent life insurance coverage up to the last day of an approved leave of absence, provided that you pay for coverage before or during the leave. For information about making payments while on a leave of absence, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter.

When your optional dependent life insurance coverage ends

Your optional dependent life insurance coverage ends:

- On the date you voluntarily drop coverage (as described below)
- At termination of your employment
- On the last day of coverage for which payment was made, if you fail to pay the amount owed for your coverage within 30 days of the date your payment was due
- On the date of your death
- On the date that you or a dependent spouse/partner or child loses eligibility (see the **Eligibility, enrollment, and effective dates** chapter). However, if your spouse/partner becomes ineligible because your job status changes to part-time hourly associate, temporary associate, or part-time OTR truck driver, coverage for your spouse/partner will end on the last day of the pay period in which your job status changes
- On the last day of an approved leave of absence (unless you return to work)
- When the benefit is no longer offered by Walmart

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

If you voluntarily drop coverage after an election change event or at Annual Enrollment, coverage ends as follows:

- **After an election change event:** coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

Continuing spouse/partner coverage after you leave Walmart or lose coverage

If you are a full-time or management associate and carry optional dependent life insurance for your spouse/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/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 OTR truck drivers.

You must apply for portability or conversion within 31 days of the date your spouse/partner coverage ends. If your spouse/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/partner could have converted, even if your dependent did not apply for portability or conversion of coverage.



You will not be able to continue your spouse/partner coverage unless you contact Prudential within 31 days of the date coverage ends.

Portability enables you to maintain similar term life insurance for your spouse/partner with Prudential after your associate coverage ends or your spouse/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 amounts owed for coverage 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/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/partner may also apply for term life coverage under the portability feature if they meet all of these conditions:

- Your spouse/partner's coverage ends due to divorce or termination of partnership
- Your spouse/partner is less than age 80
- Your spouse/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/partner provides Proof of Good Health, and Prudential accepts such proof, you may increase the amount of your spouse/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 dependent life insurance coverage to an individual policy if coverage would end for any reason other than failure to pay amounts owed for coverage 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 dependent 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 dependent coverage due to a reduction in your hours or termination of employment (other than for gross misconduct). You may elect to continue dependent coverage at your expense until you obtain coverage for your dependent under another group life insurance policy; however, the maximum period that coverage may be continued is 18 months. If you continue coverage for your dependent, at the expiration of the continuation period, you may convert your dependent 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 dependent 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 Walmart and are rehired

If you are a part-time hourly associate or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

If you are a full-time hourly, management, or OTR truck driver associate, see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

Business travel accident insurance

Business travel accident insurance	252
Naming a beneficiary	252
Filing a business travel accident insurance claim	253
When benefits are paid	253
Additional benefits	254
When benefits are not paid	254
When your business travel accident insurance coverage ends	255
If you leave Walmart and are rehired	255
International business travel medical insurance	255

The information in this chapter describes business travel accident insurance benefits that may be available to you if:

- You are an eligible associate, and
- You have met all requirements for coverage to be effective, including actively-at-work requirements.

For questions about eligibility, enrollment, and requirements for coverage to be effective, see the **Eligibility, enrollment, and effective dates** chapter.

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	**One.Walmart.com/Beneficiary**	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 Blue Cross Blue Shield Global Solutions	**bcbsglobalsolutions.com**	Call Blue Cross Blue Shield Global Solutions 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 and 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 Blue Cross Blue Shield Global Solutions.

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. 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 name your beneficiaries by using Walmart's beneficiary management tool, which can be accessed at **One.Walmart.com/Beneficiary** or at **MyWalmart**, **Me@Sams**, or **Me@Campus**.

To be valid, your beneficiary designation must be on file with the Plan before your death. The most recent beneficiary designation on file with the Plan will prevail, regardless of the method you used to complete the designation.

If you are unable to access the beneficiary management tool for any reason, for example if you are on a leave of absence, call Prudential at **877-740-2116**. You (the associate) or your beneficiary will receive any benefits payable for the injuries listed in **When benefits are paid** later in this chapter.

You can name anyone you wish as your beneficiary(ies). If the beneficiary(ies) listed in your most recent beneficiary designation on file with the Plan differs from the beneficiary(ies) named in your will, the beneficiary designation on file with the Plan prevails. If you have not named 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** on this page.

The following information is required for each beneficiary:

- Name
- Relationship to you
- Date of birth
- The percentage you wish to designate per beneficiary, up to 100%

You can also provide the following optional information for each beneficiary, which may help Prudential pay the benefit faster:

- Current address and phone number
- Social Security number

If two or more beneficiaries are named, they will share the insurance benefit equally. The beneficiary management tool will automatically calculate their percentage shares. You will have the opportunity to change these percentages, but note that your assigned percentages must add up to 100%. If they do not, you will receive an error message and be prompted to try again.

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 by using Walmart's beneficiary management tool, which can be accessed at **One.Walmart.com/Beneficiary** or at **MyWalmart**, **Me@Sams**, or **Me@Campus**. To be valid, any change in beneficiary must be on file with the Plan before your death, and the most recent beneficiary designation on file with the Plan will prevail, regardless of the method you used to complete the designation.

If you are unable to access the beneficiary management tool for any reason, for example if you are on a leave of absence, call Prudential at **877-740-2116**.

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 will go to whoever is listed in your beneficiary designation on file with the Plan, regardless of your current relationship with that person, unless applicable law says otherwise. You can check your beneficiaries on file with the Plan and/or change your beneficiary(ies) at any time at **One.Walmart.com/Beneficiary** and **MyWalmart**, **Me@Sams**, or **Me@Campus**. If you are unable to access the beneficiary management tool, call Prudential at **877-740-2116**.

Filing a business travel accident insurance 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
- Cause of injury or death (if known)

An original or certified copy of the death certificate may be 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 70182
Philadelphia, Pennsylvania 19176

If a death certificate is required, 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 Walmart. 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 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 Walmart
- Commission or attempted commission of an assault or felony
- Operating a land, water, or air vehicle while being legally intoxicated

- 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 your business travel accident insurance coverage ends

Your business travel accident insurance coverage ends on your last day of employment.

If you leave Walmart and are rehired

Any coverage that was in effect (or the most similar coverage offered under the Plan) on your termination date will be reinstated when you return to work.

International business travel medical insurance

International business travel medical insurance is available through a policy with Blue Cross Blue Shield Global Solutions for associates who travel internationally for business.

Blue Cross Blue Shield Global Solutions 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 Blue Cross Blue Shield Global Solutions policy. If you have medical coverage under the Saver HSA 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.

Blue Cross Blue Shield Global Solutions services

Business travel medical insurance through Blue Cross Blue Shield Global Solutions provides coverage for emergency medical treatment, including hospitalization, doctor visits, and prescription drug coverage (not including over-the-counter medication).

Blue Cross Blue Shield Global Solutions 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 Blue Cross Blue Shield Global Solutions Customer Service at **888-412-6403** before obtaining medical treatment to ensure that the treatment is covered.

Blue Cross Blue Shield Global Solutions 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)
- Repatriation of remains

If you incur eligible medical expenses, submit them to Blue Cross Blue Shield Global Solutions 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 **bcbsglobalsolutions.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
- Information about health and security risks

Downloading the Blue Cross Blue Shield Global Solutions app: Once you've registered, download the Blue Cross Blue Shield Global Solutions 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 Blue Cross Blue Shield Global Solutions' self-service tools, including mapping to your nearest approved medical facility/provider, making appointments, etc.

Blue Cross Blue Shield Global Solutions 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 **bcbsglobalsolutions.com**.

Claims: Claim forms are generally not required for Blue Cross Blue Shield Global Solutions services. However, if you have a question about your benefits or disagree with the benefits provided, you may contact Blue Cross Blue Shield Global Solutions or file a claim. To submit a claim via email or fax, download a claim form and view detailed instructions

in the Member Portal at **bcbsglobalsolutions.com**. Submit your claim by email to **claims@bcbsglobalsolutions.com** or by fax to **610-482-9623**.

You may also submit claims by post. Download a claim form from the Member Portal at **bcbsglobalsolutions.com** and send your completed form to:

Blue Cross Blue Shield Global Solutions
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 Blue Cross Blue Shield Global Solutions policy. Contact Blue Cross Blue Shield Global Solutions at any time by calling **888-412-6403**. Outside the U.S. call collect: **610-254-5830**.

Accident insurance

Accident insurance	260
Accident insurance benefits	260
Naming a beneficiary	263
Filing an accident insurance claim	264
When benefits are not paid	264
Break in coverage	264
When your accident insurance coverage ends	265
If you leave Walmart and are rehired	265

The information in this chapter describes accident benefits that may be available to you if:

- You are an hourly, temporary, part-time OTR truck driver, or salaried (management) associate
- You have met all requirements for coverage to be effective, including actively-at-work requirements, and
- You have enrolled in a timely manner.

For questions about eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

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 The Standard 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. The coverage is provided under forms GACWM4 or state variations thereof. The coverage has exclusions and limitations. The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by American Heritage Life Insurance Company, Jacksonville, Florida, in all states except New York. Product features and availability vary by state and are solely the responsibility of American Heritage Life Insurance Company.

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	**One.Walmart.com** or **Standard.com/Walmart**	Call The Standard at **800-514-9525**

What you need to know about accident insurance

- You may purchase accident insurance to assist you and your family in the event you or your covered dependent 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 received.
- Proof of Good Health is not required for any level of coverage.
- Coverage is provided through The Standard. The Certificate of Insurance available at **One.Walmart.com** or **Standard.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.

Choosing a coverage tier

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 OTR truck drivers)
- Associate + child(ren)
- Associate + family (except for part-time hourly associates, temporary associates, and part-time OTR truck drivers)

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 tier to associate + child(ren) or associate + family if you wish to continue covering your child after 60 days. See the **Eligibility, enrollment, and effective dates** chapter for information on when and how you may change your election.

The cost for coverage is based on the eligible dependents you choose to cover.

Any injury incurred while you are an active member of the military, naval, or air forces of any country or combination of countries is not covered. Upon notice and proof of service in such forces, The Standard will return the pro-rata portion of the premium paid for any period of such service.

Accident insurance benefits

Accident insurance pays a benefit if you or a covered dependent sustains an injury caused by an off-the-job accident, which results in any of the losses listed in the chart on the following page.

Injuries must be diagnosed by a physician. An accident generally is a covered accident if it occurs while you or your covered dependent is not working at any job for pay or benefits and is the result of a sudden, unforeseen, and unexpected event that occurs without the covered individual's intent and results in injury to you or your covered dependent. Certain accidents are not covered. See **When benefits are not paid** later in this chapter for more information.

Benefits are payable subject to terms of the Certificate of Insurance available at **One.Walmart.com** or **Standard.com/Walmart**. You can also call The Standard at **800-514-9525** for a copy and it will be provided at no cost to you. Coverage must be effective before the occurrence of an accident for the accident to be covered. No benefit is payable for any accident that occurs before your coverage effective date. If you should die before your effective date, no accident insurance benefit will be paid to your beneficiary(ies).

Accident insurance pays benefits described in the following chart for injuries resulting from a covered accident and related services, subject to the terms of the Certificate of Insurance.

Service/injury	Benefit amount	Limitations
Ambulance	$400 for ground ambulance or $4,000 for air ambulance if covered individual requires ambulance transportation to a hospital or emergency center as a result of a covered accident	The ambulance transportation must occur within 72 hours of covered accident. Service must be provided by a licensed professional ambulance company.
Appliance to aid personal locomotion or mobility	$200 if covered individual, as a result of a covered accident and on the advice of a physician, requires use of a medical appliance	Covered medical appliances are: crutches, wheelchair, leg brace, back brace, walker, and CAM boot walker. Payable once per covered individual, per covered accident.
Blood, plasma, and/or platelets	$100 if a covered individual, as a result of a covered accident, requires blood, plasma, and/or platelets	Not payable for immunoglobulins. Payable once per covered individual, per covered accident.
Burns	$100–$10,000 depending on degree of burn and size of affected area, when a covered individual sustains a burn as a result of a covered accident	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. Injuries due to sunburn are not covered.
Coma	$10,000 if a covered individual is in a coma as a result of a covered accident	Coma means a continuous state of profound unconsciousness which lasts seven or more consecutive days as a result of a covered accident. A coma is characterized by an absence of spontaneous eye movements, response to painful stimuli, and vocalization. The condition must require intubation for respiratory assistance. Medically induced comas are excluded.
Concussions (brain)	$50 if a covered individual sustains a concussion as a result of a covered accident	
Dislocation	$188–$3,750, depending on joint dislocated, when a covered individual sustains a dislocation as a result of a covered accident	Payable for only the first dislocation of a joint. Pays 25% of the benefit amount if a covered dislocation is reduced by a physician. Payable for up to two covered dislocations per covered individual, per accident. If more than two dislocations occur during a covered accident, the benefit pays for the two dislocations with the largest dollar amounts.
Emergency dental services	$50 for broken teeth resulting in extractions and $150 for broken teeth repaired with crowns	Pays the benefit amount shown when a covered individual receives dental services as a result of a covered accident. Payable once per covered individual, per covered accident.
Eye injury	$250 for surgical repair; $50 for removal of foreign body	For services performed by a physician as a result of a covered accident.
Family lodging for confinement at a non-local hospital	$100 per night for one hotel/motel room for an immediate family member of covered individual	Payable for up to 30 days per covered accident, and only during the days the covered individual is confined to the non-local hospital.
Follow-up treatment (not covered under physical therapy)	$50 per follow-up visit for required follow-up treatment after receiving emergency treatment for which a benefit is paid under immediate care benefit	Follow-up treatment must be administered by a physician in a physician's office or in a hospital on an outpatient basis and must begin within 30 days of the initial covered treatment. Payable for one follow-up treatment per day for a maximum of six treatments per covered individual, per covered accident. Not payable for treatments for which the physical therapy benefit is paid.
Fractures	$375–$3,750, depending on location of fracture when fracture is corrected by open or closed repair as a result of a covered accident; 25% for chip fractures or other fractures not corrected by open or closed repair	Payable for no more than two fractures per covered individual, per covered accident. If more than two fractures occur during a covered accident, the benefit pays for the two fractures with the largest dollar amounts.
Hospital confinement	Daily benefit of $300 for a continuous hospital confinement of at least 18 hours, up to 365 days per covered accident	Hospitalization must begin within 30 days of covered accident. Not payable on same day rehabilitation benefit is paid. Paid in addition to the initial hospitalization benefit.
Immediate care (physician fees, X-rays, and emergency department)	$170 for a covered person's required medical treatment as a result of a covered accident	Payable for physician fees, X-rays, and emergency room services. Treatment must be received within 30 days of covered accident. Payable only once for any and all treatment occurring within 24-hour period, per covered individual, per covered accident.

(Continued on the next page)

Service/injury	Benefit amount	Limitations
Initial hospitalization	$1,500 payable the first time a covered individual is hospitalized for at least 24 hours for treatment as a result of a covered injury; $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 continuous hospitalization per calendar year, per covered individual.
Intensive care unit (ICU) confinement	$900 per day, up to 15 days for any one accident	Confinement must begin within 30 days of covered accident. Paid in addition to initial hospitalization benefit.
Lacerations	$25–$400, depending on the size of the laceration	Treatment must occur within 72 hours of the covered accident. If proof of loss does not specify size of laceration, the lowest benefit amount will be paid.
Major diagnostic exams	$400 for one of the following, if a covered individual requires the exam as a result of a covered accident: CT scan, MRI, or EEG	Must be performed in a hospital, physician's office, or ambulatory surgical center. One payment per covered individual, per calendar year.
Physical therapy (not covered by follow-up treatment)	$50 per day for physical therapy received as a result of a covered accident	Therapy must be prescribed by a physician and begin within 30 days of covered accident or discharge from hospital and be received within six months of covered accident or discharge from hospital. Payable for one treatment per day, up to 10 treatments per covered accident, per covered individual. Not payable for treatments for which the follow-up treatment benefit is paid.
Post-traumatic stress disorder	$100 per day for PTSD counseling	Payable only once per day, per covered individual, up to six days per calendar year. The covered individual must have been diagnosed with PTSD by a physician or a licensed mental health professional and be receiving counseling by group and/or individual therapy. PTSD means a mental health condition that is triggered by a covered accident. Symptoms must include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the covered accident.
Prosthesis	$1,000 for a prosthetic device required as a result of a covered accident	Not payable for hearing aids, wigs, or dental aids (including false teeth). Payable once per covered individual, per covered accident.
Rehabilitation unit confinement (after hospitalization)	$100 per day if covered individual is confined to rehabilitation unit as a result of a covered accident	Must have been confined to a hospital immediately prior to being transferred to the rehabilitation unit. Payable for each day a room charge is incurred, up to 30 days per covered individual, per continuous period of confinement; maximum of 60 days. Not payable for days in which hospital confinement benefit is paid.
Skin grafts	50% of benefit amount under the burns benefit if a covered individual receives one or more skin grafts for a covered burn.	Paid in addition to the burns benefit.
Step-down ICU confinement	$200 per day for confinement of at least 18 hours	Payable per covered individual, per covered accident, in addition to any hospital confinement benefit. Payable for up to 15 days per covered individual, per covered accident.
Surgical procedures	$350–$1,400, depending on surgical procedure	Two or more surgical procedures performed through the same incision or entry point are considered one operation. The benefit will pay only for the procedure with the largest dollar amount. Must be performed within one year of covered accident. Miscellaneous surgery is surgery that requires general anesthesia and must not be covered by any other specific surgery benefit listed. The miscellaneous surgery benefit is payable once per 24 hours even though more than one surgery or procedure may be performed.
Transportation for treatment at a non-local hospital	$400 per round trip for treatment at a non-local hospital as a result of a covered accident; additional $400 per round trip for one parent or legal guardian if dependent child is receiving treatment	Physician must prescribe the treatment. Payable for up to three round trips per calendar year per covered individual. Not payable for ambulance transportation.

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/Beneficiary**. Your beneficiary designation must be completed and submitted to the Plan before your death. If you are unable to access the beneficiary management tool you should contact People Services at **800-421-1362** for assistance.

You may name your beneficiaries by using Walmart's beneficiary management tool, which can be accessed at **One.Walmart.com/Beneficiary** or at **MyWalmart**, **Me@Sams**, or **Me@Campus**. You can also name your beneficiaries through the website of The Standard at **Standard.com/Walmart**, or by using its form. A beneficiary designation that is properly completed by any of these methods is considered to be on file with the Plan.

To be valid, your beneficiary designation must be on file with the Plan before your death. The most recent beneficiary designation on file with the Plan will prevail, regardless of the method you used to complete the designation.

If you are unable to access the beneficiary management tool for any reason, for example if you are on a leave of absence, you should use the website of The Standard at **Standard.com/Walmart** to name your beneficiary(ies). Call The Standard at **800-514-9525** if you have difficulty with its website or to request its form.

Note: If you enroll in accident insurance, drop the coverage and subsequently reenroll within two years, The Standard will reinstate your prior beneficiary designation, if any. If that designation no longer reflects your wishes, you should change your beneficiary(ies) as described in the **Changing your beneficiary** section below.

You can name anyone you wish as your beneficiary(ies). If the beneficiary(ies) listed in your most recent beneficiary designation on file with the Plan differs from the beneficiary(ies) named in your will, the beneficiary designation on file with the Plan prevails. If you have not named a beneficiary(ies) under the associate accident insurance benefit, payment will be made to your surviving family members as described under **If you do not name a beneficiary** on this page.

The following information is required for each beneficiary:

- Name
- Relationship to you
- Date of birth
- The percentage you wish to designate per beneficiary, up to 100%

You can also provide the following optional information for each beneficiary, which may help The Standard pay the benefit faster:

- Current address and phone number
- Social Security number

If two or more beneficiaries are named 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, The Standard 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 covered dependent's accident coverage. If you and your dependent die at the same time, benefits will be paid as if you had not named a beneficiary. See **If you do not name a beneficiary** below.

Changing your beneficiary

You can change your beneficiaries at any time by using Walmart's beneficiary management tool, which can be accessed at **One.Walmart.com/Beneficiary** or at **MyWalmart**, **Me@Sams,** or **Me@Campus**. You can also change your beneficiaries through the website of The Standard at **Standard.com/Walmart**, or by using its form. To be valid, any change in beneficiary must be on file with the Plan before your death, and the most recent beneficiary designation on file with the Plan will prevail, regardless of the method you used to complete the designation.

If you are unable to access the beneficiary management tool for any reason, for example if you are on a leave of absence, you should use the website of The Standard at **Standard.com/Walmart** to change your beneficiary(ies). Call The Standard at **800-514-9525** if you have difficulty with its website or to request its form.

If you do not name a beneficiary

If no beneficiary is named or the beneficiary you named does not survive you, payment of any benefits due at your death will be paid in the following order:

- Spouse/partner; if not surviving, then
- Children, in equal shares; if not surviving, then
- Parents, in equal shares; if not surviving, then
- Siblings, in equal shares; if not surviving, then
- Your estate

Be sure to keep your beneficiary information up to date. Proceeds go to whoever is listed in your beneficiary designation on file with the Plan, regardless of your current relationship with that person, unless applicable law says otherwise. You can check your beneficiaries on file with the Plan and/or change your beneficiary(ies) at any time at **One.Walmart.com/Beneficiary**, and **MyWalmart**, **Me@Sams**, **Me@Campus**, or at **Standard.com/Walmart**.

Filing an accident insurance 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:

The Standard
Attn: Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488

You may also provide notice of claim as follows:

Online: **Standard.com/mybenefits**
By phone: **800-514-9525**
By fax: **877-423-8804**

Provide the following information for the covered individual:

- Name
- Social Security number
- Date the covered accident occurred

You may request a claim form from The Standard or visit **One.Walmart.com** or **Standard.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 The Standard by providing The Standard with a statement of the nature and extent of the loss.

You will be required to provide written proof of your claim to The Standard. 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 The Standard 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. See the **Claims and appeals** chapter for details.

When benefits are not paid

No benefit will be paid for an accident that occurs as a result of:

- An injury that occurs as the result of an on-the-job accident
- An injury that occurs prior to the coverage effective date
- 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 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
- Committing or attempting to commit an assault or felony
- Any injury incurred while a covered individual is an active member of the military, naval, or air forces of any country or combination of countries

Break in coverage

There may be occasions in which you must make special arrangements to pay for your accident insurance coverage 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). Failure to pay amounts owed for coverage within 30 days of the due date will result in an interruption in the payment of any benefit claims and/or cancellation of coverage.

For details on how to make payments to continue your coverage, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** 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 for your coverage before or during the leave. For information about making payments while on a leave of absence, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter.

When your accident insurance coverage ends

Your accident insurance coverage ends on the earliest of the following:

- On the date you voluntarily drop coverage (as described below)
- On the date you terminate employment
- On the last day of coverage for which payment was made, if you fail to pay the amount owed for your coverage within 30 days of the date your payment was due
- On your date of death
- On the last day of an approved leave of absence (unless you return to work)
- When accident insurance is no longer offered by Walmart

Accident insurance coverage for your spouse/partner ends:

- On the date your accident insurance coverage ends
- On the last day of the pay period in which your job status changes to part-time, temporary, or part-time OTR truck driver
- On the date you and your spouse are legally separated
- On the date you and your spouse are divorced or your partnership terminates
- On your spouse/partner's death

Accident insurance coverage for your dependent child(ren) ends on the earliest of the following:

- On the date your accident insurance coverage ends
- On the date your dependent child loses eligibility
- On your dependent child's death

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

If you voluntarily drop coverage after an election change event or at Annual Enrollment, coverage ends as follows:

- **After an election change event:** coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information
- **At Annual Enrollment:** coverage ends on December 31 of the current year

Continuation of coverage at termination

If your accident insurance coverage terminates as described above (except due to failure to pay amounts owed for coverage or death), you and your covered dependents may continue accident insurance coverage directly from The Standard through portability coverage.



You will not be able to continue your coverage unless you contact The Standard and send in the first premium within 60 days of the date your coverage ends.

Portability coverage will be effective on the day after coverage under the Plan terminates and will end on the earliest of the following:

- The date you again are eligible for accident insurance under the Plan
- The last day of coverage for which payment was made, if you fail to pay the amount owed for your coverage within 30 days of the date your payment was due
- For your covered dependents, on the date your coverage terminates or the date the dependent ceases to be an eligible dependent

Any eligible dependent covered under accident insurance at the time such coverage terminates as a result of reaching the maximum age for eligibility may also receive portability coverage under the terms described above. Contact The Standard at **800-514-9525** for information.

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 The Standard at **800-514-9525**.

If you leave Walmart and are rehired

If you are a part-time hourly associate or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

If you are a full-time hourly, management, or truck driver associate, see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

Accidental death and dismemberment (AD&D) insurance

AD&D insurance	268
Naming a beneficiary	268
AD&D coverage amount	269
When AD&D benefits are paid	269
Additional AD&D benefits	270
Filing an AD&D insurance claim	272
When benefits are not paid	272
Break in coverage	272
When your AD&D insurance coverage ends	272
If you leave Walmart and are rehired	273

The information in this chapter describes accidental death and dismemberment benefits that may be available to you if:

- You are an hourly, temporary, part-time OTR truck driver, or salaried (management) associate
- You have met all requirements for coverage to be effective, including actively-at-work requirements, and
- You have enrolled in a timely manner.

For questions about eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

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	**One.Walmart.com/Beneficiary**	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

- 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).
- The Certificate of Insurance is available at **One.Walmart.com** or at **Prudential.com/Walmart**. The certificate provides detailed information about company-paid life insurance, in addition to the highlights available in this chapter.

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.

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 OTR 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

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 name your beneficiary(ies) by using Walmart's beneficiary management tool, which can be accessed at **One.Walmart.com/Beneficiary** or at **MyWalmart**, **Me@Sams**, or **Me@Campus**.

To be valid, your beneficiary designation must be on file with the Plan before your death. The most recent beneficiary designation on file with the Plan will prevail, regardless of the method you used to complete the designation.

You (the associate) will receive any benefits payable for your covered dependents.

If you are unable to access the beneficiary management tool for any reason, for example if you are on a leave of absence, call Prudential at **877-740-2116**.

You can name anyone you wish as your beneficiary(ies). If the beneficiary(ies) listed in your most recent beneficiary designation on file with the Plan differs from the beneficiary(ies) named in your will, the beneficiary designation on file with the Plan prevails. If you have not designated a beneficiary(ies) under the associate AD&D benefit, payment will be made to your surviving family members as described under **If you do not name a beneficiary** in the next column.

The following information is required for each beneficiary:

- Name
- Relationship to you
- Date of birth
- The percentage you wish to designate per beneficiary, up to 100%

You can also provide the following optional information for each beneficiary, which may help Prudential pay the benefit faster:

- Current address and phone number
- Social Security number

If two or more beneficiaries are named, they will share the insurance benefit equally. The beneficiary management tool will automatically calculate their percentage shares. You will have the opportunity to change these percentages, but note that your assigned percentages must add up to 100%. If they do not, you will receive an error message and be prompted to try again.

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 beneficiaries at any time by using Walmart's beneficiary management tool, which can be accessed at **One.Walmart.com/Beneficiary** and at **MyWalmart**, **Me@Sams**, or **Me@Campus**. To be valid, any change in beneficiary must be on file with the Plan before your death, and the most recent beneficiary designation on file with the Plan will prevail.

If you are unable to access the beneficiary management tool for any reason, for example if you are on a leave of absence, call Prudential at **877-740-2116**.

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/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 in your beneficiary designation on file with the Plan, regardless of your current relationship with that person, unless applicable law says otherwise. You can check your beneficiaries on file with the Plan and/or change your beneficiary(ies) at any time at **One.Walmart.com/Beneficiary** and **MyWalmart**, **Me@Sams**, or **Me@ Campus**. If you are unable to access the beneficiary management tool, call Prudential at **877-740-2116**.

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
- Quadriplegia: Total paralysis of both upper and lower limbs

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

- 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
- Tuition reimbursement 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
- Tuition reimbursement and childcare 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) and 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.
Tuition reimbursement 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. Must be enrolled in a professional or trade program within 30 months after the date of your death. *Full-time hourly and management associates only.*
Tuition reimbursement 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. Child must be enrolled as a full-time student on the date of your death; or, if in the 12th grade on the date of death, becomes a full-time student within 365 days after the date of your death.
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. Child must be enrolled on the date of your death or within 90 days after the date of your death.
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.
Medical premium benefit for associate (COBRA)	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
Medical premium benefit for dependent (COBRA)	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 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 an AD&D insurance claim

The following information must be provided to Prudential regarding the claimant:

- Name
- Social Security number
- Date of death or injury
- 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 70182
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
- 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 for your AD&D insurance coverage 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). Failure to pay amounts owed for coverage within 30 days of the due date will result in an interruption in the payment of any benefit claims and/or cancellation of coverage.

For details on how to make payments to continue your coverage, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** 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 for coverage before or during the leave. For information about making payments while on a leave of absence, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter.

When your AD&D insurance coverage ends

Your AD&D coverage ends:

- On the date you voluntarily drop coverage (as described on the following page)
- At termination of your employment
- On the last day of coverage for which payment was made, if you fail to pay the amount owed for your coverage within 30 days of the date your payment was due
- 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)
- When the benefit is no longer offered by Walmart. 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 OTR truck driver, your coverage for your spouse/partner will end on the last day of the pay period in which your job status changes.

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

If you voluntarily drop coverage after an election change event or at Annual Enrollment, coverage ends as follows:

- **After an election change event:** coverage ends on the effective date of the event. See **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave Walmart and are rehired

If you are a part-time hourly associate or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

If you are a full-time hourly, management, or truck driver associate, see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

Critical illness insurance

Critical illness insurance	276
Critical illness benefits	276
Naming a beneficiary	278
Filing a critical illness insurance claim	279
When benefits are not paid	279
Break in coverage	279
When your critical illness insurance coverage ends	280
If you leave Walmart and are rehired	281

The information in this chapter describes critical illness benefits that may be available to you if:

- You are an hourly, temporary, part-time OTR truck driver, or salaried (management) associate
- You have met all requirements for coverage to be effective, including actively-at-work requirements, and
- You have enrolled in a timely manner.

For questions about eligibility, enrollment, requirements for coverage to be effective, and the impact on your benefits of a change in your job classification, see the **Eligibility, enrollment, and effective dates** chapter.

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 The Standard 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. The coverage is provided under forms GCICWM4, or state variations thereof. The coverage has exclusions and limitations. The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by American Heritage Life Insurance Company, Jacksonville, Florida, in all states except New York. Product features and availability vary by state and are solely the responsibility of American Heritage Life Insurance Company.

Critical illness insurance

If you enroll yourself and your eligible dependents in critical illness insurance, you or your beneficiary will 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	**One.Walmart.com** or **Standard.com/Walmart**	Call The Standard 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 you or your covered dependent is diagnosed with certain serious illnesses.
- You may elect coverage amounts of $5,000, $10,000, $15,000, or $20,000.
- If you or a covered dependent is diagnosed with a covered critical illness, 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 **Standard.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.

Choosing a coverage tier

When you enroll for critical illness insurance, you may 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 OTR truck drivers)
- Associate + child(ren)
- Associate + family (except for part-time hourly associates, temporary associates, and part-time OTR truck drivers)

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, enrollment, and effective dates** chapter for information on when and how you may change your election.

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.

Critical illness benefits

Benefits are payable if you are diagnosed with one of the conditions listed below, subject to terms of the Certificate of Insurance available at **One.Walmart.com** or **Standard.com/Walmart**. You can also call The Standard at **800-514-9525** for a copy. Coverage must be effective before the date of diagnosis for an illness or disease to be covered under the policy.

No benefit is payable for any disease diagnosed before the coverage effective date. If you die before your coverage effective date, no critical illness insurance benefit will be paid to your beneficiary(ies).

Benefits of 100% of the coverage amount you elect will be paid upon the occurrence of the following critical illnesses, subject to complete details in the Certificate of Insurance:

- Invasive cancer
- Alzheimer's disease (requires loss of three activities of daily living)
- Coronary artery bypass surgery (excludes balloon angioplasty, laser embolectomy, atherectomy, stent placement, and other non-surgical procedures)
- End-stage renal failure
- Heart attack
- Stroke
- Parkinson's disease (requires loss of two activities of daily living)
- Total and irreversible loss of hearing in both ears continuing for six consecutive months following the illness that caused it and that cannot be corrected by the use of any hearing aid or device
- Permanent and uncorrectable loss of sight in one or both eyes due to sickness
- Quadriplegia
- Paraplegia
- Loss of at least one foot, hand, arm, or leg
- Benign brain tumor, other than tumors of the skull, pituitary adenomas, or germinomas, resulting in persistent neurological deficits
- Coma (not medically induced) lasting at least seven consecutive days due to underlying illness or traumatic brain injury that begins within 31 days of illness
- Sickle cell anemia
- Systemic lupus
- Tuberculosis
- Major organ transplant or placement on the National Transplant List as an active or an inactive candidate for a 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 HSA 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: 25% of coverage amount
- Transient ischemic attacks (TIAs): 25% of coverage amount

- Aneurysm (ruptured or dissecting and undergoes surgery): 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
  - Systemic sclerosis (scleroderma)
  - Tetanus

All of the benefits described above will be paid once, under the Initial Critical Illness benefit.

The following Recurrence of Critical Illness benefits are paid for a second diagnosis:

- Benign brain tumor
- Invasive cancer
- Carcinoma in situ
- Ruptured or dissecting aneurysm
- Coma
- Rabies
- Coronary artery bypass surgery
- Stroke
- Heart attack

Note: The Recurrence of Critical Illness benefits will be paid a second time at 100% of the coverage amount if:

- The recurrence happens at least 181 days after the initial occurrence.
- For a recurrence of the same type of cancer, you must be symptom-free and treatment-free for 181 days after the initial occurrence. (Maintenance medications and follow-up visits do not count as treatment.)
- Diagnosis of an unrelated cancer is not excluded.

Other benefits payable include:

- Ambulance: $400 for ground ambulance or $4,000 for air ambulance if a covered individual 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 individual receives counseling for PTSD; payable once per day per covered individual and limited to six days per calendar 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 individual each calendar year.
- National Cancer Institute (NCI) evaluation or 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 NCI center or Walmart Centers of Excellence facility 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 a covered individual receives treatment for a covered illness on an outpatient basis at a treatment facility more than 100 miles from the covered individual'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 individual lives within 100 miles of the treatment facility. The Plan does not pay for transportation for someone to accompany or visit the covered individual receiving treatment; visits to a physician's office or clinic; or for other services.

Naming a beneficiary

You may name your beneficiaries by using Walmart's beneficiary management tool, which can be accessed at **One.Walmart.com/Beneficiary** or at **MyWalmart**, **Me@Sams**, or **Me@Campus**. You can also name your beneficiaries through the website of The Standard at **Standard.com/Walmart**, or by using its form. A beneficiary designation that is properly completed by any of these methods is considered to be on file with the Plan.

To be valid, your beneficiary designation must be on file with the Plan before your death. The most recent beneficiary designation on file with the Plan will prevail, regardless of the method you used to complete the designation.

If you are unable to access the beneficiary management tool for any reason, for example if you are on a leave of absence, you should use the website of The Standard at **Standard.com/Walmart** to name your beneficiary(ies). Call The Standard at **800-514-9525** if you have difficulty with its website or to request its form.

Note: If you enroll in critical illness insurance, drop the coverage and subsequently reenroll within two years, The Standard will reinstate your prior beneficiary designation, if any. If that designation no longer reflects your wishes, you should change your beneficiary(ies) as described in the **Changing your beneficiary** section below.

You can name anyone you wish as your beneficiary(ies). If the beneficiary(ies) listed in your most recent beneficiary designation on file with the Plan differs from the beneficiary(ies) named in your will, the beneficiary designation on file with the Plan prevails. If you have not named a beneficiary(ies) under the critical illness insurance, payment will be made to your surviving family members as described under **If you do not name a beneficiary** on this page.

The following information is needed for each beneficiary you name:

- Name
- Relationship to you
- Date of birth
- The percentage you wish to designate per beneficiary, up to 100%

You can also provide the following optional information for each beneficiary, which may help The Standard pay the benefit faster:

- Current address and phone number
- Social Security number

If two or more beneficiaries are named 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, The Standard 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 covered dependent's critical illness coverage. If you and your dependent die at the same time, benefits will be paid as if you had not named a beneficiary. See **If you do not name a beneficiary** on this page.

Changing your beneficiary

You can change your beneficiary(ies) at any time by using Walmart's beneficiary management tool, which can be accessed at **One.Walmart.com/Beneficiary** or at **MyWalmart**, **Me@Sams**, or **Me@Campus**. You can also change your beneficiaries through the website of The Standard at **Standard.com/Walmart**, or by using its form. To be valid, any change in beneficiary must be on file with the Plan before your death, and the most recent beneficiary designation on file with the Plan will prevail, regardless of the method you used to complete the designation.

If you are unable to access the beneficiary management tool for any reason, for example if you are on a leave of absence, you should use the website of The Standard at **Standard.com/Walmart** to change your beneficiary(ies). Call The Standard at **800-514-9525** if you have difficulty with its website or to request its form.

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 of any benefits due at your death will be paid in the following order:

- Spouse/partner; if not surviving, then
- Children, in equal shares; if not surviving, then
- Parents, in equal shares; if not surviving, then
- Siblings, in equal shares; if not surviving, then
- Your estate

Be sure to keep your beneficiary information up to date. Proceeds go to whoever is listed in your beneficiary designation on file with the Plan, regardless of your current relationship with that person, unless applicable law says otherwise. You can check your beneficiaries on file with the Plan and/or change your beneficiary(ies) at any time at **One.Walmart.com/Beneficiary**, and **MyWalmart**, **Me@Sams**, **Me@Campus**, or at **Standard.com/Walmart**.

Filing a critical illness insurance 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:

The Standard
Attn: Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488

You may also provide notice of claim as follows:

Online: **Standard.com/mybenefits**
By phone: **800-514-9525**
By fax: **877-423-8804**

Be sure to provide the following information for the covered individual:

- Name
- Social Security number
- Date the covered illness began

You may request a claim form from The Standard or visit **One.Walmart.com** or **Standard.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 The Standard by providing The Standard 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

No benefit will be paid for any critical illness due to or resulting directly or indirectly from:

- A critical illness that occurred prior to the coverage effective date
- 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
- 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 for your critical illness insurance coverage 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). Failure to pay amounts owed for coverage within 30 days of the due date will result in an interruption in the payment of any benefit claims and/or cancellation of coverage.

For details on how to make payments to continue your coverage, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** 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 for coverage before or during the leave. For information about making payments while on a leave of absence, see **Keeping your coverage payments current** in the **Eligibility, enrollment, and effective dates** chapter.

When your critical illness insurance coverage ends

Your critical illness insurance coverage ends on the earliest of the following:

- On the date you voluntarily drop coverage (as described on this page)
- On the date you terminate your employment
- On the last day of coverage for which payment was made, if you fail to pay the amount owed for your coverage within 30 days of the date your payment was due
- On your date of death
- On the last day of an approved leave of absence (unless you return to work)
- When critical illness insurance is no longer offered by Walmart

Critical illness insurance coverage for your spouse/partner ends on the earliest of the following:

- On the date your insurance coverage ends
- On the last day of the pay period in which your job status changes to part-time, temporary, or part-time OTR truck driver
- On the date you and your spouse are legally separated
- On the date you and your spouse are divorced or your partnership ends
- On your spouse/partner's death

Critical illness insurance coverage for your dependent child(ren) ends on the earliest of the following:

- On the date your insurance coverage ends
- On the date your dependent child loses eligibility
- On your dependent child's death

If your job classification changes, see the appropriate chart in the **Transferring from one job classification to another** section in the **Eligibility, enrollment, and effective dates** chapter for information on any impact to your coverage.

If you voluntarily drop coverage after an election change event or at Annual Enrollment, coverage ends as follows:

- **After an election change event**: coverage ends on the effective date of the event. See **Permitted election changes outside Annual Enrollment** in the **Eligibility, enrollment, and effective dates** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

Continuation of coverage at termination

If your coverage under critical illness insurance terminates as described above (except due to failure to pay amounts owed for coverage or death), you and your covered dependents may continue critical illness insurance coverage directly from The Standard through portability coverage. The benefits, terms, and conditions of the portability coverage will be the same as those provided under the critical illness insurance available under the Plan at the time of termination. To receive portability coverage, you must notify The Standard that you wish to continue coverage and send the first premium within 60 days of the date your coverage under critical illness insurance terminates.



You will not be able to continue your coverage unless you contact The Standard and send in the first premium within 60 days of the date your coverage ends.

Portability coverage will be effective on the day after coverage under the Plan terminates and will end on the earliest of the following:

- The date you again are eligible for critical illness insurance under the Plan
- The last day of coverage or which payment was made, if you fail to pay your premiums within 30 days of the date they were due
- For your covered dependents, on the date your coverage terminates or the date the dependent ceases to be an eligible dependent

Any eligible dependent covered under critical illness insurance at the time such coverage terminates as a result of reaching the maximum age for eligibility may also receive portability coverage under the terms described above. Contact The Standard at **800-514-9525** for information.

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 The Standard at **800-514-9525**.

If you leave Walmart and are rehired

If you are a part-time hourly associate or temporary associate who is subject to the 60-day, one-time, and annual eligibility checks for medical benefits, see the **Part-time hourly associates and temporary associates: eligibility checks for medical benefits** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

If you are a full-time hourly, management, or truck driver associate, see the **If you leave Walmart and are rehired** section in the **Eligibility, enrollment, and effective dates** chapter for details regarding the impact to your benefits of terminating employment with Walmart and then returning to work.

Claims and appeals

Deadlines to file a claim or bring legal action	284
Appealing an enrollment or eligibility status decision	284
Medical, pharmacy, Centers of Excellence, dental, and vision benefits claims	285
Claims process	286
Internal appeal process	289
Travel benefit for care	291
Special claims and appeal procedures for Centers of Excellence and advanced imaging services: network exception requests	291
Voluntary review	297
External appeal process for medical, pharmacy, or Centers of Excellence benefits	298
Other rights related to medical, pharmacy, Centers of Excellence, dental, vision, and short-term disability benefits	298
The Plan's subrogation and reimbursement rights	299
Claims for benefits and right to appeal reduction, reimbursement, and subrogation decisions	301
HMO plan options' claims and appeals procedures	302
Accident and critical illness insurance claims process	302
Company-paid life insurance, optional associate and dependent life insurance, business travel accident insurance, and AD&D claims process	305
Claims and appeals process for short-term disability coverage claims	307
Claims and appeals process for long-term disability coverage claims	312
My Mental Health Resources	314
Nicotine cessation program	314
International business travel medical insurance	314

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 determination regarding your enrollment or eligibility status or a claim for the following benefits that has been partially or fully denied: medical, pharmacy, dental, vision, HMO options, disability, and life, AD&D, critical illness, or accident insurance.

Resources	
Find what you need	
Submit a claim for benefits	Claims must be submitted within the deadlines provided in this chapter. For medical, pharmacy, dental, and vision claims, see your plan ID card for the claims address or call your health care advisor or care navigator at the number on your plan ID card. Submit Centers of Excellence claims to the administrator as shown in the **Program administration: Claims administration** chart later in the chapter. Submit all other claims to the Plan's third-party administrators or insurer, if applicable, as shown later in this chapter.
Pharmacy prior authorization and non-formulary clinical review	**TruDataRx** Electronic prior authorization can be submitted via CoverMyMeds or SureScripts by your provider, or you or your provider call TruDataRx at **833-575-0755** or fax a prior authorization request to **888-707-7324**.
Appeal a denied claim	Submit appeals to the addresses and within the deadlines provided in this chapter. Your initial claim denial notice will specify where, how, and the deadline to file an appeal.
Appeal a decision on eligibility for coverage or enrollment status	Write to: **Walmart Benefits Total Rewards Team** **Attn: Internal Appeals** **Mail Stop 3610** **806 Excellence Drive** **Bentonville, Arkansas 72716-3610** Or email **ghappeal@wal-mart.com** **Note: You must send your request to the specific address above, including the mail stop. If your request is not sent to this address, receipt by the Plan will be delayed.** Or for COBRA appeals, write to: **WageWorks (COBRA Appeals)** **P.O. Box 14390** **Lexington, Kentucky 40512-4390**
Designate an authorized representative to submit claims and appeals on your behalf	Call the number on your plan ID card or call People Services at **800-421-1362** to request the Plan's authorized representative form.

What you need to know about claims and appeals

- You have the right to appeal an adverse enrollment or eligibility decision affecting your coverage.
- You have the right to appeal an adverse decision regarding your requested benefits, including requests for prior authorization.
- You have the right to appeal a benefit claim that has been partially or fully denied.
- You can appoint another party to file a claim or 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 the claim is denied based on medical judgment or based on a determination that the claim is not subject to surprise billing protections.
- 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.

For purposes of this chapter, the claims and appeals procedures described in this chapter apply to all benefit plans offered under the Walmart Inc. Associates' Health and Welfare Plan, unless otherwise specified. When a particular benefit plan is being discussed, references to the "Plan" should be understood to mean the specific benefit plan being discussed.

Deadlines to file a claim or bring legal action

Unless otherwise specified in this chapter, initial claims for benefits under the Plan must be filed within 12 months from the date of service or other date on which the right to make a claim first arises. 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 meet all claim and appeal deadlines and exhaust your administrative remedies before you may take other legal action. 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, before you may 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 procedures described in this chapter. You can appoint another party to file a claim or appeal on your behalf by completing the Plan's authorized representative form.

You have limited time to file a lawsuit claiming benefits. If you have completed all required claims and internal appeals and you want to file a lawsuit, you must file any lawsuit for benefits within 180 days from the date you receive the decision on appeal (whether by the Plan or after external review). You may not file suit after the end of that 180-day period. If you request a voluntary review or, if applicable, an external review, the time taken by the voluntary review or external review is not counted against the 180 days you have to file a lawsuit. However, you are not required to request a voluntary review or an external review of the decision on appeal before filing a lawsuit.

Benefits may not be assigned

You may not assign your legal rights, such as the right to pursue an appeal, the right to request copies of certain Plan-related documents, the right to pursue any type of litigation on your behalf, including but not limited to litigation for payment of benefits, the right to pursue litigation for breach of fiduciary duty, the right to pursue litigation seeking equitable relief, or the right to pursue litigation to recover any statutory penalties, or your rights to any payments under this Plan. However, the Plan may choose to remit benefit 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 exercise legal rights or pursue appeals or legal causes of action on behalf of (or in place of) you or your covered dependents under any circumstances.

Appealing an enrollment or eligibility status decision

This section describes the appeal process that applies to enrollment and eligibility determinations, including whether you have met applicable waiting periods for coverage to be effective and whether you have met eligibility conditions for a specific benefit, such as weight loss surgery under the Centers of Excellence program.

If you disagree with the Plan Administrator's determination regarding your enrollment or eligibility status, you have 180 days from the date of your eligibility enrollment event to appeal in writing to Walmart Benefits Total Rewards Team, attention Internal Appeals, at the address in the **Resources** chart at the beginning of this chapter.

COBRA participants should send the appeal, in writing, to WageWorks (COBRA Appeals) at the address in 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. See the **Voluntary review** section later in this chapter.

Medical, pharmacy, Centers of Excellence, dental, and vision benefits claims

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 plan options; see **HMO plan options' claims and appeals procedures** later in this chapter
- Dental benefits (through Delta Dental)
- Vision benefits (through VSP)
- A rescission of coverage, which is a cancellation of coverage that has a retroactive effect. A cancellation of coverage due to failure to pay required contributions for coverage in a timely manner is not a rescission and is not subject to the claims process.

If you voluntarily choose to prenotify the third-party administrator ("TPA") of a scheduled medical service before you receive treatment, and the medical service is not required to be preauthorized, the TPA's response is nonbinding on the Plan and not subject to appeal. However, if the Plan terms or policies, as applied by the TPA, require you or your provider to preauthorize services and your request for prior authorization is denied, that decision is subject to appeal. See **The medical plan** chapter for more information on voluntary prenotification and required prior authorization provisions. Contact your TPA if you have questions about whether a service requires prior authorization.

For questions about prior authorization of medications on the Plan's list of covered medications, or medications on the Plan's non-formulary list that are eligible for clinical review, contact TruDataRx. If your request for prior authorization or a non-formulary clinical review is denied, that decision is subject to appeal.

Overview of claims process

When you receive medical, dental, or vision services from a provider, you or your provider must submit a "claim" to a third party who has been delegated the fiduciary authority to determine whether the Plan will pay a benefit for the services. If you receive services from a network provider, the provider will generally file the claim for you. If you receive services from a non-network provider, you may need to file the claim yourself. As a convenience to you the Plan may pay benefits for covered services directly to the provider.

Claim forms are located on **One.Walmart.com/Claims**.

The type of services you receive will determine where you or your provider must submit the claim for benefits. This chapter will provide that information. You or your authorized representative may file a claim as described in the **Claims process** section. If your claim is fully or partially denied, meaning the Plan will not pay a benefit for the services, you will receive a notice that explains why the Plan will not pay a benefit. The notice will tell you what you need to do to file an internal appeal if you would like the claim to be reviewed again.

If you want to file an internal appeal, you or your authorized representative may file an appeal as described in the **Internal appeal process** section later in this chapter. On appeal, your claim will be reviewed again, along with additional information you or your provider submit. If the denial of your claim is upheld, you will receive a notice that explains why the Plan upheld the denial. The notice will tell you whether additional internal appeals are available to you. You may also have the right to file a lawsuit claiming benefits.

If your appeal is denied you may have the right to further appeal your claim in an independent review process. See the **External appeal process for medical, pharmacy, or Centers of Excellence benefits** section later in this chapter.

Claims process

Time periods for claim determinations

After your claim is filed, the time period in which your claim is determined depends on the type of claim that is filed.

Time periods in which claims are decided	
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. Notice will be provided regardless of whether the claim is approved or denied. 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 preauthorization. See the **Prior authorization** section of **The medical plan** chapter for medical services that may require preauthorization. You should also check with your TPA to determine whether a service requires prior authorization. See **The pharmacy benefit** chapter for information about medications that require prior authorization or are eligible for a non-formulary clinical review.	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 received.	A notice of a denial of a post-service claim 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, such as a reduction in the length of a previously approved hospital stay, or a request to extend an ongoing course of treatment.	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 and obtain a determination before the coverage is reduced or terminated, unless such a reduction or termination is due to a Plan amendment or termination of the Plan.

Administration of routine medical, pharmacy, dental, and vision claims

The following chart shows the entity that has been delegated the fiduciary authority to decide routine claims for medical, pharmacy, dental, and vision claims.

See your plan ID card or contact your health care advisor or care navigator if you have questions.

Claims administration: Routine medical, pharmacy, dental, and vision	
If one or more of the following applies to you: You are enrolled in the Personalized Wellbeing Copay Plan, **or** You are enrolled in the Premier PPO, Contribution HRA, or Saver HSA **and** • UMR is your TPA, **or** • Skai Blue is your TPA **and** your work location is in Alabama, Alaska, Arizona, Colorado, Illinois, Indiana, Iowa, Kentucky, Minnesota, Missouri, North Carolina, South Carolina, Tennessee, Texas, Virginia, West Virginia, or Wisconsin	**Pre-service claims** **Specialty medications and infusion care:** Your TPA **All other pre-service claims** (including pre-service network exception requests for advanced imaging services): American Health Holding, Inc. or HealthHelp on behalf of Included Health. ***Exception:*** If Skai Blue is your TPA, prior authorization requests related to neonatal intensive care unit stays are decided by ProgenyHealth and appeals of denied pre-service claims are decided by Skai Blue. For all pre-service claims, call your TPA at the number on your plan ID card and you will be connected to the right place.
	Post-service claims **Services requiring prior authorization:** **Specialty medications and infusion care:** Your TPA **All other services** (including post-service network exception requests for advanced imaging services): American Health Holding, Inc. or HealthHelp on behalf of Included Health. ***Exception:*** If Skai Blue is your TPA, post-service claims related to neonatal intensive care unit stays are decided by ProgenyHealth and appeals of denied post-service claims are decided by Skai Blue. **All other post-service claims:** Your TPA.
If all of the following apply to you: You are enrolled in the Premier PPO, Contribution HRA, or Saver HSA Plan, **and** Skai Blue is your TPA, **and** • Your work location is not in Alabama, Alaska, Arizona, Colorado, Illinois, Indiana, Iowa, Kentucky, Minnesota, Missouri, North Carolina, South Carolina, Tennessee, Texas, Virginia, West Virginia, or Wisconsin	**All pre-service and post-service claims:** Skai Blue ***Exception:*** Claims (including prior authorization requests) related to neonatal intensive care unit stays are decided by ProgenyHealth and appeals are decided by Skai Blue.
Centers of Excellence program for family building	**Claims for medical services:** Your TPA
	Claims for travel: Consociate Health
Centers of Excellence program for heart surgery	**Program eligibility:** Your TPA **Claims for services (including travel):** Consociate Health
Pharmacy	**Reimbursement requests:** OptumRx **Prior authorization, non-formulary clinical review, claims related to formulary status, and appeals:** TruDataRx
Dental	**All claims:** Delta Dental
Vision	**All claims:** VSP

Note: Requests for network exceptions for advanced imaging services are subject to special claims and appeal procedures, as described later in this chapter. If you are requesting a network exception for advanced imaging services, please consult those procedures.

Administration of Centers of Excellence program claims (excluding family building)

The chart below lists the Centers of Excellence ("COE") program administrators that you must coordinate with prior to receiving services at a COE facility and that will process claims. Pre-service claims may be filed for some COE services. See the **Special claims and appeal procedures for Centers of Excellence and advanced imaging services: network exception requests** later in this chapter for information about requesting a network exception for hip or knee replacement, spine surgery, transplant services, or advanced imaging services.

Claims for family building services through the COE program are filed with your TPA. See the **Claims administration: Routine medical, pharmacy, dental, and vision** chart earlier in this chapter for information.

Contact your health care advisor or care navigator if you have questions.

Program administration: Centers of Excellence	
Cancer medical records review, on-site evaluation, treatment at Mayo Clinic, including travel	Coordinate with Consociate Health prior to receiving services
Heart surgery e-review and on-site surgery at Cleveland Clinic, including travel	Coordinate with your TPA prior to receiving services All claims: Consociate Health
Hip and knee replacement	Coordinate with Carrum Health prior to receiving services **Pre-service network exception request:** Carrum Health **Post-service network exception request:** the Plan
Spine surgery	Coordinate with Carrum Health prior to receiving services **Pre-service network exception request:** Carrum Health **Post-service network exception request:** the Plan
Kidney dialysis, ESRD medical records review, on-site evaluation and treatment	Coordinate with Consociate Health prior to receiving services
Rare conditions	Coordinate with Consociate Health prior to receiving services
Transplant services at Mayo Clinic	Coordinate with Consociate Health prior to receiving services **Pre-service network exception request:** Consociate Health **Post-service network exception request:** the Plan
Weight loss surgery	Coordinate with Carrum Health prior to receiving services **Pre-service claim:** Send the Provider Verification Form to Carrum Health for determination (See the **Centers of Excellence** section in **The medical plan** chapter)

Note: Requests for network exceptions for hip or knee replacement, spine surgery, and transplant services available through the Centers of Excellence program are subject to special claims and appeal procedures, as described later in this chapter. If you are requesting a network exception for one of these benefits, please consult those procedures.

Notice of claim denial

If your claim is denied, the denial notice 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)
- 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
- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist you with the internal and external appeals process

Some types of payment disputes are not claim "denials"

Not every situation in which there is a payment dispute between the Plan and your health care provider will be considered a claim for benefits under these claims procedures that results in a denial notice or a right to appeal. If a decision is limited to a question about the amount owed by the Plan to a provider and does not affect the amount you may owe to the provider, the dispute generally will not fall under these procedures. This may occur, for example, when a network provider disputes the negotiated amount paid by the TPA or when a non-network provider disputes a payment from the TPA with respect to a service for which the provider is prohibited under state or federal law from billing you for the balance of unpaid amounts. The provider may separately dispute this payment to the TPA or Plan, but it is not a claim for your Plan benefits under these procedures.

Internal appeal process

Time periods for appeals determinations

After your appeal is filed, the time period in which your appeal is determined depends on the type of claim that was filed.

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.
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.
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 calendar days for each of two VSP appeals).

Administration of internal appeals of routine medical, pharmacy, dental, and vision claims

Internal appeals of routine medical, pharmacy, dental and vision claims will be determined by the same entity that determined your initial claim, but by someone other than the party who decided the claim. See the **Claims administration: Routine medical, pharmacy, dental, and vision** chart earlier in this chapter.

The notice of claim denial is required to include information regarding available appeals, including how to initiate an appeal. Refer to the notice of claim denial for information regarding where to file the appeal.

Administration of appeals of Centers of Excellence and advanced imaging network exception requests

See the **Special claims and appeal procedures for Centers of Excellence and advanced imaging services: network exception requests** later in this chapter for information about appealing the denial of a network exception request for hip or knee replacement, spine surgery, transplant services, or advanced imaging services.

For an appeal of a determination that you are not eligible for weight loss surgery under the Centers of Excellence program, see the **Appealing an enrollment or eligibility status decision** section, above.

Appealing a claim that has been fully or partially denied

If a claim submitted by you (or on your behalf) has been denied, 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 180 days from the date you receive the claim denial
- Contain any additional information/documentation you would like considered

If your appeal involves an urgent claim, please contact your TPA for information about how to file your appeal orally.

TruDataRx allows two appeals (i.e., two levels of review) for standard appeals and one appeal (i.e., one level of review) for urgent appeals. VSP allows two appeals (i.e., two levels of review). The second appeal must be submitted within 60 days from the date you receive the first appeal denial. All other TPAs have one level of appeal.

When making an appeal, you must send your written request for review of the initial claim to the TPA that administers your claims, or as otherwise instructed in the denial letter.

Your claim denial notice will provide specific information about appealing a denied claim, including whether your TPA will accept a non-urgent appeal that is filed orally.

Note: Requests for network exceptions for **advanced imaging services** are subject to special claims and appeal procedures, as described later in this chapter. If you are appealing a denial of a network exception request for advanced imaging services, please refer to the section later in this chapter titled **Special claims and appeal procedures for Centers of Excellence and advanced imaging services: network exception requests**.

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, meaning the appeal will be an independent determination regarding the claim. 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 TPA, 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 **Time periods for appeals determinations** on the previous page.

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
- 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
- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist you with the internal and external appeals process



Note: Requests for network exceptions for **hip or knee replacement, spine surgery, or transplant services** available through the Centers of Excellence are subject to special claims and appeal procedures, as described later in this chapter. If you are appealing a denial of a network exception request for one of these benefits, please consult those procedures.

Travel benefit for care

The **Health management tools** chart in **The medical plan** chapter describes this benefit. It is administered by Included Health.

If Included Health does not pre-approve your travel benefits for care and you disagree with that determination, you may file a written pre-service claim for benefits. Claim forms are located on **One.Walmart.com/Claims** or you can call Included Health at **800-941-1384** to request a paper copy.

Claims for travel benefits for care will be decided under the general procedures and time frames for pre-service medical claims discussed in this section.

Special claims and appeal procedures for Centers of Excellence and advanced imaging services: network exception requests

Requests for network exceptions under the COE program and for advanced imaging services are subject to special claim and appeal procedures. The chart on the following page provides a brief overview of the procedures. Refer to the sections following the chart for specific details.

To receive a network exception, you must meet one of the specific exception criteria for the applicable COE program or advanced imaging services as described in **The medical plan** chapter and the chart on the following page. A network exception request is not a general review of medical necessity. Even if a service is determined to be medically necessary, you will not receive a network exception unless you meet one of the specific exception criteria for the applicable COE program or advanced imaging services.

Administration of network exception requests		
	Network exception requests: Pre-service claims	**Network exception requests: Post-service claims**
Hip and knee replacement and spine surgery	You may request a pre-service network exception if: • Travel to a COE facility would, with a high degree of medical certainty, pose a significant and immediate risk of paralysis or loss of life. • The COE facility's pre-surgical recommendations for risk factor optimization, when evaluated in the context of generally accepted evidence-based medical standards (e.g., clinical practice guidelines and evidence-based protocols), are not likely to reduce the risk of surgical complications (e.g., surgical site infection, implant dislocation, need for explant and/or revision) and medical complications (e.g., pneumonia, thromboembolic disease, myocardial infarction, stroke) or to improve clinical outcomes. • The COE facility does not recommend hip or knee replacement or spine surgery because it is not the appropriate medical course of treatment. File a **pre-service network exception** request with Carrum Health. File an **internal appeal of a denied pre-service network exception** request with the Plan.	You may request a post-service network exception if your circumstances called for immediate surgery, without which you would have been, with a high degree of medical certainty, at a significant and immediate risk of paralysis or loss of life. File a **post-service network exception** request with the Plan. File an **internal appeal of a denied post-service network exception** request with the Plan.
Transplant services at Mayo Clinic	You may request a pre-service network exception if: • If you are age 19 or older, travel to Mayo Clinic would, with a high degree of medical certainty, pose a significant and immediate risk of loss of life. • If you are under age 19, Mayo Clinic's review of your medical records would, with a high degree of medical certainty, pose a significant and immediate risk of loss of life. • If you are any age and Mayo Clinic does not recommend transplant services, including VAD, TAH, LVRS, or CAR-T services because they are not the appropriate medical course of treatment or you are not an appropriate candidate. File a **pre-service network exception request** with Consociate Health. File an **internal appeal of a denied pre-service network exception** request with the Plan.	You may request a post-service network exception if your circumstances called for immediate transplant services, without which you would have been, with a high degree of medical certainty, at a significant and immediate risk of loss of life. File a **post-service network exception** request with Consociate Health. An **internal appeal of a denied network exception** request with the Plan.
Advanced imaging	You may request a pre-service or post-service network exception if: • You are currently undergoing treatment for active malignancy or a serious or complex medical condition (e.g., multiple sclerosis, lung nodules, etc.), the advanced imaging services for which you are requesting prior authorization are related to treatment of such active malignancy or serious or complex medical condition, and you have had prior imaging related to the treatment of such active malignancy or serious or complex medical condition from the TPA network provider; or • You require IV sedation to undergo the advanced imaging services File a **network exception** request and **internal appeal of a denied network exception** request with the party identified in the **Claims administration: Routine medical, pharmacy, dental, and vision** chart earlier in this chapter.	

Hip and knee replacement and spine surgery: requesting network exception for coverage outside the Centers of Excellence program

As described in **The medical plan** chapter, hip and knee replacement or spine surgery covered under the Centers of Excellence (COE) program must be performed at a COE facility for covered services to be paid under the COE benefit. You may request an exception to receive hip or knee replacement or spine surgery performed at a facility other than a COE facility and have the Plan pay for covered services according to the Plan's regular terms and conditions of coverage, as described in **The medical plan** chapter. The procedures to request a network exception are described below.

Pre-service exception request to receive hip or knee replacement or spine surgery outside the COE program

You may file a pre-service exception request (a "pre-service" claim) for the Plan to pay benefits for covered services

received outside the COE program according to the Plan's regular terms and conditions of coverage, as described in **The medical plan** chapter if:

- Travel to a COE facility would, with a high degree of medical certainty, pose a significant and immediate risk of paralysis or loss of life, or
- The COE facility's pre-surgical recommendations for risk factor optimization, when evaluated in the context of generally accepted evidence-based medical standards (e.g., clinical practice guidelines and evidence-based protocols), are not likely to reduce the risk of surgical complications (e.g., surgical site infection, implant dislocation, need for explant and/or revision) and medical complications (e.g., pneumonia, thromboembolic disease, myocardial infarction, stroke) or to improve clinical outcomes, or
- The COE facility does not recommend hip or knee replacement or spine surgery because it is not the appropriate medical course of treatment.

Send your written pre-service exception request for hip or knee replacement or spine surgery or to:

Carrum Health
Attn: Appeals
640 North La Salle Drive, Suite 675
Chicago, Illinois 60654

Your pre-service exception request will be considered by Carrum Health. Carrum Health will utilize an Independent Review Organization ("IRO") which will not include any associate of Walmart, the COE facility, or your TPA. The IRO will review any relevant medical files that were reviewed or generated by the COE facility, as well as any additional materials you submit, and will consider various factors, including 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.

If you are filing a pre-service exception request because travel to a COE facility would, with a high degree of medical certainty, pose a significant and immediate risk of paralysis or loss of life, you should file as soon as possible. If you are filing a pre-service exception request because a COE facility has made pre-surgical recommendations that you believe are not reasonable or the COE facility does not recommend hip or knee replacement or spine surgery because it is not an appropriate medical course of treatment, your pre-service exception request must be received by the Plan within 120 calendar days of the COE facility's determination.

If the pre-service exception request is urgent, the IRO designated by Carrum Health will make its determination within 72 hours after receipt of the request (otherwise, the IRO will make its determination within 15 days of receipt of the request). If the urgent pre-service exception request is determined to be incomplete, you will receive a notice within 24 hours of receipt of the request, and you will have 48 hours to provide additional information.

For non-urgent requests, the deadline to decide the request may be extended 15 days, and Carrum Health will send a notice explaining the extension, if one is necessary. If an 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 IRO will make a determination within 15 days from the date Carrum Health receives your information, or, if earlier, the deadline to submit your information.

Post-service exception request to receive hip or knee replacement or spine surgery outside the COE program

If you have already received hip or knee replacement or spine surgery because your circumstances called for immediate surgery, without which you would have been, with a high degree of medical certainty, at a significant and immediate risk of paralysis or loss of life, you may request that the Plan pay benefits for covered services received outside the COE program (a "post-service" claim) according to the Plan's regular terms and conditions of coverage, as described in **The medical plan** chapter.

Send your written post-service exception request for hip or knee replacement or spine surgery to:

By email: **ghappeal@wal-mart.com**
By mail: **Walmart Benefits Total Rewards Team**
Attn: Internal Appeals
Mail Stop 3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

Your post-service exception request will be considered by an IRO designated by the Plan Administrator. The IRO will not include any associate of Walmart, the COE facility, or your TPA. The IRO will review any relevant medical files that were reviewed or generated by the COE facility, as well as any additional materials you submit, and will consider various factors, including 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. You must file your exception request within 120 calendar days of the date of service.

If you file a post-service exception request, the IRO will make its determination within 30 days of receipt of the post-service request. The deadline to decide the request may be extended 15 days, and the IRO will send a notice explaining the extension, if one is necessary. If an 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 IRO will make a determination within 15 days from the date the IRO receives your information, or, if earlier, the deadline to submit your information.

Internal appeal of denial of a pre-service or post-service exception request to receive hip or knee replacement or spine surgery outside the COE program

If your request is denied (whether it is a pre-service claim considered by Carrum Health or a post-service claim considered by an IRO), you will have 180 days from the date you receive the denial notice to appeal the denial and request that an IRO conduct an internal review of the denial. The denial notice will provide information about how to request an appeal.

Or, you can send your appeal to:

By email: ghappeal@wal-mart.com
By mail: **Walmart Benefits Total Rewards Team**
Attn: Internal Appeals
Mail Stop 3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

The appeal will be decided by the IRO. The IRO will not include any associate of Walmart, the COE facility, or your TPA. Your appeal will be conducted without regard to the initial determination, by someone other than the party who decided your initial exception request. No deference will be afforded to the initial determination, meaning the appeal will be an independent determination regarding the initial request. 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 request.

The IRO will decide a request for an urgent appeal of a pre-service exception request within 72 hours of receipt, a non-urgent appeal of a pre-service exception request within 30 days of receipt, and an appeal of a post-service exception request within 60 days of receipt.

If your internal appeal is denied, you may appeal the denial under the external appeal process described later in this chapter if the denial was based on medical judgment.

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

Transplant services: requesting network exception for coverage outside the Centers of Excellence program

As described in **The medical plan** chapter:

If you are under the age of 19, you must undergo a pretransplant medical records review by Mayo Clinic. If you do not agree to a pretransplant medical records review by Mayo Clinic, or you do agree to a pretransplant medical records review and Mayo Clinic determines that transplant services are not the appropriate medical course of treatment for you, or you are not an appropriate candidate, the Plan will not pay a benefit for transplant services unless you receive a network exception.

If you are age 19 or older, transplant services must be performed at Mayo Clinic, or the Plan will not pay a benefit for transplant services unless you receive a network exception.

You may request an exception to receive transplant services at a facility other than Mayo Clinic and have the Plan pay for covered services according to the Plan's regular terms and conditions of coverage, as described in the **Centers of Excellence** section of **The medical plan** chapter. The procedures to request a network exception are described below.

Pre-service exception request to receive transplant services outside the COE program

You may file a pre-service exception request (a "pre-service" claim) to receive transplant services outside the Centers of Excellence ("COE") program and have the Plan pay benefits for covered services according to the Plan's regular terms and conditions of coverage, as described in **The medical plan** chapter if:

- You are under age 19 and Mayo Clinic's review of your medical records would, with a high degree of medical certainty, pose a significant and immediate risk of loss of life; or
- You are age 19 or older and travel to Mayo Clinic would, with a high degree of medical certainty, pose a significant and immediate risk of loss of life; or
- You are any age and Mayo Clinic does not recommend transplant services, including VAD, TAH, LVRS, or CAR-T services, because they are not the appropriate medical course of treatment or you are not an appropriate candidate.

Send your written pre-service exception request to:

By email: wmcoenetworkexceptions@consociate.com
By mail: **Consociate Health**
Attn: Internal Appeals–COE
P.O. Box 1002
Mabelvale, Arkansas 72103

Your pre-service exception request will be considered by Consociate Health. Consociate Health will utilize an Independent Review Organization ("IRO") which will not include any associate of Walmart, the COE facility, or your TPA. The IRO will review any relevant medical files reviewed or generated by Mayo Clinic, as well as any additional materials you submit, and will consider various factors, including 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 services.

If you are filing a pre-service exception request because Mayo Clinic's review of your medical records (if you are under the age of 19), or because travel to Mayo Clinic (if you are age 19 or older), would, with a high degree of medical certainty, pose a significant and immediate risk of loss of life, you should file as soon as possible. If you are filing a pre-service exception request because Mayo Clinic has determined that transplant services, including VAD, TAH, LVRS, or CAR-T services, are not an appropriate medical course of treatment, or you are not an appropriate candidate, your request must be received by the Plan within 120 calendar days of Mayo Clinic's determination.

If the request is urgent, the IRO will make its determination within 72 hours after receipt of the request (otherwise, the IRO will make its determination within 15 days of receipt of the request). If the urgent pre-service exception request is determined to be incomplete, you will receive a notice within 24 hours of receipt of the request, and you will have 48 hours to provide additional information.

For non-urgent requests, the deadline to decide the request may be extended 15 days, and the IRO will send a notice explaining the extension, if one is necessary. If an 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 IRO will make a determination within 15 days of the date the IRO receives your information, or, if earlier, the deadline to submit your information.

Post-service exception request to receive transplant services outside the COE program

If you have already received transplant services because your circumstances called for immediate transplant services, without which you would have been, with a high degree of medical certainty, at a significant and immediate risk of loss of life, you may request that the Plan pay benefits for covered services received outside the COE program (a "post-service" claim) according to the Plan's regular terms and conditions of coverage, as described in **The medical plan** chapter.

Send your written post-service exception request for transplant services to:

By email: ghappeal@wal-mart.com
By mail: Walmart Benefits Total Rewards Team
Attn: Internal Appeals
Mail Stop 3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

Your post-service exception request will be considered by an IRO appointed by the Plan Administrator. The IRO will not include any associate of Walmart, Mayo Clinic, or your TPA. The IRO 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 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. You must file your exception request within 120 calendar days of the date of service.

If you file a post-service exception request, the IRO will make its determination within 30 days of receipt of the post-service request. The deadline to decide the request may be extended 15 days, and the IRO will send a notice explaining the extension, if one is necessary. If an 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 IRO will make a determination within 15 days from the date the IRO receives your information, or, if earlier, the deadline to submit your information.

Internal appeal of denial of a pre-service or post-service network exception request to receive transplant services outside the COE program

If your network exception request is denied, you will have 180 days from the date you receive the denial notice to appeal the denial and request that an IRO conduct an internal review of the denial. The denial notice will provide information about how to request an appeal.

Or, you can send your appeal to:

By email: ghappeal@wal-mart.com
By mail: Walmart Benefits Total Rewards Team
Attn: Internal Appeals
Mail Stop 3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

The appeal will be decided by the IRO. The IRO will not include any associate of Walmart, Mayo Clinic, or your TPA. Your appeal will be conducted without regard to the initial determination, by someone other than the party who

decided your initial exception request. No deference will be afforded to the initial determination, meaning the appeal will be an independent determination regarding the initial request. 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 request.

The IRO will decide a request for an urgent appeal of a pre-service exception request within 72 hours after receipt, a non-urgent appeal of a pre-service exception request within 30 days after receipt, and an appeal of a post-service exception request within 60 days after receipt. If your internal appeal is denied, you may appeal the denial under the external appeal process described later in this chapter if the denial was based on medical judgment.

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

Advanced imaging: requesting a network exception to receive services from a TPA network provider who is not an AMP Alternate network provider

As described in **The medical plan** chapter, advanced imaging services must be preauthorized and must also be performed by an AMP Alternate network provider for the Plan to pay the highest benefit (or any benefit). You may request an exception to receive advanced imaging services from a TPA network provider who is not an AMP Alternate network provider under the circumstances described below. If the exception is granted, the Plan will pay for covered services according to the Plan's regular terms and conditions of coverage, as described in the **Advanced imaging** section of **The medical plan** chapter.

Pre-service exception request to receive services from a TPA network provider who is not an AMP Alternate network provider

You may file a pre-service exception request (a "pre-service" claim) for the Plan to pay benefits for covered services received from a provider in your TPA network who is not an AMP Alternate network provider according to the Plan's regular terms and conditions of coverage if:

- You are currently undergoing treatment for active malignancy or a serious or complex medical condition (e.g., multiple sclerosis, lung nodules, etc.), the advanced imaging services for which you are requesting prior authorization are related to treatment of such active malignancy or serious or complex medical condition, and you have had prior imaging related to the treatment of such active malignancy or serious or complex medical condition from the TPA network provider; or
- You require IV sedation to undergo the advanced imaging services

Send your written pre-service exception request to the party that administers pre-service claims for advanced imaging services as described in the **Claims administration: Routine medical, pharmacy, dental, and vision** chart earlier in this chapter.

Your pre-service exception request will be considered by the appropriate claims administrator, or a party with whom the claims administrator has contracted. The claims administrator will review any relevant medical files, as well as any additional materials you submit, and will consider various factors, including 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 procedure would have.

If the pre-service exception request is urgent, it will be determined within 72 hours after receipt of the request (otherwise, the determination will be made within 15 days of receipt of the request). If the urgent pre-service exception request is determined to be incomplete, you will receive a notice within 24 hours of receipt of the request, and you will have 48 hours to provide additional information.

For non-urgent requests, the deadline to decide the request may be extended 15 days, and you will be sent a notice explaining the extension, if one is necessary. If an 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 request will be determined within 15 days from the date your information is received, or, if earlier, the deadline to submit your information.

Post-service exception request to receive services from a TPA network provider who is not an AMP Alternate network provider

If you have already received advanced imaging services, you may request that the Plan pay benefits for covered services received from a TPA network provider who is not an AMP Alternate provider according to the Plan's regular terms and conditions of coverage (a "post-service" claim) if:

- You are currently undergoing treatment for active malignancy or a serious or complex medical condition (e.g., multiple sclerosis, lung nodules, etc.), the advanced

imaging services for which you are requesting prior authorization are related to treatment of such active malignancy or serious or complex medical condition, and you have had prior imaging related to the treatment of such active malignancy or serious or complex medical condition from the TPA network provider, or

- You require IV sedation to undergo the advanced imaging services

Send your written post-service exception request to the party that administers post-service claims for advanced imaging services as described in the **Claims administration: Routine medical, pharmacy, dental, and vision** chart earlier in this chapter.

Your post-service claim will be considered by the appropriate claims administrator or a party with whom the claims administrator has contracted. The claims administrator will review any relevant medical files that you submit, and will consider various factors, including 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 procedure would have. You must file your exception request within 120 calendar days of the date of service.

If you file a post-service exception request, the claims administrator will make its determination within 30 days of receipt of the post-service request. The deadline to decide the request may be extended 15 days, and the claims administrator will send a notice explaining the extension, if one is necessary. If an 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 claims administrator will make a determination within 15 days from the date the claims administrator receives your information, or, if earlier, the deadline to submit your information.

Internal appeal of denial of a pre-service or post-service exception request to receive services from a TPA network provider who is not an AMP Alternate network provider

If your request is denied (whether it is a pre-service claim or a post-service claim), you will have 180 days from the date you receive the denial notice to appeal the denial and request that the claims administrator conduct an internal review of the denial. The denial notice will provide information about how to request an appeal.

Send your written request for an internal appeal to the claim administrator at the address indicated in the denial notice.

Your appeal will be conducted without regard to the initial determination, by someone other than the party who decided your initial exception request. No deference will be afforded to the initial determination, meaning the appeal will be an independent determination regarding the initial request. 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 request.

The claims administrator will decide a request for an urgent appeal of a pre-service exception request within 72 hours after receipt, a non-urgent appeal of a pre-service exception request within 30 days after receipt, and an appeal of a post-service exception request within 60 days after receipt.

If your internal appeal is denied, you may appeal the denial under the external appeal process described later in this chapter if the denial was based on medical judgment.

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

Voluntary review

In situations described below, you may request a voluntary review of an appeal that has been denied. Voluntary review is optional. *You are not required to request a voluntary review to be treated as exhausting your administrative remedies.*

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 from the date you receive 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:

By email: ghappeal@wal-mart.com
By mail: Walmart Benefits Total Rewards Team
Attn: Voluntary Appeals
Mail Stop 3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

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 from the date you receive 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:

By email: ghappeal@wal-mart.com
By mail: **Walmart Benefits Total Rewards Team**
Attn: Voluntary Appeals
Mail Stop 3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

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 or based on a determination that the claim is not subject to surprise billing protections, you may have the right to further appeal your claim in an independent external review process. The denial notice will contain information on the external appeal process.

Your external appeal will be conducted by an Independent Review Organization ("IRO") not affiliated with the Plan. If the IRO overturns the Plan's decision, the IRO's decision will be binding on the Plan and will be implemented immediately, although the Plan may seek further review by a court in appropriate cases. 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.

The IRO will provide notice of the decision on an urgent request for external review within 72 hours after receipt. The IRO will provide notice of a decision on a non-urgent request for external review within 45 days after receipt.

Send a written request for an external medical appeal (including an exception request related to Centers of Excellence benefits) to:

By email: ghappeal@wal-mart.com
By mail: **Walmart Benefits Total Rewards Team**
Attn: External Appeals
Mail Stop 3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

Send a written request for an external pharmacy appeal to:

Walmart PA Services
Attn: Appeals Coordinator
P.O. Box 1221
Norwich, Vermont 05055
Fax: 888-707-7324

Other 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 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 another plan or insurance was considered primary or that any other circumstances have occurred that resulted in the Plan paying greater benefits than permitted or required under the Plan terms, the Plan has the right to recover the overpayment. The Plan (or the third-party administrator or other service provider acting on behalf of the Plan) will try to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek recovery of an overpayment from

any participant, beneficiary, or dependent. Failure to comply with this request will entitle the Plan to withhold benefits due a 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 an overpayment is made to a provider, the Plan (or any third-party administrator acting on behalf of the Plan) may reduce, offset, 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 or offset payments otherwise owed to the provider from such other health plans by the amount of the overpayment.

The Plan's right to audit

The Plan has the right to audit your claims, including claims of medical providers. The Plan (or the applicable 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 on behalf of 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, such as for benefits that are overpaid or for which you were not entitled under the Plan terms, or to recover participant contributions that are past due, you shall be deemed, by virtue of your enrollment in the Plan, to have agreed that Walmart may deduct such amounts from your wages, salary, or other compensation or benefits, and pay the same to the Plan until recovery is complete. If you enroll for coverage under the Plan, you are deemed to have consented to the applicable payroll deductions for such coverage. In addition, if you fail to affirmatively enroll or reenroll during Annual Enrollment, you are deemed to have consented to the automatic reenrollment described in the **Eligibility, enrollment, and effective dates** chapter, including the applicable payroll deductions.

The Plan's subrogation and reimbursement rights

Note: This section applies to Plan benefits that are funded through company assets. These benefits are generally referred to throughout the *Associate Benefits Book* as self-funded benefits, or self-insured benefits, to indicate they are not insured through an insurance contract issued by an insurer. Insurers of insured benefits may have separate subrogation and reimbursement rights applicable to the benefits they insure. Please see the respective policy and certificate of coverage applicable to any insured benefit you may be enrolled in.

If you or a covered dependent (a covered person) is injured or otherwise harmed due to the conduct of another party and the Plan pays company-funded benefits as a result of such injury or harm, the Plan Administrator has the right to recover payments it makes on the covered person's behalf from the covered person or any party responsible for compensating the covered person for their illnesses or injuries. The legal term for this right of recovery is "subrogation." The Plan shall have a first-priority lien against any amounts the covered person recovers from another responsible party or insurer for the full amount of the benefits that are paid to or for the benefit of the covered person as a result of the third-party injury or harm, and the Plan shall have a right to offset such benefit amounts against future benefits due under the Plan.

The Plan has the right to do any of the following to enforce its lien and right of reimbursement and recovery:

- Reduce or deny benefits otherwise payable by the Plan ("reduction"), 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 that result in a whole-body impairment rating of at least 50%, as determined by an Independent Review Organization in accordance with American Medical Association guidelines for the evaluation of permanent impairment, total *and* permanent physical or mental disability, or death), regardless of how such judgment, settlement, or payment is characterized, including payments by any other insurance, whether providing third-party coverage or first-party coverage

- Any auto or recreational vehicle insurance coverage or benefits, including uninsured/underinsured motorist coverage
- Business medical and/or liability insurance coverage or payments
- Attorney fees

The Plan's lien exists at the time the Plan pays any benefits to or for the benefit of a covered person. 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
- The Plan's first priority right to reduction, reimbursement, and subrogation shall not be reduced due to the covered person'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 that result in a whole-body impairment rating of at least 50%, as determined by an Independent Review Organization in accordance with American Medical Association guidelines for the evaluation of permanent impairment
- Total *and* permanent physical or mental disability
- Death

The Plan Administrator has the authority, in its sole discretion, to determine to limit or not 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 or has met the requirements to qualify for Social Security disability income benefits, and the injuries that are the basis for the covered person's recovery are the sole cause of the disability for which benefits have been paid. 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 individuals and their representatives to notify the Plan if they are involved in an incident that gives rise to such right of reduction, reimbursement, or subrogation. Covered individuals are required to cooperate with the Plan and execute any documents that the administrator, acting on the Plan's behalf, deems necessary to protect the Plan's rights of reduction, reimbursement, or subrogation. Covered individuals shall not do anything to hinder, delay, impede, or jeopardize the Plan's priority right of reduction, reimbursement, or subrogation. Failure to comply will entitle the Plan to withhold benefits due to you under the Plan. This is in addition to any and all other rights that the Plan has pursuant to its rights of reduction, reimbursement, and subrogation.

The Plan's rights to reduction, reimbursement, and subrogation apply regardless of any allocation or designation of the applicable settlement or award (e.g., pain and suffering or medical benefits) and regardless of the specific claims or causes of action being settled or adjudicated. The Plan's rights apply regardless of whether the covered person has been made whole or fully compensated for the covered person's injuries and without regard to any state law or equitable doctrine, such as the make whole doctrine, that would limit the Plan's right of

recovery based on whether the covered person has been made whole, it being intended that the Plan's right of recovery is a right to first dollar recovery.

Additionally, the Plan has the right to file suit on the covered person's behalf for the condition related to the medical expenses to recover benefits paid or to be paid by the Plan. The Plan may also enforce its rights of reduction, reimbursement, and subrogation against any fund, tortfeasor, responsible party, or available insurance coverages, including underinsured, no-fault, or uninsured motorist coverages to the fullest extent allowed by law.

To aid the Plan in its enforcement of its right of reduction, recovery, reimbursement, and subrogation, a covered person or their 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
- Provide the Plan with any requested information related to the claim involved, including information with respect to other insurance, judgments, payments, or settlements

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.

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 a claimant receives a notice that benefits are subject to reduction, reimbursement, or subrogation, and the claimant believes that the case falls within one of the exceptions or limitations to the Plan's right to reduction, reimbursement, or subrogation, the claimant may file a claim for benefits with the Plan.

A claimant may also designate an authorized representative to submit claims for benefits or appeals on their 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 from the date you receive 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 the claimant believes applies to the case
- 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:

By email: ghappeal@wal-mart.com
By mail: Walmart Benefits Total Rewards Team
Attn: Subrogation Review
Mail Stop 3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

Within a reasonable time, but no later than 30 days after the date the Plan receives the initial claim for benefits, 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 the claimant has 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
- Notice regarding the claimant's 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 the claimant prior to the end of the 30-day period if an extension or additional information is required. If asked to provide additional information, the claimant will have 45 days from the date they receive the notice to provide the information. The time to make a determination will be suspended until the claimant provides the requested information (or the deadline to provide the information, if earlier).

Right to appeal a claim denial

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 the appeal to be considered, it must:

- Be in writing
- Be sent to the correct address
- Be submitted within 180 days from the date the claim denial is received
- Contain any additional information/documentation the claimant would like considered

Send a written request for an appeal to:

By email: ghappeal@wal-mart.com
By mail: Walmart Benefits Total Rewards Team
Attn: Internal Appeals
Mail Stop 3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

The appeal will be conducted without regard to the initial determination by someone other than the party who decided the initial claim for benefits. The claimant has the right to request copies, free of charge, of all documents, records, or other information relevant to the claimant's claim for benefits. The claimant also has 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 the claimant upon request, regardless of whether the Plan relied on the advice. The Plan must provide the claimant written notice of the Plan's decision on review within 60 days following the Plan's receipt of the claimant's appeal.

If the claim for benefits is denied on appeal, the Plan will provide a denial notice 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 the claimant's right to request copies, free of charge, of all documents, records, or other information relevant to the claim for benefits
- A statement that the claimant has 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
- Notice regarding the claimant's right to bring a court action following a denial on appeal

A claim for benefits is the exclusive way to seek an exception to the plan's right of reduction and recovery

The only method by which a claimant can request the Plan not to reduce benefits using the Plan's rights of reduction and recovery is to file a claim for benefits, following the process described above. A claimant must complete the required claims and appeals process described in these claims procedures before bringing any legal action. A claimant may not file a lawsuit for benefits if the initial claim for benefits or appeal is not made within the time periods set forth in these claims procedures. A claimant must file any lawsuit for benefits within 180 days from the date the decision on appeal is received. You may not file suit after that 180-day period expires.

HMO plan options' claims and appeals procedures

In some locations, 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.

Accident and critical illness insurance claims process

Accident and critical illness insurance claims must be submitted within 60 days after the occurrence or commencement of any covered accident or critical illness, or as soon as reasonably possible, to:

The Standard
Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488

You may also provide notice of claim as follows:

Online: **Standard.com/Walmart**
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)
- Date the covered illness or accident occurred or commenced

You may request a claim form from The Standard or visit **One.Walmart.com** or **Standard.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 The Standard by providing The Standard with a statement of the nature and extent of the loss.

The Standard has the right to recover any overpayments due to fraud or an error they make in processing a claim. You or your beneficiary will be required to reimburse The Standard in full. The Standard will work with you or your beneficiary to develop a reasonable method of repayment if you or your beneficiary is financially unable to repay The Standard in a lump sum.

Accident insurance

When you submit a claim to The Standard, the claim determination will be made within a reasonable time period, but no later than 90 days after The Standard receives the claim. If The Standard determines that an extension is necessary due to special circumstances, this time may be extended an additional 90 days. In that case, you will receive written notice of the extension before the end of the 90-day period, indicating the circumstances requiring the extension and the date by which The Standard expects to render a determination.

If your claim is denied, you will receive a denial notice that will consist of a written explanation, which will include:

- The specific reasons for the denial
- Reference to specific Plan provisions on which the denial was based
- A description of additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary
- Information about the claims review procedures and the time limits for appeal, including a statement that you have a right to file a lawsuit following a denial on appeal

Written proof must be given to The Standard within 90 days of the covered accident. If it is not possible to provide written proof within that time period, The Standard will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to The Standard no later than 15 months from the time specified, unless the covered person is legally incapacitated.

Your beneficiary must reasonably cooperate during any investigation and/or determination of a claim. This includes the authorization for the release of medical records and other information.

The Standard has the right, at their own expense, to have any covered person examined by a physician of their choosing, as often as may be reasonably required while a claim is pending. The Standard may also have an autopsy performed while a claim is pending, where permitted by law.

Appealing an accident insurance claim that has been fully or partially denied

You may appeal any denial of a claim for benefits by filing a written request with:

The Standard
P.O. Box 41488
Jacksonville, Florida 32203-1488

Your appeal must be filed within 60 days of receipt of the written notice of denial of a 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 request, free of charge, all documents that are relevant (as defined by ERISA) to your claim. You may have representation throughout the review procedure.

A final decision on appeal will be made within a reasonable period of time, but no later than 60 days after receipt of your written appeal. If The Standard determines that an extension is necessary due to special circumstances, this time may be extended an additional 60 days. In that case, you will receive written notice of the extension before the end of the 60-day period indicating the circumstances requiring the extension and the date by which The Standard expects to render a determination.

If your appeal is denied, you will receive a written notice of the denial that will include:

- The specific reasons for the denial
- Reference to specific Plan provisions 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 description of any voluntary review procedures offered by the Plan and your right to obtain information about such procedures
- A statement regarding your right to bring an action under Section 502(a) of ERISA

If your claim is denied, you have the right to bring action in federal court in accordance with Section 502(a) of ERISA, 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 deadline to bring legal action.

Critical illness insurance

When you submit a claim to The Standard, the claim determination will be made within a reasonable time period, but no later than 30 days after The Standard receives the claim. If The Standard determines that an extension is necessary due to matters beyond their control, this time may be extended an additional 15 days. In that case, you will receive written notice of the extension before the end of the 30-day period indicating the circumstances requiring the extension and the date by which The Standard 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 from your receipt of the written notice of denial to submit the information. The Standard will then make their determination within 15 days from the date they receive the information, or, if earlier, the deadline to submit the information.

If your claim is denied, your denial will consist of a written explanation, which will include:

- The specific reasons for the denial
- Reference to specific Plan provisions on which the denial was based
- A description of additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary
- A description of the 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 a denial of your claim on review
- A disclosure of any internal rule, guideline, or protocol relied on in denying the claim or a statement that you have the right to obtain, upon request and free of charge, such information
- If your denial is based on medical necessity or experimental treatment or similar limitations, an explanation of the scientific or clinical judgment for the determination or a statement that you have the right to obtain, upon request and free of charge, such information

Written proof must be given to The Standard within 90 days of each covered critical illness. If it is not possible to provide written proof within that time period, The Standard will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to The Standard no later than 15 months from the time specified, unless the covered person is legally incapacitated.

Your beneficiary must reasonably cooperate during any investigation and/or determination of a claim. This includes the authorization for the release of medical records and other information.

The Standard has the right, at their own expense, to have any covered person examined by a physician of their choosing, as often as may be reasonably required while a claim is pending. The Standard may also have an autopsy performed while a claim is pending, where permitted by law.

Appealing a critical illness insurance claim that has been fully or partially denied

You may appeal any denial of a claim for critical illness benefits by filing a written request with:

The Standard
Walmart Claims Unit
P.O. Box 41488
Jacksonville, Florida 32203-1488
Attention: Appeals

Your appeal must be filed within 180 days of receipt of the written notice of denial of a 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 request, free of charge, all documents that are relevant (as defined by ERISA) to your claim. The appeal will be conducted by a person different from the person who made the initial decision. No deference will be given to the initial determination. You may have representation throughout the review procedure.

If the claim involves a medical judgment question, The Standard 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 Standard will provide you with the identification of any medical expert whose advice was obtained in connection with the appeal.

A final decision on appeal will be made within a reasonable period of time, but no later than 60 days after receipt of your written appeal.

If your appeal is denied, you will receive a written notice of the denial that will include:

- The specific reasons for the denial
- Reference to specific Plan provisions 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 description of any voluntary review procedures offered by the Plan and your right to obtain information about such procedures
- A disclosure of any internal rule, guideline, or protocol relied on in denying the claim or a statement that you have the right to obtain, upon request and free of charge, such information
- If your denial is based on medical necessity or experimental treatment or similar limitations, an explanation of the scientific or clinical judgment for the determination or a statement that you have the right to obtain, upon request and free of charge, such information
- A statement regarding your right to bring an action under Section 502(a) of ERISA

If your claim is denied, you have the right to bring action in federal court in accordance with Section 502(a) of ERISA, 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 deadline 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 chapter for information that must be provided to Prudential when filing a claim. Claims for benefits insured by Prudential may also be submitted by sending the claim to:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 70182
Philadelphia, Pennsylvania 19176

Claims for benefits under life insurance coverage must be filed within 90 days after the date of loss.

Claims for benefits under business travel accident insurance coverage must be filed within 365 days after the date of loss.

Claims for benefits under accidental death and dismemberment insurance coverage must be filed within 90 days after the date of loss.

Life, business travel accident, or accidental death and dismemberment insurance

When you submit a life insurance claim to Prudential, a claim determination will be made within 45 days from the date the claim is received by Prudential. This period may be extended for an additional 30 days if an extension is necessary due to matters beyond the control of Prudential. A written notice of the extension, the reason for the extension, and the date by which Prudential expects to decide on your claim, will be furnished to you within the initial 45-day period if an additional extension of time is needed. This period may be extended for an additional 30 days beyond the original 30-day extension, if necessary, due to matters beyond the control of Prudential. A written notice of the additional extension, the reason for the additional extension, and the date by which Prudential expects to decide the claim will be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will

be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

- The specific reason(s) for the denial
- Reference to the specific plan provisions on which the benefit determination was based
- A description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary
- A description of Prudential's appeals procedures and applicable time limits
- If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request

Appealing a life, business travel accident, or accidental death and dismemberment insurance claim that has been fully or partially denied

You may appeal any denial of a claim for benefits by filing a written request with:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 70182
Philadelphia, Pennsylvania 19176

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of your receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records, and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential will make a determination on your claim 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. A written notice of the extension, the reason for the extension, and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

- The specific reason(s) for the adverse determination
- Reference to the specific plan provisions on which the determination was based
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents, and other information relevant to your benefit claim upon request
- 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
- A statement describing any appeals procedures offered by the plan

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

Voluntary second appeal of life, business travel accident, or accidental death and dismemberment insurance claims

If the appeal of your benefit claim 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 second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. *You are*

not required to request a voluntary review to be treated as exhausting your administrative remedies. See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

You may submit with your second appeal any written comments, documents, records, and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.

Prudential will make a determination on your second claim 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. A written notice of the extension, the reason for the extension, and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and will include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Claims and appeals process for short-term disability coverage claims

Filing a claim for short-term disability benefits

Note: For claims filed under the short-term disability plans for salaried associates and OTR truck driver associates before February 1, 2026, the claims and appeals procedures described in the **Salaried short-term disability** chapter or the **Truck driver short-term disability** chapter, as applicable, in the 2025 *Associate Benefits Book* apply.

If you become disabled, you should file your claim for benefits promptly. A delay in filing could result in delayed benefit payment, disruption in your wages, or the denial of your claim. The timing and the process you need to follow when filing a claim for short-term disability benefits depend on whether the short-term disability plan is available at your location (i.e., whether you are in a state or locality that provides legally mandated benefits). See the **Claim filing instructions** on the following page for information about filing your claim.

STEP 1: Contact Sedgwick to apply for a leave of absence. Regardless of the process you follow to file a short-term disability claim with the Plan, you will need to contact Sedgwick by going to **One.Walmart.com/TimeAndSupport** or by calling **800-492-5678** to apply for a leave of absence 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.

The leave of absence policy is not a benefit offered under, or administered as part of, the Plan and is not discussed here in detail. For specific details about the leave of absence policy, refer to **One.Walmart.com**. The approval of a leave of absence under Walmart's leave of absence policy does not automatically mean your short-term disability claim is approved. See **When benefits begin** in the **Full-time hourly short-term disability**, **Salaried short-term disability**, and **Truck driver short-term disability** chapters for details.

STEP 2: File a claim for short-term disability or legally mandated benefits. Your claim for short-term disability benefits cannot be fully processed until you have stopped working. Notify your manager if your illness or injury is related to your Walmart work, so a workers' compensation claim can be initiated.

Note: Your claim filing date is the date on which you submit your disability claim to Sedgwick. In order for Sedgwick to begin their review of your claim, you must have fully stopped working. If you file your claim prior to your first date of absence, Sedgwick will begin processing your claim as of your first date of absence. If you file your claim on or after your first date of absence, Sedgwick will begin their review as of your reported date.

To file a claim with Sedgwick, you may call **800-492-5678** or file by mail to:

Sedgwick Claims Management Services, Inc.
P.O. Box 14748
Lexington, Kentucky 40512-4748

If you are in a state or locality that offers a mandated benefit, you should file your claim with the appropriate state or locality. See the chart on the following page for details on where and when to file your claim.

Claim filing instructions

Your state or locality may have unique filing periods, which could potentially exclude benefits for periods prior to the date of your benefits application. It is strongly advised that you promptly apply to your state or locality for any benefits that are mandated by law.

State or locality	Eligibility	Claim administrator	Filing instructions
California **Rhode Island**	Not eligible for Walmart short-term disability basic or enhanced Eligible for maternity, as a supplement to legally mandated benefits	State for legally mandated benefit Sedgwick for maternity	**California:** Go to **edd.ca.gov** or call **800-480-3287** for instructions **Rhode Island:** Go to **dlt.ri.gov/tdi** or call **401-462-8420** for instructions For maternity benefit, file a claim with Sedgwick within 90 days of the date your disability begins; you will need to provide the determination letter from the state with benefit details. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
Hawaii **New Jersey**	Not eligible for Walmart short-term disability basic or enhanced Eligible for maternity, as a supplement to legally mandated benefits	Lincoln Sedgwick for maternity	**Hawaii:** File a claim with Sedgwick within 90 days of the date your disability begins, and Sedgwick will forward to Lincoln. **New Jersey:** File a claim with Sedgwick within 30 days of the date your disability begins, and Sedgwick will forward to Lincoln. For maternity benefit, file a claim with 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.
Colorado **Connecticut** **Maine** **Massachusetts** **Minnesota** **Oregon** **Washington, D.C.** **Washington state**	Eligible for Walmart short-term disability plan as a supplement to legally mandated benefits	State or district for legally mandated benefit Sedgwick for supplemental benefits and maternity	**Colorado:** Go to **famli.colorado.gov** or call **866-263-2654** for instructions **Connecticut:** Go to **ctpaidleave.org** or call **877-499-8606** for instructions **Maine:** Go to **maine.gov/paidleave** or call **207-621-5024** for instructions **Massachusetts:** Go to **paidleave.mass.gov** or call **833-344-7365** for instructions **Minnesota:** Go to **paidleave.mn.gov** or call **844-556-0444** for instructions **Oregon:** Go to **paidleave.oregon.gov** or call **833-854-0166** for instructions **Washington, D.C.:** Go to **dcpaidfamilyleave.dc.gov** or call **202-899-3700** for instructions **Washington state:** Go to **paidleave.wa.gov** or call **833-717-2273** for instructions **Sedgwick:** File a claim with Sedgwick within 90 days of the date your disability begins; you will need to provide the determination letter from the state or district with state or district benefit details. Claims filed later than 90 days after the date of disability may be denied unless Sedgwick determines you had good cause for filing late.
Delaware **New York**	Eligible for Walmart short-term disability plan as a supplement to legally mandated benefits	Lincoln Sedgwick for supplemental benefits and maternity	File a claim with Sedgwick within 30 days of the date your disability begins and Sedgwick will forward to Lincoln. For maternity benefit, file a claim with 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.
All others	Eligible for Walmart short-term disability plan	Sedgwick	File a claim with 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 3: Let your doctor's office know it will be contacted for information. Tell your doctor's office that it will be contacted and asked to complete an attending physician's statement and provide objective 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
- Doctor visit notes

You must sign a form authorizing your doctor to release this information. (This release will be included in the initial packet that you receive from Sedgwick; however, if you are filing your claim online, an electronic signature is accepted.)

STEP 4: Follow up with your doctor to ensure that the requested information was forwarded to Sedgwick. Any delay in sending information to Sedgwick could result in a delay, or denial, in the processing of your claim and the payment of benefits.

Claims are determined under the time frames and requirements set out in this chapter. You have the right to appeal a claim denial. See **Appealing a short-term disability claim that has been fully or partially denied** later in this chapter.

You may be required to provide written proof of your disability or additional medical information before your claim is approved.

Initial claim determination

See the chart on the previous page for filing deadlines. 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 the Plan's 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 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
  - 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
- 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)

Appealing a short-term disability claim that has been fully or partially denied

Note: For claims filed under the short-term disability plans for salaried associates and OTR truck drivers before February 1, 2026, the claims and appeals procedures described in the **Salaried short-term disability** chapter or the **Truck driver short-term disability** chapter, as applicable, in the 2025 *Associate Benefits Book* apply.

Note: If your claim for short-term disability benefits is denied because Sedgwick did not receive objective medical documentation supporting your claim, or the documentation provided did not support your claim, you will have 30 calendar days from the date of your denial letter to submit objective medical information to Sedgwick for review without the need to file an appeal. Once the 30 days have passed, if your claim remains denied and you would like to appeal, you must submit a formal 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 programs in California, Colorado, Connecticut, Maine, Massachusetts, Minnesota, Oregon, Rhode Island, Washington, D.C., and Washington state, you should submit your appeal of a determination relating to a claim for mandated benefits 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 **Full-time hourly short-term disability** chapter.

If your appeal relates to a claim that was denied by Sedgwick or Lincoln and you would like to appeal, you must submit a written or oral appeal to Sedgwick or a written appeal to Lincoln (as applicable) within 180 days of the denial at the following address, as applicable:

Walmart Disability and Leave Service Center at Sedgwick
National Appeals Unit
P.O. Box 14748
Lexington, Kentucky 40512-4748

Appeals for associates in Delaware, Hawaii, New Jersey, and New York: Based on your particular circumstances, send your appeal to the appropriate entity listed below:

Benefit	Address your appeal to
Enhanced short-term disability appeals and New York paid family leave	**Group Benefits Claims Appeal Unit** **Lincoln Financial Group** **Group — Charlotte WM** **Attn: Appeal Review Unit** **P.O. Box 2578** **Omaha, Nebraska 68172-9688**
New York Disability Benefits Law appeals	**Workers' Compensation Board** **Disability Benefits Bureau** **P.O. Box 9029** **Endicott, New York 13761-9029**
New Jersey Temporary Disability Insurance appeals	**New Jersey Department of Labor and Workforce Development** **Division of Temporary Disability Insurance** **Private Plan Compliance** **P.O. Box 957** **Trenton, New Jersey 08625-0957**
Hawaii TDI Appeals	**Department of Labor and Industrial Relations Disability Compensation Division** **P.O. Box 3769** **Honolulu, Hawaii 96812-3769**
Delaware PFML Associates can appeal either to Lincoln or directly to the state	**Lincoln:** **Group Benefits Claims Appeal Unit** **Lincoln Financial Group** **Group-Charlotte WM** **Attn: Appeal Review Unit** **P.O. Box 2578** **Omaha, Nebraska 68172-9688** **or** **Delaware Paid Leave at:** **PFMLAppeals@delaware.gov** **Phone: 302-761-8375** **labor.delaware.gov/delaware-paid-leave**

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 third-party administrator, on behalf of 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 third-party administrator, on behalf of 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
  - 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
- 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.

See **Appealing an enrollment or eligibility status decision** earlier in this chapter for information on appealing eligibility determinations.

For salaried associates and truck drivers, see the **Salaried short-term disability** chapter or the **Truck driver short-term disability** chapter, as appropriate, for detailed information on the appeals process for those plans.

Authority of short-term disability claims administrator

Sedgwick or Lincoln (as applicable) shall, subject to the requirements of ERISA, have the sole and exclusive discretionary authority to interpret the Plan's short-term disability provisions with respect to all claims for short-term disability benefits properly brought by a Plan participant or beneficiary. Sedgwick's or Lincoln's (as applicable) determination on review of an appeal shall be made in a fair and consistent manner to ensure the independence and impartiality of persons involved in the decision-making process, in accordance with the Plan terms, and their decision shall be final, subject only to a determination by a court of competent jurisdiction that their decision was arbitrary or capricious.

Voluntary second appeal of a claim for short-term disability benefits

If your 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.

Note: For claims filed under the short-term disability plans for salaried associates and OTR truck drivers before February 1, 2026, the claims and appeals procedures

described in the **Salaried short-term disability** chapter or the **Truck driver short-term disability** chapter, as applicable, in the 2025 *Associate Benefits Book* apply.

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.

Claims and appeals process for long-term disability coverage claims

Claims under the long-term disability plan should be submitted to:

Group Benefits Claims
Lincoln Financial Group
Group — Charlotte WM
P.O. Box 2578
Omaha, Nebraska 68172-9688

If you are on an approved short-term disability claim, Sedgwick will automatically transition the claim to Lincoln for consideration. You may also call Lincoln at **877-353-6404** to request a claim form as soon as you know you will need to use your long-term disability benefit, but no later than 30 days after the long-term disability benefit would otherwise start. If that is not possible, you should call Lincoln as soon as reasonably possible to do so. Lincoln will provide you with additional information regarding how to complete your claim.

If you elected truck driver long-term disability and were required to submit Proof of Good Health but your proof was not approved, you may submit an appeal in writing to Lincoln Financial Group. Contact Lincoln Financial Group for specific procedures regarding the appeal of a Proof of Good Health decision, including timing requirements. Submit your appeal via email at **EOIQuestions@lfg.com** or by U.S. mail to:

Lincoln Financial Group
ATTN: Medical Underwriting
P.O. Box 2870
Omaha, Nebraska 68103-2870

Once a claim has been filed, Lincoln will notify you of its decision on your claim within a reasonable period of time, but 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 Lincoln's 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 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
  - 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
- 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)

Appealing a long-term disability claim that has been fully or partially denied

If your claim for long-term disability benefits is denied and you would like to appeal, you must submit a written appeal to Lincoln within 180 days of the denial.

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. Lincoln 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, Lincoln 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, Lincoln will provide you with the identification of any medical expert whose advice was obtained in connection with your appeal. Lincoln 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 Lincoln 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
  - 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
- 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.

See **Appealing an enrollment or eligibility status decision** earlier in this chapter for information on appealing eligibility determinations.

My Mental Health Resources

You do not have to file a claim for My Mental Health Resources benefits. As long as you remain eligible, you may access the Lyra website or contact Lyra 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:

Walmart Benefits Total Rewards Team
Attn: Custodian of Records
Mail Stop 3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

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 earlier in this chapter.

Nicotine cessation program

You do not have to file a claim for benefits under the nicotine cessation program. As long as you remain eligible, you may access the Lyra website or contact Lyra 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:

Walmart Benefits Total Rewards Team
Attn: Custodian of Records
Mail Stop 3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

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 earlier in this chapter.

International business travel medical insurance

Claim forms are generally not required for Blue Cross Blue Shield Global Solutions services. However, if you have a question about your benefits or disagree with the benefits provided, you may contact Blue Cross Blue Shield Global Solutions or file a claim. To submit a claim via email or fax, download a claim form and view detailed instructions in the Member Portal at **bcbsglobalsolutions.com**. Submit your claim by email to **claims@bcbsglobalsolutions.com** or by fax to **610-482-9623**.

You may also submit claims by post. Download a claim form from the Member Portal at **bcbsglobalsolutions.com** and send your completed form to:

Blue Cross Blue Shield Global Solutions
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 Blue Cross Blue Shield Global Solutions policy. Contact Blue Cross Blue Shield Global Solutions at any time by calling **888-412-6403**. Outside the U.S. call collect: **610-254-5830**.

Legal information

Associates' Health and Welfare Plan	318
Plan identifying information	318
Plan funding	319
Plan amendment or termination	319
Your rights under ERISA	319
Use of associate and participant data	320
HIPAA Notice of Privacy Practices	320
Medicare and your prescription drug coverage	324
Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP)	325
Valued plan participant	328

Legal information

The 2027 *Associate Benefits Book* contains separate chapters that, taken together, constitute the Summary Plan Description (SPD) for the Walmart Inc. Associates' Health and Welfare Plan (the Plan). Specifically, the SPD for the Plan (2027 *Associate Benefits Book)* includes the following chapters:

- **Eligibility, enrollment, and effective dates**
- **Eligibility, enrollment, and effective dates for associates in Hawaii**
- **The medical plan**
- **The pharmacy benefit**
- **The dental plan**
- **The vision plan**
- **Associate assistance resources (excluding Help Now)**
- **COBRA**
- **Full-time hourly short-term disability plan**
- **Salaried short-term disability plan**
- **Truck driver short-term disability plan**
- **Full-time hourly and salaried long-term disability insurance**
- **Truck driver long-term disability insurance**
- **Company-paid life insurance**
- **Optional associate life insurance**
- **Optional dependent life insurance**
- **Business travel accident insurance**
- **Accident insurance**
- **Accidental death and dismemberment (AD&D) insurance**
- **Critical illness insurance**
- **Claims and appeals**
- **Legal information**

In this **Legal information** chapter of the SPD, you will 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** **Administrative Committee** **Associates' Health and Welfare Plan** **Mail Stop 3610** **806 Excellence Drive** **Bentonville, Arkansas 72716-3610** **Note:** You must send your request to the specific address above, including the mail stop. If your request is not sent to this address, receipt by the Plan Administrator will be delayed. 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 prescription drug plans	**medicare.gov**	**800-MEDICARE** (**800-633-4227**) TTY users should call **877-486-2048**
Answers to your questions about Medicaid/CHIP	**insurekidsnow.gov**	**877-KIDS NOW** (**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

Walmart Inc. maintains the Plan for the exclusive benefit of its eligible associates and their eligible family members. The Plan provides health and welfare benefits through the following component benefit programs:

- Self-insured medical benefits, including pharmacy[1]
- Medical insurance (including HMOs)[2]
- Self-insured dental benefits
- Vision insurance
- Self-insured employee assistance program (associate assistance resources, excluding Help Now)
- Self-insured short-term disability benefits
- Long-term disability insurance
- Company-paid life insurance
- Optional associate life insurance
- Optional dependent life insurance
- Business travel accident insurance
- Accident insurance
- Accidental death and dismemberment insurance
- Critical illness insurance

Each component benefit program (except for medical insurance) is summarized in the respective chapter of this SPD. Medical insurance (including HMOs) is summarized in a certificate of insurance booklet issued by an insurance company, a summary prepared specifically for that component benefit program. These summaries are also part of the Plan's SPD.

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. The Wrap Document, together with this book and the other incorporated documents, constitutes the written instrument under which the Plan is established and maintained. An amendment to an incorporated document, including this SPD, is considered an amendment to the Plan.

[1] Self-insured medical benefits include the following plan options: Premier PPO Plan, Contribution HRA Plan, Saver HSA Plan, and Personalized Wellbeing Copay Plan.

[2] Medical insurance includes the following plan options: HMOs.

Plan identifying information

Plan Sponsor:
Walmart Inc.
1 Customer Drive
Bentonville, Arkansas 72716-0295

Plan Sponsor's EIN: 71-0415188

Plan Number: 501

Type of Plan: Welfare, including medical, dental, vision, employee assistance program, short-term disability, long-term disability insurance, company-paid life insurance, optional associate and dependent life insurance, business travel accident insurance, accident insurance, accidental death and dismemberment (AD&D), and critical illness insurance.

Type of Administration: The Plan is administered by the Plan Administrator. The Plan Administrator has discretion to delegate some or all of its fiduciary responsibility to a third party. The Plan Administrator has delegated fiduciary responsibility for determinations of claims for benefits and appeals under the self-funded benefit components to third-party administrators. For insured benefit components, insurers have fiduciary responsibility for determinations of claims for benefits and appeals. The **Claims and appeals** chapter in this SPD identifies the specific third party, including insurers that administer claims and appeals for the respective benefits.

The Plan Administrator (or its delegates, including third-party administrators and insurers deciding claims and appeals) has complete discretion to interpret and construe the provisions of the Plan, including any communications about the Plan or its component benefits, 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 Administrator and Named Fiduciary:
Walmart Plan Administrator
Administrative Committee
Associates' Health and Welfare Plan
Mail Stop #3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

Named Fiduciary (for self-funded medical, pharmacy, dental, and short-term disability benefits): For each of the self-funded component benefit programs, the applicable third-party administrator is a named fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the Plan.

Named Fiduciary (for insured medical, vision, company-paid life, optional associate life, optional dependent life, business travel accident, long-term disability, accident, AD&D, and critical illness insurance): For each of the insured component benefit programs, the applicable insurance company is a named fiduciary with respect to decisions regarding whether a claim for benefits will be paid under the insurance contract.

Plan Trustee:
J. P. Morgan
4 New York Plaza, 15th Floor
New York, New York 10004-2413

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 Year: January 1 through December 31

Plan funding

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 associates, 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 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. The Plan may be amended only in accordance with the terms of the Wrap Document.

Neither the Plan nor the benefits described in this 2027 *Associate Benefits 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, a management associate of Walmart, a representative in the benefits call center, or a third-party administrator. In addition, any written representations or statements from anyone, including any AI-generated material, do not amend or modify the Plan.

Only written statements relating to interpretation of current Plan terms by the Plan Administrator and amendments adopted in accordance with the terms of the Wrap Document 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 2027 *Associate Benefits Book* 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.

The Plan's medical benefit component does not have a preexisting 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**.

Use of associate and participant data

Information such as your address, email, phone number, dependent information, and other details you provide during an enrollment session will be used to enroll you in the Plan. Solely for purposes of effectively operating the Plan, including providing you with important information about your benefits, Walmart Inc. may share the information you provide during enrollment with the Plan or with the service providers to the Plan, as reasonably necessary and as permitted by law. See the **Walmart Associate Information Privacy Notice** for additional details.

The Plan may share data relating to your benefits among service providers to the Plan solely for the purposes of providing Plan benefits, as permitted by law. Walmart Inc., the Plan, or service providers to the Plan may contact you regarding your benefits at the email address or the personal phone number you provide.

Plan service providers may also offer access to proprietary applications that are subject to vendor-specific terms and conditions and privacy notices. You should read those carefully.

HIPAA Notice of Privacy Practices

This notice was updated October 1, 2025

This notice applies to the Associates' Medical Plan (AMP), dental plan, My Mental Health Resources, and the nicotine cessation program, referred to collectively as the "plans."

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) and a fully insured international business travel medical plan. For these benefit options, the insurer of the HMO 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.

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, My Mental Health Resources, and the nicotine cessation program 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, My Mental Health Resources, and the nicotine cessation program.

How the AMP, dental plan, My Mental Health Resources, and the nicotine cessation program 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 Plans 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 use and 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 use and 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 use your PHI for health oversight activities and 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 Judicial and Administrative Proceedings.** The Plans may use or disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.
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 PHI 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 disclose your PHI in compliance with state law relating to workers' compensation or other 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 Plans will not condition your eligibility to participate in the Plans or payment of benefits under the Plans 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.

Part 2 program records

The Plans may receive your PHI from a substance use disorder program that includes information subject to 42 CFR Part 2 ("Part 2") governing the confidentiality of substance use disorder records. Part 2 provides additional confidentiality protections to substance use disorder records we receive from a Part 2 program. The Plans will not use or disclose substance use disorder records that we receive from a Part 2 program, or testimony relaying the content of such records, in civil, criminal, administrative, or legislative proceedings against you unless based on your written consent or a court order after notice and an opportunity to be heard is provided to you or the holder of the record. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Stricter state privacy laws

Under the HIPAA Privacy Regulations, the Plans are 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 Plans maintain 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, My Mental Health Resources', or the nicotine cessation program'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 Plans. 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 Plans at the address on the next page 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, My Mental Health Resources, the nicotine cessation program, 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, My Mental Health Resources, the nicotine cessation program, or with the U.S. Department of Health and Human Services.

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 Benefits Total Rewards Team
Attn: HIPAA Compliance Team
Mail Stop #3610
806 Excellence Drive
Bentonville, Arkansas 72716-3610

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' Medical Plan (the AMP) 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two 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. For purposes of the *Associate Benefits Book*, any of the Medicare drug plans covered under this notice are considered Part D plans.
- The AMP has determined that the prescription drug coverage offered under all self-funded options of the AMP is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered creditable coverage. If you enroll in one of these options, you may keep your current coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Part D drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you also will be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

When will you pay a higher premium (a penalty) to join a Medicare drug plan?

You should also know that if you are enrolled in an AMP option and drop or lose your AMP coverage and do not join a Medicare drug plan within 63 continuous days after your current AMP coverage ends, you may pay a higher premium (a penalty) to join the Medicare drug plan later.

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 higher 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 AMP will be affected. Plan guidelines restrict you from enrolling in the AMP if you are enrolled in a Medicare drug plan. If your dependent is enrolled in a Medicare drug plan 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 AMP, be aware that you and your dependents will be able to reenroll, but only during Annual Enrollment or due to an election change event, provided you are not still enrolled in a Medicare drug plan.

If you enroll in a Medicare drug plan and decide within 60 days to switch back to a plan option under the AMP, you will need to call People Services at **800-421-1362** to reenroll. See the **Eligibility, enrollment, and effective dates** chapter for further details.

For more information about this notice or your prescription drug coverage

Contact People Services at **800-421-1362** for further information. **Note:**

- You will get this notice each year before the next period during which you can join a Medicare drug plan.
- If we make a plan change that affects your creditable coverage under the AMP, you will receive another notice.
- If you need a copy of this notice, you can request one at any time from People Services at **800-421-1362**.

For more information about your options under Medicare prescription drug coverage

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 drug plans. You will get a copy of the handbook in the mail every year from Medicare.

For more information about Medicare prescription drug coverage:

- Visit **medicare.gov**.
- Call your State Health Insurance 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**.

If you have limited income and resources, extra help paying for the Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at **socialsecurity.gov**, or call **800-772-1213** (TTY **800-325-0778**).

Remember

Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained 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 page, 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 visit **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, 2026. 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: **https://health.alaska.gov/dpa/Pages/default.aspx**

ARKANSAS – Medicaid
Website: **http://myarhipp.com**
Phone: **855-MyARHIPP** (**855-692-7447**)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: **https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance**
Phone: **916-445-8322**
Fax: **916-440-5676**
Email: **hipp@dhcs.ca.gov**

COLORADO – Health First Colorado (Medicaid) & 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://hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service: **800-359-1991** / State Relay **711**
Health Insurance Buy-In Program (HIBI): **https://www.mycohibi.com**
HIBI Customer Service: **855-692-6442**

FLORIDA – Medicaid
Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: **877-357-3268**

GEORGIA – Medicaid
GA HIPP website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: **678-564-1162**, press **1**
GA-CHIPRA website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Phone: **678-564-1162**, press **2**

ILLINOIS – Medicaid
Illinois Medicaid Premium Assistance Information
Medicaid application website: **https://abe.illinois.gov**
HIPP hotline number: **217-524-8268**
HIPP email: **hfs.boc.hipp@illinois.gov**

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: **https://www.in.gov/medicaid**
http://www.in.gov/fssa/dfr
Family and Social Services Administration
Phone: **800-403-0864**
Member services phone: **800-457-4584**

IOWA MEDICAID AND CHIP (Hawki)
Medicaid website: **https://hhs.iowa.gov/programs/welcome-iowa-medicaid**
Medicaid phone: **800-338-8366**
Hawki website: **https://hhs.iowa.gov/medicaid/plans-programs/hawki**
Hawki phone: **800-257-8563**
HIPP website: **https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program**
HIPP phone: **888-346-9562**

KANSAS – Medicaid
Website: **https://www.kancare.ks.gov**
Phone: **800-792-4884**
HIPP phone: **800-967-4660**

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**
Phone: **855-459-6328**
Email: **KIHIPP.program@ky.gov**
KCHIP website: **https://kynect.ky.gov**
Phone: **877-524-4718**
Medicaid website: **https://chfs.ky.gov/agencies/dms**

LOUISIANA – Medicaid
Website: **www.ldh.la.gov/healthy-louisiana**
Phone: **888-342-6207** (Medicaid customer service)
Louisiana Health Insurance Premium Program (LaHIPP)
Website: **www.ldh.la.gov/lahipp**
Phone: **877-697-6703**
Email: **La.HIPP@la.gov**
Fax: **888-716-9787**
LaHIPP mailing address:
100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid
Enrollment website: **https://www.mymaineconnection.gov/benefits/s/?language=en_US**
Phone: **800-442-6003** TTY: Maine relay **711**
Private health insurance premium webpage: **https://www.maine.gov/dhhs/ofi/applications-forms**
Phone: **800-977-6740** TTY: Maine relay **711**

MASSACHUSETTS – Medicaid and CHIP
Website: **https://www.mass.gov/masshealth/pa**
Phone: **800-862-4840** TTY: **711**
Email: **masspremassistance@accenture.com**

MINNESOTA – Medicaid
Website: **https://mn.gov/dhs/health-care-coverage**
Phone: **800-657-3672**

MISSOURI – Medicaid
Website: **https://mydss.mo.gov/mhd/healthcare**
Phone: **573-751-2005**

MONTANA – Medicaid
Website:
https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: **800-694-3084**
Email: **HHSHIPPProgram@mt.gov**

NEBRASKA – Medicaid
Website: **https://dhhs.ne.gov/Pages/ACCESSNebraska.aspx**
Phone: **855-632-7633**
Lincoln: **402-473-7000**
Omaha: **402-595-1178**

NEVADA – Medicaid
Website: **https://dhcfp.nv.gov**
Phone: **800-992-0900**

NEW HAMPSHIRE – Medicaid
Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Phone: **603-271-5218**
Toll-free for HIPP program: **800-852-3345**, ext **5218**
Email: **DHHS.ThirdPartyLiabi@dhhs.nh.gov**

NEW JERSEY – Medicaid and CHIP
Medicaid website: **https://www.nj.gov/humanservices/dmahs/individuals-families/familycare**
Phone: **800-356-1561**
CHIP premium assistance phone: **609-631-2392**
CHIP website: **https://www.njfamilycare.org/index.html**
CHIP phone: **800-701-0710** (TTY: **711**)

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: **https://www.hhs.nd.gov/healthcare**
Phone: **844-854-4825**

OKLAHOMA – Medicaid and CHIP
Website: **https://www.insureoklahoma.org**
Phone: **888-365-3742**

OREGON – Medicaid
Website: **https://healthcare.oregon.gov/Pages/index.aspx**
Phone: **800-699-9075**

PENNSYLVANIA – Medicaid and CHIP
Website:
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: **800-692-7462**
CHIP website:
https://www.pa.gov/agencies/dhs/resources/chip
CHIP phone: **800-986-KIDS (5437)**

RHODE ISLAND – Medicaid and CHIP
Website: **https://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: **https://dss.sd.gov**
Phone: **888-828-0059**

TEXAS – Medicaid
Website: **https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**
Phone: **800-440-0493**

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: **https://medicaid.utah.gov/upp**
Email: **upp@utah.gov**
Phone: **888-222-2542**
Adult expansion website: **https://medicaid.utah.gov/expansion**
Utah Medicaid Buyout Program website:
https://medicaid.utah.gov/buyout-program
CHIP website: **https://chip.utah.gov**

VERMONT – Medicaid
Health Insurance Premium Payment (HIPP) Program / Department of Vermont Health Access website:
https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: **800-250-8427**

VIRGINIA – Medicaid and CHIP
Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select**
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP phone: **800-432-5924**

WASHINGTON – Medicaid
Website: **https://www.hca.wa.gov**
Phone: **800-562-3022**

WEST VIRGINIA – Medicaid and CHIP
Website: **https://bms.wv.gov/cms/west-virginia-state-medicaid-plan**
https://mywvhipp.com
Medicaid phone: **304-558-1700**
CHIP toll-free phone: **855-MyWVHIPP** (**855-699-8447**)

WISCONSIN – Medicaid and CHIP
Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**
Phone: **800-362-3002**

WYOMING – Medicaid
Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility**
Phone: **800-251-1269**

To see if any other states have added a premium assistance program since July 31, 2026, 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**

Valued plan participant

The Associates' Health and Welfare Plan (AHWP) respects the dignity of each individual who participates in the plan.

The Associates' Health and Welfare Plan (AHWP) complies with applicable federal civil rights laws and 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 reasonable modifications, 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. This notice is also available on the My Health page at **One.Walmart.com** under **Resources and help**.

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 for 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

عربية (Arabic)
تنبيه: إذا كنت تتحدث اللغة العربية، يمكنك الحصول على مساعدة لغوية مجانية. يرجى الاتصال بالرقم 1-800-421-1362. كما يسعدنا تقديم المساعدة اللغوية، بالإضافة إلى الوسائل والخدمات المساعدة، للمشاركين معنا مجانًا.

বাংলা (Bengali)
মনোযোগ দিন: আপনি যদি বাংলা ভাষায় কথা বলেন, তাহলে বিনামূল্যে ভাষাগত সহায়তা পেতে পারেন। 1-800-421-1362 নম্বরে কল করুন। এছাড়াও, আমরা আমাদের অংশগ্রহণকারীদের জন্য বিনামূল্যে ভাষাগত সহায়তা, পাশাপাশি সহায়ক উপকরণ ও সেবাসমূহ প্রদান করতেও আনন্দিত।

မြန်မာ (Burmese)
အသိပေးချက် - အကယ်၍ သင်သည် မြန်မာဘာသာစကားကို ပြောဆိုသူဖြစ်ပါက ဘာသာစကားဆိုင်ရာ အကူအညီကို အခမဲ့ ရယူနိုင်ပါသည်။ 1-800-421-1362 သို့ ဖုန်းခေါ်ဆိုပါ။ ကျွန်ုပ်တို့၏ အစီအစဉ်တွင် ပါဝင်သူများအား ဘာသာစကားဆိုင်ရာ အကူအညီများအပြင် အထောက်အကူပြု ပစ္စည်းများနှင့် ဝန်ဆောင်မှုများကိုပါ အခမဲ့ ပံ့ပိုးပေးရသည့်အတွက် ဝမ်းမြောက်မိပါသည်။

廣州話 (Cantonese)
注意：如果你識講廣東話，你可以免費獲得語言協助。打去1-800-421-1362。我哋亦都好樂意為我哋嘅參與者免費提供語言協助，同埋輔助輔助同服務。

Pilipino/Tagalog (Filipino/Tagalog)
PAALALA: Kung ikaw ay nagsasalita ng Filipino/Tagalog, maaari kang makatanggap ng libreng tulong sa wika. Tumawag sa 1-800-421-1362. Ikinalulugod din naming magbigay ng tulong sa wika, pati na rin ng mga karagdagang kagamitan at serbisyo, sa aming mga kalahok nang walang bayad.

Français (French)
ATTENTION : Si vous parlez français, vous pouvez bénéficier d'une assistance linguistique gratuite. Appelez le 1-800-421-1362. Nous sommes également heureux de fournir gratuitement une assistance linguistique, ainsi que des aides et services auxiliaires, à nos participants.

Kreyòl (Creole)
ATANSYON: Si w pale Kreyòl, ou ka jwenn asistans lengwistik gratis. Rele 1-800-421-1362. Nou kontan tou pou n bay patisipan nou yo asistans lengwistik, ansanm ak sèvis ak èd oksilyè, san okenn frè.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlose sprachliche Unterstützung erhalten. Rufen Sie die Nummer 1-800-421-1362 an. Gerne stellen wir unseren Teilnehmern zudem kostenlos sprachliche Unterstützung sowie Hilfsmittel und unterstützende Dienstleistungen zur Verfügung.

ગુજરાતી (Gujarati)
ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોવ, તો તમે ભાષા અંગેની મફત સહાય મેળવી શકો છો. 1-800-421-1362 પર કૉલ કરો. અમે અમારા સહભાગીઓને ભાષાકીય સહાય તેમજ સહાયક સાધનો અને સેવાઓ વિનામૂલ્યે પૂરી પાડતા પણ આનંદ અનુભવીએ છીએ.

हिंदी (Hindi)
ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपको भाषा संबंधी सहायता मुफ़्त मिल सकती है। 1-800-421-1362 पर कॉल करें। हमें अपने प्रतिभागियों को बिना किसी शुल्क के भाषा संबंधी सहायता, साथ ही सहायक साधन और सेवाएँ प्रदान करने में भी खुशी होगी।

Italiano (Italian)
ATTENZIONE: Se parla italiano, può ricevere assistenza linguistica gratuita. Chiami il numero 1-800-421-1362. Siamo inoltre lieti di fornire assistenza linguistica, nonché ausili e servizi supplementari, ai nostri partecipanti a titolo gratuito.

日本語 (Japanese)
ご注意：日本語を話される方は、無料の言語支援サービスをご利用いただけます。1-800-421-1362までお電話ください。また、参加者の皆様には、言語支援に加え、補助的な支援やサービスも無料で提供しております。

(한국인 (Korean)
알림: 한국어를 사용하시는 경우 무료 언어 지원을 받으실 수 있습니다. 1-800-421-1362번으로 전화해 주십시오. 또한 참가자분들께 언어 지원은 물론 보조 도구 및 서비스도 무료로 제공해 드립니다.

普通话 (Mandarin Chinese)
提醒： 如果您讲普通话，您可以获得免费的语言协助服务。请致电 1-800-421-1362。我们也很高兴为我们的参与者免费提供语言协助，以及额外的资源和服务。

فارسی/افارسی/دری (Persian/Farsi/Dari)
توجه: اگر به زبان فارسی (یا دری) صحبت می‌کنید، می‌توانید از خدمات رایگان کمک‌زبانی بهره‌مند شوید. با شماره 1-800-421-1362 تماس بگیرید. ما همچنین با کمال میل، خدمات کمک‌زبانی و نیز امکانات و خدمات کمکی را به‌صورت رایگان به شرکت‌کنندگان خود ارائه می‌دهیم.

Polski (Polish)
UWAGA: Osoby posługujące się językiem polskim mogą skorzystać z bezpłatnej pomocy językowej. Prosimy dzwonić pod numer 1-800-421-1362. Ponadto z przyjemnością zapewniamy naszym uczestnikom bezpłatną pomoc językową oraz niezbędne środki pomocnicze i usługi.

Português (Portuguese)
ATENÇÃO: Se você fala português, pode receber assistência linguística gratuita. Ligue para 1-800-421-1362. Também temos prazer em oferecer assistência linguística, bem como recursos e serviços auxiliares, aos nossos participantes, sem custo algum.

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਸੀਂ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। 1-800-421-1362 'ਤੇ ਕਾਲ ਕਰੋ। ਸਾਨੂੰ ਆਪਣੇ ਭਾਗੀਦਾਰਾਂ ਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਖਰਚੇ ਦੇ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਦੇ ਨਾਲ-ਨਾਲ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਪ੍ਰਦਾਨ ਕਰਕੇ ਵੀ ਖੁਸ਼ੀ ਹੁੰਦੀ ਹੈ।

Kiswahili (Swahili)
TAHADHARI: Ikiwa unazungumza Kiswahili, unaweza kupata usaidizi wa lugha bila malipo. Piga simu namba 1-800-421-1362. Pia tunafurahi kutoa usaidizi wa lugha, pamoja na vifaa na huduma za ziada, kwa washiriki wetu bila gharama yoyote.

Soomaali (Somali)
OGEYSIIS: Haddii aad ku hadasho afka Soomaaliga, waxaad heli kartaa caawimaad xagga luqadda ah oo bilaash ah. Wac 1-800-421-1362. Waxaan sidoo kale ku faraxsanahay inaan ka qaybgalayaashayada siino caawimaad xagga luqadda ah, iyo waliba agab iyo adeegyo dheeraad ah, iyada oo aan wax kharash ah lagaa qaadaynin.

Español (Spanish)
ATENCIÓN: Si habla español, puede recibir asistencia lingüística gratuita. Llame al 1-800-421-1362. También nos complace ofrecer asistencia lingüística, así como ayudas y servicios auxiliares, a nuestros participantes sin costo alguno.

Română (Romanian)
ATENȚIE: Dacă vorbiți limba română, puteți beneficia de asistență lingvistică gratuită. Sunați la 1-800-421-1362. De asemenea, oferim cu plăcere asistență lingvistică, precum și mijloace și servicii auxiliare, participanților noștri, fără niciun cost.

Русский (Russian)
ВНИМАНИЕ! Если вы говорите по-русски, вы можете получить бесплатную языковую помощь. Звоните по номеру 1-800-421-1362. Мы также рады бесплатно предоставить языковую помощь, а также вспомогательные средства и услуги нашим участникам.

Tiếng Việt (Vietnamese)
LƯU Ý: Nếu quý vị nói tiếng Việt, quý vị có thể nhận được sự hỗ trợ ngôn ngữ miễn phí. Vui lòng gọi số 1-800-421-1362. Chúng tôi cũng sẵn lòng cung cấp miễn phí dịch vụ hỗ trợ ngôn ngữ, cũng như các phương tiện và dịch vụ hỗ trợ bổ sung, cho những người tham gia chương trình.

اردو (Urdu)
توجہ فرمائیں: اگر آپ اردو بولتے ہیں تو آپ زبان سے متعلق مفت معاونت حاصل کر سکتے ہیں۔ 1-800-421-1362 پر کال کریں۔ ہمیں اپنے شرکاء کو زبان سے متعلق معاونت کے ساتھ ساتھ اضافی امدادی سہولیات اور خدمات بلا معاوضہ فراہم کرنے میں بھی خوشی ہوگی۔

The Walmart 401(k) Plan

Walmart 401(k) plan eligibility	332
Enrolling in the Plan	333
Your Walmart 401(k) Plan accounts	333
Making a rollover from a previous employer's plan or IRA	334
Repaying certain distributions to the Plan	334
Making contributions to your account	334
Making an In-Plan Roth Conversion	337
Walmart's contributions to your Company Match Account	337
Investing your account	338
More about owning Walmart stock	339
Account balances and statements	340
Receiving a payout while working for Walmart	340
If you die: your designated beneficiary	343
If you get divorced	344
If you leave Walmart	344
If you leave and are rehired by Walmart	346
The income tax consequences of a payout	346
Filing a Walmart 401(k) Plan claim	349
Administrative information	349
Special tax notice addendum	352
Special tax notice addendum: Roth contributions	356

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, Roth, and/or your catch-up contribution	**One.Walmart.com** or **benefits.ml.com**	Call the Customer Service Center at **888-968-4015**
• Request an In-Plan Roth Conversion • Get information on how 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 distribution or loan from the Plan	**benefits.ml.com**	Call the Customer Service Center at **888-968-4015**
Designate a beneficiary	**One.Walmart.com** (if you are an active associate) or **benefits.ml.com**	Call the Customer Service Center at **888-968-4015**

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/or 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).
- You are also eligible to convert pretax contributions to after-tax Roth contributions by requesting an In-Plan Roth Conversion.
- 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.
- While the Plan is intended to provide retirement income, subject to Plan rules, you can access your account while you are still working for Walmart. For instance, you can request a loan from your Plan account and you can request a withdrawal in connection with financial hardship, the birth or adoption of your child, to assist you with emergency personal or family expenses (referred to as a limited emergency withdrawal), or if you are impacted by a federally declared major disaster (referred to as a qualified disaster recovery withdrawal).

This is a summary of benefits offered under the Plan as of October 1, 2026 (unless otherwise noted). 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, and
- Associates represented by a collective bargaining representative after Walmart has negotiated in good faith to impasse with the representative on the question of benefits.

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 (pretax contributions and/or Roth contributions) to the Plan. (If you are classified as a highly compensated employee, you must also have attained age 21.) (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, 2026 and you are credited with 1,095 hours by December 15, 2027 (your first anniversary), then you will begin receiving matching contributions on January 1, 2028, 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 matching contributions will be determined based on hours credited 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, 2026, and you are credited with only 895 hours by December 15, 2027 (your first anniversary), but you work 1,095 hours during the February 1, 2027–January 31, 2028 Plan year, you will begin receiving matching contributions on February 1, 2028 with respect to any contributions you make to the Plan on or after that date.

If you leave Walmart during your first year with more than 500 hours of service, those hours and your first anniversary date are retained for matching eligibility. If you are later rehired, you will become eligible for matching contributions when you reach 1,000 hours—either before your first anniversary date, or during a subsequent Plan year (February 1 to January 31).

For example, if you are hired November 1, 2026, leave on February 25, 2027, with 600 hours, and return October 1, 2027, your hours and anniversary date are retained. If you do not reach 1,000 hours by your first anniversary (November 1, 2027), you will begin receiving matching contributions on the February 1 following the Plan year in which you reach 1,000 hours.

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 Pretax Account and/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.

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** or **benefits.ml.com**. You can also call the Customer Service Center at **888-968-4015**. 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 whether your contributions will be pretax contributions or Roth contributions or a combination of both (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, or both, 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. 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 three 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 (including your Roth catch-up contributions, if any), as adjusted for earnings or losses on those contributions. The Roth Account will also hold any amounts you elected to convert in an In-Plan Roth Conversion, to the extent those amounts were not otherwise distributable under the Plan at the time of conversion, as adjusted for earnings or losses.
- **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 (other than contributions from a designated Roth salary deferral account) 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, as well as any amounts that you elected to convert in an In-Plan Roth Conversion, to the extent those amounts were otherwise distributable under the Plan at the time of conversion, as adjusted for earnings or losses.
- **Company Funded 401(k) Account:** This account holds the discretionary Walmart contributions to 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 Plan made for Plan years ended on or before January 31, 2011, as adjusted for earnings or losses on those contributions.

Differences between these accounts 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. If you think this applies to you, you can obtain more information on your other accounts by calling the Customer Service Center at **888-968-4015**.

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 generally roll over only pretax funds, but 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 or your Roth Rollover Account, as applicable, 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 more information on how to make a rollover.

Repaying certain distributions to the Plan

If you previously received one of the following types of distributions from the Plan, you may repay all or any part of those distributions to the Plan as long as you do so within three years of the date you received the distribution, and they will be considered part of your Rollover Account, subject to the rules above:

- A qualified birth or adoption distribution.
- A limited emergency withdrawal.
- A qualified disaster recovery withdrawal.

In addition, if you receive a hardship withdrawal for the purpose of purchasing or constructing your principal residence but are not able to use it for that purpose due to a federally declared major disaster, you generally may repay the withdrawal to the Plan within 180 days from the first day of the incident period (that is, the period specified by the Federal Emergency Management Agency (FEMA) as the period in which the disaster occurred).

For more information on these distributions, see the **Receiving a payout while working for Walmart** section below. If you're interested in recontributing all or part of your prior distribution to the Plan, contact the Customer Service Center at **888-968-4015** or visit **benefits.ml.com**.

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 2026, the limit is $24,500. This amount will be increased from time to time by the IRS. As of the publication date of this 2027 *Associate Benefits Book*, the IRS has not released adjustments to contribution limits for the 2027 calendar year. The IRS will announce any changes to 2027 calendar year limits in the fall of 2026.

In addition, 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.

- 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 (or until you elect an In-Plan Roth Conversion). 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.)

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 (except as noted below) 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
- 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
- Welfare benefits
- Fringe benefits
- Allowances
- Approved disability pay
- A signing bonus paid to you for coming to work for Walmart
- Severance pay
- Deferred compensation and stock 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** 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 three 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 of up to 75% of your eligible annual pay (but not to exceed the legal limits described below). These are called "catch-up contributions" and are made by payroll deduction just like your other contributions. Except as noted below for "high earners," you can choose whether your catch-up contributions will be either pretax contributions or Roth contributions, or both. Your catch-up contributions (including both pretax catch-up contributions and Roth catch-up contributions) in any calendar year may not exceed a limit set by the IRS. For 2026, your catch-up contributions may not exceed $8,000 or, if you turn age 60, 61, 62, or 63 by the end of 2026, $11,250. These dollar amounts may be adjusted from time to time by the IRS. The IRS will announce any changes to the 2027 calendar year limits in the fall of 2026. 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.

For example, if you are age 55 and you elect to contribute the maximum amount in the 2026 calendar year, which is the lesser of $24,500 or the maximum percentage of your eligible annual pay allowed under the Plan, you could elect to contribute up to an additional $8,000 during the 2026 calendar year. If, in this example, you are age 61, you could have elected to contribute up to an additional $11,250 during the 2026 calendar year. If you are interested in making catch-up contributions, you can enroll online at **One.Walmart.com** or **benefits.ml.com**, or by calling the Customer Service Center at **888-968-4015**.

If you are a "high earner" and make catch-up contributions

If you are considered to be a "high earner" under the law, any catch-up contributions you make to the Plan must be Roth catch-up contributions. High earners are not permitted to make catch-up contributions on a pretax basis.

You will be considered to be a "high earner" for a calendar year if you will be at least age 50 by the end of the calendar year and your FICA wages from Walmart for the prior calendar

year are more than a threshold dollar amount. For instance, you are a high earner for 2026 if you are at least age 50 by the end of 2026 and earned more than $150,000 in FICA wages from Walmart in 2025. The threshold dollar amount that makes someone a high earner may be adjusted by the IRS from year to year and any change will be announced by the IRS in the fall of the preceding calendar year.

Even though you may be a "high earner," the enrollment system will still permit you to make four separate salary deferral contribution elections: (1) pretax regular contributions, (2) pretax catch-up contributions, (3) Roth regular contributions, and (4) Roth catch-up contributions.

The combined (pretax and Roth) regular contribution limit is $24,500 for 2026. The combined (pretax and Roth) catch-up limit is $8,000 for 2026, except the catch-up limit will increase to $11,250 if you will turn age 60, 61, 62, or 63 by the end of 2026. This means the maximum amount you may contribute to the plan for 2026 if you are over age 50 is $32,500 (or $35,750 if you'll reach age 60, 61, 62, or 63 during the year). As noted, these dollar amounts may be adjusted from time to time by the IRS. The IRS will announce any changes to the 2027 calendar year limits in the fall of 2026.

Note that Plan terms designed to comply with these requirements may automatically limit your contributions, regardless of your elections. The new Plan terms will impact your elections as follows:

- Once your total pretax contributions (including both regular and catch-up contributions) reach the legal limit ($24,500 for 2026), your pretax elections (both regular and catch-up) will stop and you will not be able to make any additional pretax contributions for the year.
- Once your total regular contributions (including both pretax and Roth contributions) reach the legal limit ($24,500 for 2026), your regular elections (both pretax and Roth) will stop.
- Once your total catch-up contributions (including both pretax and Roth contributions) reach the legal limit (for 2026, $8,000, or $11,250 if you will be age 60, 61, 62, or 63 during the year), your catch-up elections (both pretax and Roth) will stop.

If these rules result in any of your elections stopping during a calendar year, your contribution elections will automatically restart at the beginning of the following calendar year unless you make a different election.

Under the Plan terms, your total contributions for a calendar year will be limited to the legal limit ($24,500 in 2026) if either of these scenarios applies to you:

- You elect to make only regular contributions (pretax regular, Roth regular, or a combination of both), or
- You elect to make only a combination of pretax regular and pretax catch-up contributions.

If you want to contribute more than the legal limit ($24,500 in 2026), you will need to make a Roth election, using one of the following scenarios:

- You elect both pretax regular contributions and Roth catch-up contributions,
- You elect both pretax regular and pretax catch-up and a Roth contribution (Roth regular, Roth catch-up, or both),
- You elect both Roth regular contributions and a catch-up contribution (pretax catch-up, Roth catch-up or both), or
- You elect both pretax regular and Roth regular contributions, and a catch-up contribution (pretax catch-up, Roth catch-up or both).

These new rules are illustrated in the following examples:

Example 1: You are a high earner and you have a 10% pretax regular contribution election and a 10% pretax catch-up contribution election in place for 2026. Your salary deferral contributions will stop when you have contributed the legal limit for the calendar year ($24,500 for 2026). If you want to make additional contributions, you will need to make a Roth contribution (Roth regular, Roth catch-up, or both).

Example 2: You are a high earner and you have a 15% pretax regular contribution election, a 10% pretax catch-up contribution election, and a 5% Roth regular contribution election in place for 2026. In June 2026, you have made pretax contributions up to the legal limit ($24,500 in 2026). At that time, your pretax contribution deferral elections will stop, but your 5% Roth regular contribution election will continue until you reach the regular contribution limit described above.

If you are a high earner and you inadvertently make pretax catch-up contributions to the Plan that should have been Roth catch-up contributions, appropriate correction will be made, which may include refunding the contributions to you. Generally, any contributions refunded to you will be taxable in the year deferred and earnings on those amounts will be taxable in the year refunded to you.

Contributing to more than one plan during the year

The maximum 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) during 2026 is (1) $24,500, (2) $32,500 if you are eligible for catch-up contributions, or (3) $35,750 if you will turn age 60, 61, 62, or 63 during 2026. These amounts 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 the year deferred and will be taxed. Earnings on the excess amount are taxable in the year refunded to you. 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 the Customer Service Center at **888-968-4015** 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 the Customer Service Center at **888-968-4015**.

Making an In-Plan Roth Conversion

You can choose to convert all or any part of the vested contributions in your account (other than Roth contributions and related earnings, and funds that are part of an outstanding loan balance) to Roth contributions through an "In-Plan Roth Conversion." The contributions you choose to convert, along with any earnings on those contributions through the date of the conversion, will be subject to applicable federal, state, and local taxes in the year of conversion. No taxes will be withheld at the time of conversion, however, so it will be up to you to ensure that you can pay the related taxes when due. Accordingly, you may want to increase your payroll withholdings or make estimated tax payments. The amount converted is not subject to a 10% penalty. Once converted, the funds may not be converted back to pretax funds.

The rules applicable to your funds after conversion differ depending on whether the funds were eligible for distribution from the Plan at the time of the conversion.

- If the funds you convert were otherwise eligible for distribution (for instance, you are age 59½) and eligible for rollover, then the funds will be treated as though they were distributed from the Plan and then rolled back into the Plan. This means they will be credited to your Roth Rollover Account and may be withdrawn at any time.
- If the funds you convert were not eligible for distribution, they will be credited to your Roth Account and will remain subject to the same distribution rules after the conversion as they were before the conversion. For instance, if you elect to convert your pretax salary deferral contributions, those funds generally will not be eligible for distribution until you reach age 59½, incur a financial hardship, or terminate employment.

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) for the Plan year, up to 6% of your eligible annual pay for the Plan year. 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. The IRS also limits the amount of compensation that can be taken into account under the Plan for any participant for a Plan year. For the Plan year ending January 31, 2027, this limit is $360,000. The IRS may adjust this amount for the Plan year ending January 31, 2028.

Note: The matching contribution limit is applied on a *Plan* year basis (February 1–January 31). Because the dollar limit on your 401(k) contributions ($24,500 for 2026) is applied on a calendar year basis, it is important that you consider the timing of your 401(k) contributions to ensure that you receive the full matching contribution. For instance, if you contribute the full $24,500 in 401(k) contributions in January of 2026, you may not receive a matching contribution on those amounts if you have already received the maximum matching contribution limit earlier in the Plan year ended January 31, 2026.

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[1]

Years of service	Vested percentage
Less than 2	0%
2	20%
3	40%
4	60%
5	80%
6 or more	100%

[1] Applies to participants actively employed on or after January 31, 2008.

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 (see **Your Walmart 401(k) Plan accounts** earlier in this summary).

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 the Investment Guide. These documents can 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 and Investment Guide. You may obtain these documents free of charge, as well as other specific information regarding your

investment rights and investment options under the Plan, 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.

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.gov/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 by mail the notice generally distributed to the shareholders of Walmart, which provides information on how you may access or request a paper copy of the proxy materials and how to instruct the trustee to vote the shares in your Plan account.

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 provide 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 (even if those amounts have been converted to a Roth Account or a Roth 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 (even if those amounts have been converted to a Roth Account or a Roth 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 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 vested accounts while you're still working:

- In the case of a financial hardship.
- To assist with limited emergency expenses.

- If you are impacted by a federally declared major disaster.
- After you reach age 59½.
- In connection with the birth or adoption of your child.
- Rollovers can be withdrawn at any time.
- You may request a loan from your Plan account.

You can request any of these withdrawals online at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

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.

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 and that plan was merged into this Plan, you may have other withdrawal options with respect to amounts from your prior employer's plan. For more information regarding withdrawal options available for your other accounts, call the Customer Service Center at **888-968-4015**.

Financial hardship withdrawals

You may withdraw some or all of your vested Plan accounts as necessary to meet a "financial hardship." You will be required to certify that you have insufficient cash or other liquid assets to satisfy the need.

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).
- Expenses and losses (including loss of income) incurred by you on account of a federally declared disaster 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 the disaster.

Federal tax law requires that you must have already obtained all in-service payouts available (including in-service withdrawals of rollover contributions and withdrawals after age 59½) before you can request a financial hardship payout. Pursuant to the terms of the Plan, you must have also obtained any available limited emergency withdrawal 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.

Note that if you take a hardship withdrawal to purchase or construct your principal residence in a federally declared disaster area, but you are not able to do so because of the disaster, you may be able to repay the withdrawal to the Plan and avoid taxation. For this to apply, you must have taken the withdrawal during the period from 180 days before the "incident period" through 30 days after the end of the incident period, and you generally must repay the withdrawal to the Plan within 180 days from the first day of the incident period. The incident period is the period specified by the Federal Emergency Management Agency (FEMA) as the period in which the disaster occurred. If you think this may apply to you, you should contact the Customer Service Center at **888-968-4015** for more information.

Limited emergency withdrawals

You may request a withdrawal from your vested account of up to $1,000 (or, if less, the vested amount in your account in excess of $1,000) for any unforeseeable emergency or immediate financial need relating to necessary personal or family emergency expenses. You are required to make a representation to the Plan that your request is for this purpose. You can request one withdrawal per calendar year and cannot request another in the following three calendar years, unless you timely repay the full withdrawal amount to the Plan or, since your withdrawal, you have made 401(k) contributions at least equal to the withdrawal amount. If you want to repay your withdrawal, you must do so within three years of the date you receive it.

Qualified disaster recovery withdrawals

You may request a withdrawal from your vested account of up to $22,000 if your principal residence is in a federally declared disaster area and you sustain an economic loss due to the disaster, such as damage to your home or expenses you incur because you cannot live in your home.

(Note that this $22,000 limit applies, in the aggregate, to all withdrawals you receive from all plans and IRAs that you own.) Your distribution generally must be taken within 180 days after the first day of the "incident period" (the period specified by FEMA as the period in which the disaster occurred). You will be required to make a representation to the Plan that you are eligible for this withdrawal. If you want to repay your withdrawal, you must do so within three years of the date you receive it.

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.

Withdrawals related to the birth or adoption of your child

You may request a withdrawal of up to $5,000 from the vested portion of your Plan account within one year of the birth or adoption of your child. In the case of adoption, the adoptee must be under the age of 18 or physically or mentally incapable of self-support and must not be the child of your spouse. You are required to make a representation to the Plan that the withdrawal is related to the birth or adoption of your child. If you want to repay your withdrawal, you must do so within three years of the date you receive it.

Note: Your distribution will not be considered a qualified birth or adoption distribution unless you include the name, age, and taxpayer identification number of the child or adoptee on your federal income tax return for the year in which the distribution is made.

Withdrawals of rollover contributions

You may withdraw all or any portion of your Pretax Rollover Account, Roth 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 assessed 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.

Note that if your principal residence is in a federally declared disaster area and you sustain an economic loss due to the disaster, you may be eligible for the following loan relief:

- If you take a loan within 180 days after the first date of the "incident period" (the period specified by FEMA as the period in which the disaster occurred), the maximum loan amount increases to the lesser of 1) 100% of the total of your vested Plan account, or 2) $100,000 (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).
- You may delay repayment of any loan payments due during the period beginning on the first day of the incident period through 180 days after the end of the incident period for up to one year. Your payments after the delay will be adjusted to reflect the deferred payments and any interest accruing during the delay.

Note: As the Plan only allows one general purpose loan and one residential loan outstanding at any time, if you already have a loan outstanding, you may not take another loan of that type, even if you are impacted by a federally declared disaster.

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.

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 to ensure that your beneficiary under the Plan reflects your current intent. You may make beneficiary choices at **One.Walmart.com** (if you are an active associate) or **benefits.ml.com**. If your spouse's consent is required, you must submit a paper Beneficiary Designation Form with the Spousal Consent section completed (as explained below). If you are unable to access the online beneficiary tools, you may obtain a paper Beneficiary Designation Form by contacting the Customer Service Center at **888-968-4015**.

Since your spouse 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 Beneficiary Designation Form, and your spouse must complete the Spousal Consent portion of that form. (Note that spousal consents or waivers in any other documents between you and your spouse are not recognized by the Plan for this purpose.) The Spousal Consent portion must be notarized and must accompany the complete Beneficiary Designation Form in order to be valid. The Beneficiary Designation Form may be obtained at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**. Return the completed Beneficiary Designation Form to Merrill Lynch in accordance with the instructions on the form. Any beneficiary designation you make will be effective for all of your Plan accounts.

If you do not designate a beneficiary and you die on or after February 1, 2027, your death benefit will be distributed in accordance with the Plan's default provisions in the following order, as stated below:

- Spouse; if none, then
- Living children (stepchildren are not included); if none, then
- Living parents; if none, then
- Living siblings; if none, then
- Living partner (as defined below); if none, then
- Your estate, to be distributed per the terms of your will or as a court determines.

If you do not designate a beneficiary and you die prior to February 1, 2027, your death benefit will be distributed in accordance with the Plan's prior default provisions.

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, including with respect to any primary or contingent beneficiaries named. If you want your former spouse or any other individual previously designated as a beneficiary to continue to be your designated beneficiary, you will need to complete a new beneficiary designation election. Similarly, if you do not have a spouse and you later marry, your prior beneficiary designation election will not be effective after the marriage, including with respect to both your primary and contingent beneficiaries named. If you want to designate someone other than your new spouse as your beneficiary, you will need to complete a Beneficiary Designation Form with your spouse's consent.

Generally, if a designated primary beneficiary dies before his or her benefit check is issued, the deceased primary beneficiary's benefit will be paid to the remaining living primary beneficiaries (if any) on a pro rata basis, according to their listed percentages, or, if none, to the living contingent beneficiaries (if any), 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 is your beneficiary, your spouse's benefit will always be paid to your spouse's estate if he or she dies after you, even if he or she dies before the benefit check is issued. Again, it is very important for you to keep your beneficiary information up to date.

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.

If you have a "partner" and you have not made an affirmative beneficiary designation, your partner will be your beneficiary only if you do not have children, parents, or siblings then living, 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 the relationship to be permanent;
  - 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.

To be treated as a partner for this purpose, you will be required to provide evidence of your relationship to the Plan. While no single factor is determinative as to whether or not you qualify as a partner for this purpose, the Plan may take into account several factors, including without limitation the following:

- Legal and financial indicators: evidence of financial interdependence and shared expenses and assets, such as joint bank accounts, joint property ownership, joint utility bills, and joint tax returns, if available; designation of each other as beneficiaries for insurance and retirement benefits; joint estate planning, such as inclusion in each other's wills; having financial powers of attorney over each other's assets, including in the event of incapacity; documents or communications from state or local governments indicating partner status similar to marriage.
- Social and personal indicators: principally residing together for at least 12 months; listing each other as emergency contacts; raising children together; holding each other out to family and friends as in a committed relationship similar to marriage; presentation on your social media accounts as in a committed relationship similar to marriage.
- Health care indicators: evidence of mutual caring for each other during illnesses or end-of-life care; sharing of medical and funeral expenses; having health care powers of attorney to make health care decisions for each other.

Beneficiary designations made on or 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 may be made at **One.Walmart.com** (if you are an active associate) or **benefits.ml.com**.

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 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, 2027, you may elect your payout on or after August 18, 2027.

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 payout of your entire vested account will automatically be made to you:

- **If your total vested Plan balance 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 18, 2027, your payout will automatically be made to you as soon as possible after October 31, 2027, or

- **If you are over age 72½, 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 72½, unless you consent to an earlier payout as described above. For instance, if you turn age 72½ in July 2026 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, 2026, according to Plan provisions.

If your total vested Plan balance is more than $1,000 and you are under age 72½, you must consent to payout of all or any portion of your account. 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 some or all of your payout until any date up to age 72½, 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 available to be paid out to you. In addition, if you have a Company Funded Profit Sharing Account (see **Your Walmart 401(k) Plan accounts** earlier in this summary), the vested portion of your Company Funded Profit Sharing Account will also be available for payout to you. 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** section 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 (even if those amounts have been converted to your Roth Account or Roth 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. (Only whole shares of Walmart stock will be distributed; partial shares will be distributed in cash.) You may also elect to have your Pretax Account, your Company Funded 401(k) Account, and your Rollover Accounts (even if those amounts have been converted to your Roth Account or Roth Rollover Account) 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 72½ (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 72½. 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.

Note: If your vested account cannot be paid to you because you cannot be found, the Administrator will make a diligent attempt to locate you. If you still cannot be found, your vested account will be forfeited. If you are later found, your account will be reinstated but you will not receive any

earnings for the period after forfeiture. (This also applies if you die and your beneficiary cannot be located.) Thus, it is important that you make sure you update your contact information if there is a change.

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). For more information on how your eligibility is determined if you were not eligible for matching contributions, or had not satisfied the 1,000-hour requirement when you left, contact the Customer Service Center at **888-968-4015**.

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 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 (or you elect to make an In-Plan Roth Conversion of such amounts). 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 IRA rollover)

Although payouts from the Plan (other than from your Roth and Roth Rollover Accounts) are subject to federal income taxes, the Internal Revenue Code provides favorable tax treatment to payouts in certain circumstances. For example, you normally 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 your payout is eligible for rollover and 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 your payout is eligible for rollover and 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 that not all payouts from the Plan are eligible for rollover to an IRA or other eligible retirement plan. For instance, financial hardship withdrawals, payouts on account of the birth or adoption of your child, limited emergency withdrawals, and qualified disaster recovery withdrawals are not eligible for rollover. More information on the taxation of these payouts is provided below.

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 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 2022, your five-year participation period will end on December 31, 2026. 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).

Note: If you elect an In-Plan Roth Conversion, the amount converted is treated as a Roth contribution made at the time of the conversion. When those amounts are later distributed, the rules described above generally apply. For this purpose, an In-Plan Roth Conversion will be considered a contribution for purposes of starting the five-year participation period described above.

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 because they are not taxable at payout. There are some other exceptions to the penalty, such as payouts on account of death, disability, retirement after age 55, payouts for certain medical expenses, payouts related to the birth or adoption of your child, limited emergency withdrawals, and qualified disaster recovery withdrawals. 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 a taxable 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 spouse or former spouse of a participant who receives a payout from the Plan under a qualified domestic relations order (QDRO) generally has 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 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 financial hardship withdrawals

A financial hardship payout (other than Roth contributions and, if the payout is a qualified distribution, earnings on your Roth contributions) is immediately taxable to you, including the 10% early withdrawal penalty unless you are eligible for an exemption. You may not roll over the distribution and Walmart is not required to withhold 20%, but the distribution will be subject to 10% withholding, unless you elect a different withholding rate.

Taxation of limited emergency withdrawals

If you receive a limited emergency withdrawal from the Plan, the distribution is immediately taxable to you (other than Roth contributions and, if the payout is a qualified distribution, earnings on your Roth contributions) but is not subject to the 10% early withdrawal penalty. You may not roll over the distribution and Walmart is not required to withhold 20%, but the distribution will be subject to 10% withholding, unless you elect a different withholding rate.

Taxation of qualified birth or adoption distributions

If you receive a distribution related to the birth or adoption of your child, the distribution (other than Roth contributions and, if the payout is a qualified distribution, earnings on your Roth contributions) is taxable to you for federal income tax purposes, but is not subject to the 10% early withdrawal penalty. You may not roll over the distribution and Walmart is not required to withhold 20%, but the distribution will be subject to 10% withholding unless you elect a different rate.

Taxation of qualified disaster recovery withdrawals

If you receive a distribution related to a federally declared major disaster, the distribution amount is taxable to you over a three-year period, beginning with the year in which the distribution is received, unless you elect to have the entire distribution taxed in the year you receive it. You may not roll over the distribution and Walmart is not required to withhold 20%, but the distribution will be subject to 10% withholding, unless you elect a different withholding rate. The distribution is not subject to the 10% early withdrawal penalty.

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 (Bank of America), you may file a claim with the Administrator or its delegate at:

Walmart Inc.
Attn: 401(k) Plan Administrator
Mail Stop 3500
806 Excellence Drive
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: Benefits Compliance
Mail Stop 3500
806 Excellence Drive
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: 401(k) Plan Administrator
Mail Stop 3500
806 Excellence Drive
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 Total Rewards, of Walmart Inc. 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 Total Rewards/Administrator
Walmart Inc.
Mail Stop 3500
806 Excellence Drive
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.
Mail Stop 3500
806 Excellence Drive
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. Additionally, in some cases, the IRS may enforce a federal tax levy against your accounts to repay federal taxes you owe.

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 and Chief People Officer. 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: Benefits Compliance
Mail Stop 3500
806 Excellence Drive
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 may be entitled to 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: Benefits Compliance
  Mail Stop 3500
  806 Excellence Drive
  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

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 or Roth Rollover Account in the Plan, see the **Special tax notice addendum: Roth contributions** addendum that follows this notice.

General information about rollovers

What can I do with an amount that is eligible for rollover?

When an amount payable (that is, an amount you are eligible to take as a payment from the Plan) is eligible for rollover, you generally may choose some combination of the following:

- Leave it in the Plan, that is, do not take the payment,
- Roll it over into another employer plan,
- Roll it over into an IRA, or
- Take it, don't roll it over, and pay any required taxes.

Whether these options are available to you depends on your circumstances and the terms of the Plan. For example, you may be required to take a payment (and not roll it over) based on your age or if your benefit is below a certain threshold.

How can a payment affect my taxes?

If you don't do a rollover, you will be taxed on a payment from the Plan, and, if you are under age 59½, you will also have to pay a 10% additional tax (unless an exception applies).

How can a rollover affect my taxes?

If you do a rollover, you won't have to pay tax until you receive payments later.

What types of retirement accounts and plans may accept my rollover?

You may roll over the payment to either an IRA (an individual retirement account or individual retirement annuity) or an employer plan (a tax-qualified plan (such as a section 401(k) plan), a section 403(b) plan, or a governmental section 457(b) plan) that will accept the rollover. The rules of the IRA or employer plan that receives the rollover will determine your investment options, fees, and rights to payment from the IRA or employer plan (for example, IRAs aren't subject to spousal consent rules, 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. For additional information on IRAs, see IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*, and IRS Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*.

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. You should contact the IRA provider or the administrator of the employer plan for information on how to do a direct rollover.

If you do a 60-day rollover, you will receive a payment from the Plan and then make a deposit into an IRA or eligible employer plan that will accept it. Generally, you will have 60 days after you receive the payment to make the deposit. If you don't do a direct rollover, the Plan is required to withhold 20% of the payment 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, you must use other funds to make up for the amount withheld. If you don't roll over the entire amount of the payment, the portion not rolled over will be taxed and will be subject to the 10% additional tax on early distributions if you are under age 59½ (unless an exception applies).

How much may I roll over?

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;
- Hardship distributions;
- Payments of employee stock ownership plan (ESOP) dividends;
- Corrective distributions of contributions that exceeded tax law limitations;
- Loans treated as deemed distributions (for example, loans in default due to missed payments before your employment ends);
- Withdrawals related to the birth or adoption of your child;
- Limited emergency withdrawals; and
- Qualified disaster recovery withdrawals.

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 tax on distributions before age 59½?

If you are under age 59½, you will have to pay the 10% additional tax on early distributions for any payment from the Plan (including amounts withheld for income tax) that you don't roll over, unless one of the exceptions listed below applies. This tax applies to the part of the distribution that you must include in income and is in addition to the regular income tax on the payment not rolled over.

The 10% additional tax doesn't apply to the following payments from the Plan:

- Payments made after you separate from service if you are at least age 55 in the year of the separation;
- Payments made due to disability;
- Payments made 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);
- Payments from a defined contribution plan that are qualified birth or adoption distributions;
- Payments from a defined contribution plan for purposes of meeting unforeseeable or immediate financial needs relating to personal or family emergency expenses (emergency personal expense distributions);
- Payments to a victim of domestic abuse (domestic abuse victim distributions);
- Payments after you receive a certification from a physician that you have a terminal illness (terminal illness distributions);
- Payments that are qualified disaster recovery distributions;
- Payments made from a defined contribution plan that are qualified long-term care distributions;
- Payments up to the amount of your deductible medical expenses (without regard to whether you itemize deductions for the taxable year); and
- 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.

For more information about the 10% additional tax and the exceptions to the 10% additional tax, see IRS Publication 575, *Pension and Annuity Income*, under the heading *Tax on Early Distributions*. For information on how to claim an exception, see the Instructions for IRS Form 5329, Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts.

If I do a rollover to an IRA, will the 10% additional tax apply to a later distribution from the IRA before age 59½?

If you receive a payment from an IRA when you are under age 59½, you will have to pay the 10% additional tax on early distributions on the part of the payment that you must include in income, unless an exception applies. In general, the exceptions to the 10% additional 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:

- The exception for payments from a plan made after you separate from service if you are at least age 55 in the year of the separation doesn't apply to payments from an IRA;
- The exception for payments made pursuant to a QDRO under a plan doesn't apply to an IRA (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); and
- The exception for substantially equal periodic payments from a plan also applies to payments from an IRA but without regard to whether you have had a separation from service.

Also, there are exceptions to the 10% additional tax that do not apply to payments from a plan but that do apply to payments from an IRA, including:

- Payments for qualified higher education expenses;
- Payments up to $10,000 used in a qualified first-time home purchase; and
- 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).

For more general information about the 10% additional tax and the exceptions to the 10% additional tax on payments from an IRA, see the Instructions to IRS Form 5329, Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts. See also, IRS Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*, under the heading Early Distributions.

Will I owe state income taxes?

This notice doesn't address 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 the following Addendum if you have made Roth contributions to the Plan.)

After-tax contributions included in a payment aren't taxed. If you receive a partial payment of your total benefit, an allocable portion of your after-tax contributions is included in the payment, so you can't 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 the 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 rolled over consists first of the amount that would be taxable if not rolled over. For example, assume you are receiving a payment 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 isn't a Roth IRA, no amount is taxable because the $2,000 amount not 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.

Similarly, if you do a 60-day rollover to an IRA of only a portion of a payment made to you, the portion rolled over consists first of the amount that would be taxable if not rolled over. For example, assume you are receiving a payment of $12,000, of which $2,000 is after-tax contributions, and no part of the payment is directly rolled over. In this case, if you roll over $10,000 to an IRA that isn't 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 isn't 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 can't be extended. However, the IRS has 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)*, under the heading *Rollovers*.

If your payment includes employer stock that you don't roll over

If you don't do a rollover, you can apply a special rule to payments of employer stock (or other employer securities) that are either attributable to after-tax contributions or 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 won't 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 to an IRA or an employer plan 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 won't apply to any later payments from the IRA or, generally, the plan. The 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 outstanding amount of the loan (offset amount), typically when your employment ends. The offset amount is treated as a distribution to you at the time of the offset, even though you will not receive the offset amount. Generally, you may roll over all or any portion of the offset amount using other funds. Any offset amount that isn't rolled over will be taxed (including the 10% additional 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 separate from service. If your plan loan offset occurs for any other reason (such as a failure to make level loan repayments that results in a deemed distribution), then you have 60 days from the date the offset occurs to complete your rollover.

If you receive a payment 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 payment that you don't 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 SIMPLE IRA

You can only roll over a payment from the Plan to a SIMPLE IRA plan after the end of the 2-year period beginning on the date you first participated in the SIMPLE IRA plan.

If you roll over your payment to a Roth IRA

If you roll over a payment from the Plan to a Roth IRA (which, for purposes of this explanation, includes a Roth SIMPLE IRA), a special rule applies under which the amount of the payment rolled over, reduced by any after-tax amounts, will be taxed. In general, the 10% additional tax on early distributions won't apply. However, if you take the amount rolled over out of the Roth IRA within the 5-year period that begins on January 1 of the year of the rollover, the 10% additional tax will apply on the amount includible in gross income (unless an exception applies).

If you roll over the payment to a Roth IRA, you won't have to take required minimum distributions from the Roth IRA during your lifetime. Later payments from the Roth IRA that are qualified distributions won't 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 5 years. In applying this 5-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 aren't qualified distributions will be taxed to the extent of earnings after the rollover, including the 10% additional tax on early distributions (unless an exception applies). For more information, see IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*, and IRS Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*.

If you roll over your payment to a designated Roth account in the Plan

You can't roll over a payment to a designated Roth account in another employer's plan. However, you can roll the payment over into a designated Roth account in the distributing Plan. If you roll over a payment from the Plan to a designated Roth account in the Plan, the amount of the payment rolled over, reduced by any after-tax amounts directly rolled over, will be taxed. In general, the 10% additional tax on early distributions won't apply. However, if you take the amount rolled over out of the designated Roth account within the 5-year period that begins on January 1 of the year of the rollover, the 10% additional tax will apply on the amount includible in gross income (unless an exception applies).

If you roll over the payment to a designated Roth account in the Plan, you won't have to take required minimum distributions from the designated Roth account during your lifetime. Later payments from the designated Roth account that are qualified distributions won't be taxed, including earnings after the rollover. A qualified distribution from a designated Roth account is a payment made both after you are age 59½ (or after your death or disability) and after you have had a designated Roth account in the Plan for at least 5 years. In applying this 5-year rule, you count from January 1 of the year of the first contribution to your designated Roth account. However, if you made a direct rollover to a designated Roth account in the Plan from a designated Roth account in a plan of another employer, the 5-year period begins on January 1 of the year you made the first contribution to the designated Roth account in the Plan or, if earlier, to the designated Roth account in the plan of the other employer. Payments from the designated Roth account that aren't qualified distributions will be taxed to the extent of earnings after the rollover, including the 10% additional tax on early distributions (unless an exception applies).

If you aren't a Plan participant

Payments after death of the participant. If you receive a payment after the participant's death that you don't roll over, the payment generally will be taxed in the same manner described elsewhere in this notice. However, the 10% additional tax on early distributions doesn't apply, and the special rule described under the section "If you were born on or before January 1, 1936" applies only if the deceased 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 either 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 tax on early distributions (unless an exception applies) and required minimum distributions from your IRA will be based on your age.

If you treat the IRA as an inherited IRA, payments from the IRA won't be subject to the 10% additional tax on early distributions. However, if the participant had started taking required minimum distributions from the Plan, required minimum distributions must continue to be made from the inherited IRA. If the participant had not started taking

required minimum distributions from the Plan, distributions from the inherited IRA must begin when the participant would have been required to begin required minimum distributions.

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. Payments from the inherited IRA won't be subject to the 10% additional tax on early distributions. You will have to take required minimum distributions from the inherited IRA.

For more information, see IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*, and IRS Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*.

Payments under a qualified domestic relations order (QDRO). If you are the spouse or former spouse of the participant who receives a payment from the Plan under a 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 to your own IRA or an eligible employer plan that will accept it). However, payments under the QDRO won't be subject to the 10% additional tax on early distributions.

For more information, see IRS Publication 504, *Divorced or Separated Individuals*.

If you are a nonresident alien

If you are a nonresident alien and you don't 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 IRS Form 1040NR, U.S. Nonresident Alien Income Tax Return, and attaching your IRS Form 1042-S, Foreign Person's U.S. Source Income Subject to Withholding. See IRS Form W-8BEN, Certificate of Foreign Status of Beneficial Owner for United States Tax Withholding and Reporting (Individuals), 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, not including payments from a designated Roth account in the Plan, the Plan isn't required to allow you to do a direct rollover and isn't required to withhold federal income taxes. However, you may do a 60-day rollover.

You may have the ability to repay certain distributions from your retirement plan. If you took a qualified disaster recovery distribution, a qualified birth or adoption distribution, or an emergency personal expense distribution, you generally may repay that distribution to an eligible retirement plan within a certain time period. For more information on repayments of qualified reservist distributions, see IRS Publication 3, *Armed Forces' Tax Guide*. For more information on other repayments, see IRS Publication 575, *Pension and Annuity Income*, or consult a professional tax advisor.

For more information

You may wish to consult with the 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 **1-800-TAX-FORM**.

Special tax notice addendum: Roth contributions

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 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 or Roth Rollover Account (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 are described in the separate **Special tax notice addendum** above.

General information about rollovers

What can I do with an amount that is eligible for rollover?

When an amount payable (that is, an amount you are eligible to take as a payment from the Plan) is eligible for rollover, you generally may choose some combination of the following:

- Leave it in the Plan, that is, do not take the payment,
- Roll it over into a designated Roth account in another plan,
- Roll it over into a Roth IRA, or
- Take it, don't roll it over, and pay any required taxes.

Whether these options are available to you depends on your circumstances and the terms of the Plan. For example, you may be required to take a payment (and not roll it over) based on your age or if your benefit is below a certain threshold.

How can a payment affect my taxes?

After-tax contributions included in a payment from a designated Roth account aren't 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 designated Roth account, the payment will include an allocable portion of the earnings in your designated Roth account.

If the payment from the Plan isn't a qualified distribution and you don't do a rollover to a Roth IRA or a designated Roth account in an employer plan, you will be taxed on the portion of the payment that is earnings. If you are under age 59½, a 10% additional tax on early distributions (generally, distributions made before age 59½) will also apply to the earnings (unless an exception applies).

If the payment from the Plan is a qualified distribution, you won't be taxed on any part of the payment even if you don't do a rollover. A qualified distribution from a designated 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 designated Roth account in the Plan for at least 5 years. In applying the 5-year rule, you count from January 1 of the year the first contribution was made to the designated Roth account. However, if you did a direct rollover to a designated Roth account in the Plan from a designated Roth account in another employer plan, your participation will count from January 1 of the year the first contribution was made to the designated Roth account in the Plan or, if earlier, to the designated Roth account in the other employer plan.

How can a rollover affect my taxes?

If the payment isn't a qualified distribution and you do a rollover, you won't have to pay taxes currently on the earnings and you won't have to pay taxes later on payments that are qualified distributions. If the payment is a qualified distribution and you do a rollover, you won't be taxed on the amount you roll over and any earnings on the amount you roll over won't be taxed when paid later.

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(b) 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, Roth IRAs cannot 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 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 aren't 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 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. For example, assume you are receiving a nonqualified distribution of $12,000, of which $2,000 is earnings. In this case, if you directly roll over $10,000 to an IRA that is a Roth IRA, no amount is taxable because the $10,000 amount rolled over includes the $2,000 in earnings and the remaining $2,000 paid to you is attributable to after-tax contributions.

If you do a 60-day rollover, you will receive a payment from the Plan and then make 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 doesn't exceed the amount of the earnings in the payment. You can't do a 60-day rollover to an employer plan of any part of a qualified distribution.

If you do a 60-day rollover and the payment isn't 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 amount withheld.

How much may I roll over?

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 to a beneficiary;
- Hardship distributions;
- Payments of employee stock ownership plan (ESOP) dividends;
- Corrective distributions of contributions that exceeded tax law limitations;
- Loans treated as deemed distributions (for example, loans in default due to missed payments before your employment ends);
- Withdrawals related to the birth or adoption of your child;
- Limited emergency withdrawals; and
- Qualified disaster recovery withdrawals.

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 tax on distributions before age 59½?

If a payment isn't a qualified distribution and you are under age 59½, you will have to pay the 10% additional tax on early distributions with respect to the earnings allocated to the payment that you don't 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 tax doesn't apply to the following payments from the Plan:

- Payments made after you separate from service if you are at least age 55 in the year of the separation;
- Payments made due to disability;
- Payments made 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);
- Payments from a defined contribution plan that are qualified birth or adoption distributions;
- Payments from a defined contribution plan for purposes of meeting unforeseeable or immediate financial needs relating to personal or family emergency expenses (emergency personal expense distributions);
- Payments to a victim of domestic abuse from a defined contribution plan that isn't subject to the qualified joint survivor annuity or qualified preretirement survivor annuity rules (domestic abuse victim distributions);
- Payments after you receive a certification from a physician that you have a terminal illness (terminal illness distributions);
- Payments that are qualified disaster recovery distributions;
- Payments made from a defined contribution plan that are qualified long-term care distributions;
- Payments up to the amount of your deductible medical expenses (without regard to whether you itemize deductions for the taxable year); and
- 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.

For more information about the 10% additional tax and the exceptions to the 10% additional tax, see IRS Publication 575, *Pension and Annuity Income*, under the heading Tax on Early Distributions. For information on how to claim an exception, see the Instructions for IRS Form 5329, Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts.

If I do a rollover to a Roth IRA, will the 10% additional tax apply to a later distribution from the Roth IRA before age 59½?

If you receive a payment from a Roth IRA when you are under age 59½, you will have to pay the 10% additional 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 tax for early distributions from a Roth IRA listed above are the same as the exceptions for early distributions from a designated Roth account in an employer plan. However, there are a few differences for payments from a Roth IRA, including:

- The exception for payments from a plan made after you separate from service if you are at least age 55 in the year

of the separation (or the earlier of age 50 or attainment of 25 years of service under the Plan for qualified public safety employees and private-sector firefighters) doesn't apply to payments from an IRA;

- The exception for payments made pursuant to a QDRO under a plan doesn't apply to an IRA (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); and
- The exception for substantially equal periodic payments from a plan also applies to payments from an IRA but without regard to whether you have had a separation from service.

Also, there are exceptions to the 10% additional tax that do not apply to payments from a plan but that do apply to payments from a Roth IRA, including:

- Payments for qualified higher education expenses;
- Payments up to $10,000 used in a qualified first-time home purchase; and
- 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).

For more general information about the 10% additional tax and the exceptions to the 10% additional tax on payments from an IRA, see the Instructions to IRS Form 5329, Additional Taxes on Qualified Plans (Including IRAs) and Other Tax-Favored Accounts. See also, IRS Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*, under the heading *Early Distributions*.

Will I owe state income taxes?

This notice doesn't address 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 can't be extended. However, the IRS has 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)*, under the heading *Rollovers*.

If your payment includes employer stock that you don't roll over

If you receive a payment that isn't a qualified distribution and you don't roll it over, you can apply a special rule to payments of employer stock (or other employer securities) 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 included in the earnings in the payment won't be taxed when distributed to you from the Plan and will be taxed at capital gain rates when you sell the stock. If you do a rollover to a Roth IRA or a designated Roth account in another employer plan for a nonqualified distribution that includes employer stock (for example, by selling the stock and rolling over the proceeds within 60 days of the distribution), you won't have any taxable income and the special rule relating to the distributed employer stock won't apply to any later payments from the Roth IRA or, generally, the plan. Net unrealized appreciation is generally the increase in the value of the employer stock after it was acquired by the Plan. The Administrator can tell you the amount of any net unrealized appreciation.

If you receive a payment that is a qualified distribution that includes employer stock and you don't roll it over, your basis in the stock (used to determine gain or loss when you later sell the stock) will equal the fair market value of the stock at the time of the payment from the Plan.

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 (offset amount), 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 isn't a qualified distribution and you don't roll over the offset amount, you will be taxed on any earnings included in the distribution (including the 10% additional 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 separate from service. If your plan loan offset occurs for any

other reason (such as a failure to make level repayments that results in a deemed distribution), then you have 60 days from the date the offset occurs to complete your rollover.

If you receive a payment 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 payment that isn't a qualified distribution and that you don't 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 roll over your payment to a Roth SIMPLE IRA

You can only roll over a payment from the Plan to a Roth SIMPLE IRA plan after the end of the 2-year period beginning on the date you first participated in the Roth SIMPLE IRA plan.

If you aren't a Plan participant

Payments after death of the participant. If you receive a payment after the participant's death that you don't roll over, the payment generally will 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 tax on early distributions and the special rules for public safety officers don't 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 deceased 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 either 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 won't have to take 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 tax on early distributions unless an exception applies.

If you treat the Roth IRA as an inherited Roth IRA, payments from the Roth IRA won't be subject to the 10% additional tax on early distributions. An inherited Roth IRA is subject to required minimum distributions.

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, won't be subject to the 10% additional tax on early distributions. You will have to take required minimum distributions from the inherited Roth IRA.

For more information, see IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)*, and IRS Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*.

Payments under a qualified domestic relations order (QDRO). If you are the spouse or a former spouse of the participant who receives a payment from the Plan under a 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 to your own Roth IRA or to a designated Roth account in an eligible employer plan that will accept it).

For more information, see IRS Publication 504, *Divorced or Separated Individuals*.

If you are a nonresident alien

If you are a nonresident alien, the payment isn't a qualified distribution, and you don't do a direct rollover to a U.S. Roth IRA or designated Roth account in a U.S. employer plan, the Plan is generally required to withhold 30% (instead of withholding 20%) of the earnings 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 IRS Form 1040NR, U.S. Nonresident Alien Income Tax Return, and attaching your IRS Form 1042-S, Foreign Person's U.S. Source Income Subject to Withholding. See IRS Form W-8BEN, Certificate of Foreign Status of Beneficial Owner for United States Tax Withholding and Reporting (Individuals), 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 isn't required to allow you to do a direct rollover and isn't required to withhold federal income taxes. However, you can do a 60-day rollover.

You may have the ability to repay certain distributions from your retirement plan. If you took a qualified disaster recovery distribution, a qualified birth or adoption distribution, or an emergency personal expense distribution, you generally may repay that distribution to an eligible retirement plan within a certain time period. For more information on repayments of qualified reservist distributions, see IRS Publication 3, *Armed Forces' Tax Guide*. For more information on other repayments, see IRS Publication 575, *Pension and Annuity Income*, or consult a professional tax advisor.

For more information

You may wish to consult with the 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 **1-800-TAX-FORM**.

The Associate Stock Purchase Plan (ASPP)

Associate Stock Purchase Plan eligibility	364
Enrolling in the Associate Stock Purchase Plan	364
Walmart's contribution to your company stock ownership	364
Selling stock through the Plan	364
Keeping track of your Merrill account	365
Ending your participation and closing your account	365
If you leave the company	365

Prospectus	**366**
Introduction and overview	366
Plan administration; account management	367
Plan participation and eligibility	367
Plan contributions—Associate Stock Purchase Program	368
Stock ownership, fees, and risks	369
Stock delivery and Stock sales	370
Termination of participation; account closure	371
Plan amendment and termination	371
Tax information	372
Available information	372
Electronic delivery of prospectuses and other documents	372
Documents incorporated by reference	373

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 $26,000 withheld from your biweekly paycheck to buy stock (for a maximum annual payroll deduction amount of $26,000). 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	**benefits.ml.com**	Call Merrill at **888-968-4015**
• Access your account information • Get your account statement • Get a Form 1099	Go to Merrill Benefits Online at **benefits.ml.com** or the Merrill Benefits Online app[1]	Download the Merrill Benefits Online app[1] or scan the QR code below (available for Apple or Android devices)

[1] The Merrill Benefits Online app is available only in English and does not support other languages at this time. Participants seeking content in another language should use the web version, which may offer translation functionality (e.g., Spanish, French, or French Canadian).

What you need to know about the Associate Stock Purchase Plan

- All eligible associates can purchase Walmart stock through convenient payroll deductions and through a Merrill Edge account.
- 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.
- Your shares will be credited to an individual account that is maintained in your name at Merrill. 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 age of majority in your payroll state to participate (19 is the age of majority in Alabama and Nebraska). If you live in Puerto Rico, you must be 21 years of age to participate. If you live in Canada, you must be 18 years of age or the age of majority in your payroll province or territory to participate (19 is the age of majority in British Columbia, New Brunswick, Newfoundland and Labrador, Northwest Territories, Nova Scotia, Nunavut, and Yukon). If you have questions about the age requirement, review your respective state laws on the age of majority.

Enrolling in the Associate Stock Purchase Plan

You can enroll in the Plan by completing a benefits online enrollment session at **One.Walmart.com** (U.S. and Puerto Rico only) or **benefits.ml.com**.

Before you enroll in this Plan, you should carefully review this Associate Stock Purchase Plan document 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 Plan allows all eligible associates to buy Walmart stock conveniently through payroll deductions. Any whole dollar amount from $2 to $26,000 can be withheld from your paycheck to buy stock (up to a maximum annual payroll deduction of $26,000).

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 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.

The value of the stock you purchase can fluctuate and may decline. There is no guarantee that your stock will have the same value in the future that it had when purchased or that the value of the stock will increase.

When deciding 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, which is incorporated by reference in the Plan Prospectus.

Selling stock through the Plan

No fees are charged to you for buying stock. The fees charged by Merrill as described in this section are subject to change.

Walmart's contribution to your company stock ownership

If you contribute	Your Plan year payroll deduction contribution is	Walmart's annual matching contribution[1] 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

[1] Company contributions will be made only on stock purchased through payroll deductions.

If you choose to sell your stock, your stock will be sold pursuant to a market order or limit order. Your stock will be sold as soon as your request can be reasonably processed. Generally, market orders placed when the stock market is open 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 NASDAQ stock exchange. If the NASDAQ is closed when your order is ready to be processed, your order will be processed as early as possible on the next NASDAQ trading day.

You can sell stock from **benefits.ml.com**, from the Benefits Online app (available for Apple and Android devices), or by calling Merrill at **888-968-4015**. 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 Merrill. If you choose to deposit your proceeds in a bank account, your funds are sent to the bank on the trade settlement date, which is one business day from the date of sale. Please note it will vary depending upon your bank when the funds will be reflected in your checking or savings account. If you select to receive your sale 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.

Each time you sell stock, you will receive a transaction summary form. For tax reporting purposes, you will receive appropriate tax documents (1099-B and/or 1099-DIV) enclosed with your annual statement in the first quarter of the following year (January through March). Depending upon delivery preference, these documents will be either mailed to your address on file with Merrill, or you will be notified via email when the documents are available. You should use these documents 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 Merrill account

You will receive a statement from Merrill at least annually (first quarter) that shows the activity in your account. 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 **benefits.ml.com**.

The annual statement will contain important tax information. Maintain your statement so that you 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 **benefits.ml.com** or by phone at **888-968-4015**.

You can obtain copies of your account statements free of charge through the website at **benefits.ml.com**.

Ending your participation and closing your account

You can cancel your payroll deductions to the Plan by completing an enrollment session at **One.Walmart.com** (U.S. and Puerto Rico only) or **benefits.ml.com**.

After you cancel your payroll deductions, you can close your account by selling or transferring the remaining stock in your account. Confirm the latest share purchase has been posted to your account before closing your account. You also have the option to stop payroll deductions and to hold your Plan shares at Merrill.

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 without the company match.
- If you physically reside in the United States, you can make voluntary cash purchases and benefit from having no broker's fee. To make voluntary cash purchases you will need to open a Merrill Edge Self-Directed account, which will be a different account than your limited-purpose ASPP account.
- You can close your account and transfer your shares to another broker.
- You can close your account and sell some or all shares in your account.

In order to prevent any residual balances, wait until you receive your final paycheck and confirm your latest share purchase has posted before closing your account.

Please update Merrill and Walmart 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.

100,490,485 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 ("SEC") 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 SEC 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 July 31, 2026

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 shareholders of Walmart at our Annual Shareholders' Meeting held on June 3, 2016. As of July 31, 2026, up to 100,490,485 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; 60,000,000 shares of Stock were available for purchase from the Company under the Plan; and 90,000,000 shares of Stock were available for purchase on the open market under the Plan.

On November 30, 2018, 150,000,000 shares (as adjusted to reflect the Company's 3-for-1 forward stock split effective February 23, 2024) were registered with the United States SEC for offer and sale on Registration Statements on Form S-8. Shares of the Stock are listed for trading on the NASDAQ stock exchange ("the NASDAQ"). 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 in a Merrill Edge Self-Directed account that you will establish. 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 Ms. Carla Harris, Ms. Marissa Mayer, Mr. Shishir Mehrotra, and Mr. Randall Stephenson.

The Committee has selected a Third-Party Administrator, currently Merrill Lynch, Pierce, Fenner & Smith ("Merrill"), to establish and maintain accounts under the Plan.

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** (U.S. and Puerto Rico only) or **benefits.ml.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 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 change your biweekly deduction amounts, acquire, or sell shares of Stock may be restricted at certain times.

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 of absence must be approved by the Committee.

Plan contributions—Associate Stock Purchase Program

To make payroll deduction contributions, you need to complete a benefits online enrollment session at **One.Walmart.com** (U.S. and Puerto Rico only) or **benefits.ml.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 a benefits online enrollment session at **One.Walmart.com** (U.S. and Puerto Rico only) or **benefits.ml.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 $26,000 per biweekly payroll period (for a maximum annual payroll deduction amount of $26,000). The amount of any biweekly 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 fifteen percent (15%) 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 reside in the United States and participate or have participated in payroll deductions under the Plan, 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 outside of 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 Merrill in a Merrill Edge Self-Directed account that you will need to establish. Instructions for making such voluntary contributions are available from Merrill. Neither the Company nor your Participating Employer will make matching contributions on amounts you contribute directly to Merrill in the Merrill Edge Self-Directed account. 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 Merrill.

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 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 periodically.

Your Stock under the Outstanding Performance Award component will be delivered through an account maintained on your behalf by Merrill.

Stock purchases

Your employer will send all payroll deductions along with any matching contributions to Merrill as soon as practicable following each pay period. Merrill will purchase Stock for your Plan account no later than five (5) business days after it receives the funds. If you make a voluntary cash contribution outside of payroll deductions, Merrill will purchase your Stock with that voluntary cash contribution no later than five (5) business days after it receives the funds in your Merrill Edge Self-Directed account.

Merrill may purchase Stock for the Plan accounts on a national stock exchange, from the Company, or from a combination of these places. The Committee reserves the right to direct Merrill to purchase from a particular source, consistent with applicable securities rules and the applicable rules of any national stock exchange.

Typically, when Merrill 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 Merrill. A participant is not permitted to direct an order for Merrill to purchase shares of Stock solely for himself or herself that are part of the bundled group.

If Merrill 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 NASDAQ—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 NASDAQ on the date 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, 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, and 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 Merrill; however, that may not be practicable in all circumstances.

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 Merrill's name until you do one of two things: request to have your shares deposited into a "General Shareholder" 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, similar to any other shareholders of the Company. You may not transfer or assign your Plan account to another person who is not an eligible participant in the Plan. The Company does not maintain an 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 with other shares of Stock you may own, subject to compliance with our Insider Trading Policy.

Dividends and voting

Unless you elect otherwise, 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 shareholders. To vote the shares of Stock held in your Plan account, you must deliver in a timely manner signed voting instructions, also known as proxy instructions, 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. 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 NASDAQ 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). You must pay any commissions or charges resulting from other Merrill services you request, for example, brokerage commissions and other fees applicable to the sale of Stock. Merrill can advise if a particular request will incur a charge. The fees charged by Merrill described in this Prospectus are subject to change periodically.

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 time specified in the statement. You may elect to receive your statements online. If you do so, you will receive an email informing you that your statement is ready and can be found on **benefits.ml.com**. 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 preparation of your income tax return.

You may also access information regarding your account at any time by logging on to **benefits.ml.com**. You can access your account information by phone at **888-968-4015**.

You can obtain copies of your account statements free of charge through the website at **benefits.ml.com**.

Risks

Many of your risks of Plan participation are the same as those of any other shareholder 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 Merrill 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 delivery and Stock sales

Upon your request, we will arrange to send you 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 maintain and the dividends related to those shares will not be reinvested under the Plan. To request a stock certificate please contact People Services at **800-421-1362**.

You may also have Merrill transfer any or all 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 at any time request that Merrill sell all or a portion of the shares of Stock (including any fractional interests) credited to your Plan account, 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 Merrill sell shares of Stock held in your Plan account. Any brokerage commission or fees will be at the rates posted by Merrill from time to time. These rates are available upon request from Merrill. A current schedule of Merrill's fees applicable to the Plan can be found at **benefits.ml.com**. The Company negotiated the amount of such fees with Merrill.

If you choose to sell your Stock, the sale will be executed in accordance with the order type you select (for example, market order or limit order). If you direct Merrill to sell any shares of Stock credited to your Plan account in a market order, Merrill will sell those shares in the open market at the then current best available price. Please note 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 Merrill sells shares credited to your Plan account in the open market, we could be the purchaser of such shares. 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 NASDAQ, but orders for those sales need not be executed over the NASDAQ. If the NASDAQ is closed when your order is ready to be processed, your sale transaction will be processed as early as practicable on the next NASDAQ trading day. Orders for the sale of shares of Stock under the Plan may be executed by or through an affiliate of Merrill 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 Merrill 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 generally the exchange rate one business day immediately after the day of the trade, but that may not be practicable in all circumstances.

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 Merrill. Specifically:

- You may keep your Plan account open (without the weekly or biweekly payroll deduction and your employer's matching contributions).
- If you own **at least one full share of Plan Stock**, you may choose to leave your Merrill brokerage account (LIIA) open or close it, by transferring your shares to another brokerage account. This transfer can be completed electronically at your request. Please contact Merrill for more information about maintaining your account or completing a transfer.
- Alternatively, you may close your Merrill brokerage account (LIIA) by requesting that all shares of Stock in your account be sold and the proceeds paid to you or transferred to your designated account. The proceeds from the sale of full and fractional shares will be net of applicable brokerage commissions, sales fees, and other charges. Your account will be closed automatically if your employment terminates and no full or fractional shares remain in the account.

If you die before your Plan account has been closed, your Plan account will be distributed per the legal documentation submitted to Merrill or to your estate, unless you had previously arranged with Merrill 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 Merrill to move your shares into a General Shareholder account maintained by Merrill at his or her own expense or to have the Stock (or proceeds from the sale thereof) distributed, less any applicable fees or commissions.

For inquiries regarding those legacy accounts that were established prior to July 31, 2026 that remain at Computershare, you may contact Computershare at **800-438-6278** (hearing impaired: **800-952-9245**).

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 shareholder 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 in a Merrill Edge Self-Directed account. 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 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 equivalent to 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 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 equal 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 the shares of Stock held in your Plan account. When you sell or otherwise dispose of your shares of Stock—whether through Merrill 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: **800-421-1362**. You can also write to:

Walmart People Services
Walmart Inc.
806 Excellence Drive
Bentonville, Arkansas 72716-0295

Merrill may be contacted by calling **888-968-4015** (**888-WMT-401K**), or online at **benefits.ml.com**.

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 via **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, 2026;
- The Company's Quarterly Reports on Form 10-Q for the fiscal quarters ended April 30, 2026 and July 31, 2026;
- The Company's Current Reports on Form 8-K filed with the Commission on August 20, 2026;
- The Company's definitive Proxy Statement for the 2026 Annual Shareholders' Meeting, filed with the Commission on April 23, 2026; 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 Shareholders 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
806 Excellence Drive
Bentonville, Arkansas 72716-0295

Or you may call People Services: **800-421-1362**.

For more information

If you have questions about...	Website	Phone
When you're eligible for benefits or how to enroll	**One.Walmart.com/Benefits** **One.Walmart.com/BenefitsChat**	People Services: **800-421-1362**
Medical benefits, claims, or care management	See **Find a doctor and get medical plan help** on the next page	
Naming your beneficiaries	**One.Walmart.com/Beneficiary**	People Services: **800-421-1362**
Pharmacy benefits	**One.Walmart.com/Pharmacy** **welcome.optumrx.com/walmart-comprehensivedruglist/landing**	OptumRx: **844-705-7493** Find a pharmacy or benefits inquiries TruDataRx **833-575-0755** Prior authorization, non-formulary clinical review, or appeal questions
Health savings account (HSA) for associates enrolled in the Saver HSA Plan	**MyHealthEquity.com** **One.Walmart.com/Saver**	HealthEquity: **866-296-2860**
Centers of Excellence	**One.Walmart.com/COE** **Carrum.me/Walmart**	Skai Blue Cross Blue Shield: **866-823-3790** UMR: **855-870-9177** Carrum Health: **888-890-7359** Hip and knee replacement, spine surgery, weight loss surgery programs, and related travel benefits Consociate Health: **800-804-1289** Cancer medical record review, heart surgery, kidney dialysis or ESRD medical record review, rare conditions, and related travel benefits (including family building) Consociate Health: **479-621-2830** Transplant Kindbody: **855-454-7663** Family building benefit
Digestive health program: All states except Hawaii	**One.Walmart.com/Cylinder** **Cylinder.com/Walmart**	Cylinder: **833-336-9488**
Digital physical therapy program: All states except Hawaii	**HingeHealth.com/Walmart**	HingeHealth: **877-699-6844**
Vision plan	**One.Walmart.com/Vision**	VSP: **866-240-8390**
Dental plan	**One.Walmart.com/Dental**	Delta Dental: **800-462-5410**
Short-term disability insurance	**One.Walmart.com/TimeAndSupport** For information about state plans, see the short-term disability chapters	Sedgwick/Lincoln: **800-492-5678**
Long-term disability insurance	**One.Walmart.com/TimeAndSupport**	Lincoln: **877-353-6404**
Accident and critical illness insurance	**One.Walmart.com/Accident** **One.Walmart.com/Critical** **Standard.com/Walmart**	The Standard 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.com/Walmart**	Prudential: **877-740-2116**
Associate assistance resources	Help Now: **One.Walmart.com/HelpNow** My Mental Health Resources and the nicotine cessation program: **Walmart.LyraHealth.com**	**855-4HLPNOW** (**855-445-7669**) Mon.–Fri. 7 a.m.–7 p.m. CT **800-825-3555**, available 24/7

If you have questions about...	Website	Phone
Humankind: Personalized support for well-being	**One.Walmart.com/Humankind**	**855-445-7669**
Family building support	**One.Walmart.com/FamilyBuilding** **One.Walmart.com/LifeWithBaby**	Call your health plan administrator at the number on your plan ID card
Nicotine cessation program	**One.Walmart.com/QuitTobacco**	Lyra: **800-825-3555**
Twin Health: Diabetes and Metabolic Management	**One.Walmart.com/TwinHealth**	**888-99-TWINHEALTH** or **888-998-9464**
Walmart 401(k) Plan	**benefits.ml.com** **One.Walmart.com/401k**	Merrill: **888-968-4015**
Associate Stock Purchase Plan	**ComputerShare.com/Walmart** **One.Walmart.com/ASPP**	Merrill: **888-968-4015**

Find a doctor and get medical plan help

Your contact information for medical plan help depends on two things:

- Where you work, or in some cases which plan you're enrolled in.
- Which plan administrator serves your area. You'll find yours on the back of your plan ID card.

Location or plan	Plan administrator	Find a doctor	Claims, customer service, care management
Premier PPO, Contribution HRA, Saver HSA Plan	Skai Blue Cross Blue Shield UMR	Skai Blue Cross Blue Shield and UMR (through Included Health): **800-941-1384** **IncludedHealth.com/Walmart** Virtual primary care doctor: **One.Walmart.com/VirtualPrimaryCare**	Skai Blue: **866-823-3790** UMR: **855-870-9177**
Personalized Wellbeing Copay Plan	Included Health	**IncludedHealth.com/Walmart**	Included Health: **855-633-7073**
Hawaii	HMSA Kaiser	**HMSA.com**: **808-948-6111** **KP.org**: **800-966-5955**	HMSA: **808-948-6111** Kaiser: **800-966-5955**

Associates enrolled in HMO plans: Find a doctor and get medical plan help

If you have questions about finding a doctor, benefits, medical claims, or care management for an HMO plan:

HMO plan	Website	Phone
Health Net	**HealthNet.com**	**800-722-5342**
HMSA Hawaii	**HMSA.com**	**808-948-6111** **800-776-4672**
Kaiser of California	**kp.org**	**800-464-4000** (English) **800-788-0616** (Spanish)
Kaiser of Colorado	**kp.org**	Denver metro: **303-338-3800** Other areas: **800-632-9700**
Kaiser of Georgia	**kp.org**	Atlanta metro: **404-261-2590** Other areas: **888-865-5813**
Kaiser of Hawaii	**kp.org**	Oahu: **808-432-5955** Neighbor islands: **800-966-5955**
Kaiser of the Mid-Atlantic	**kp.org**	Kaiser: **855-249-5018**
Kaiser of Oregon	**kp.org**	Portland area: **503-813-2000** Other areas: **800-813-2000**
Kaiser Foundation Health Plan of Washington	**kp.org**	Kaiser: **888-901-4636**



2027 Associate Benefits Book | Summary Plan Descriptions

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