

Your 2020 Medical Plan Options.

Only in-network benefits are shown.



Costs		<u>Saver Plan</u>	<u>Premier Plan</u>	<u>Contribution Plan</u>	<u>Mercy Arkansas Local Plan</u>
Your cost per biweekly paycheck <i>Tobacco-free rates shown</i>	Associate only	\$32.50	\$29.20	\$82.40	\$47.60
	Associate + spouse/partner	\$154.40	\$147.70	\$278.90	\$197.80
	Associate + child(ren)	\$51.00	\$46.80	\$116.20	\$74.50
	Associate + family	\$178.30	\$173.30	\$298.60	\$233.90
Walmart's annual max contribution	Associate only	HSA match: up to \$350	None	\$250 credited to your HRA	None
	Associate + dependent(s)	HSA match: up to \$700	None	\$500 credited to your HRA	None
Annual deductible	Associate only	\$3,000	\$2,750	\$1,750	\$1,750
	Associate + dependent(s)	\$6,000	\$5,500	\$3,500	\$3,500
Annual out-of-pocket maximum	Per person	\$6,650	\$6,850	\$6,850	\$6,850
	Entire family	\$13,300	\$13,700	\$13,700	\$13,700



See the [2020 Associate Benefits Book](#) for more information about these plans, your benefits, and eligibility. This document will control in the event of any conflict. To enroll, visit One.Walmart.com/Enroll.



Services		<u>Saver Plan</u>	<u>Premier Plan</u>	<u>Contribution Plan</u>	<u>Mercy Arkansas Local Plan</u>
Doctors	Primary care doctor visit	75% covered after deductible	\$35 copay**	75% covered after deductible	\$35 copay**
	Specialist doctor visit	75% covered after deductible	\$75 copay**	75% covered after deductible	\$75 copay**
	Virtual doctor visits	\$4 copay** after deductible Doctor On Demand	\$4 copay** Doctor On Demand	\$4 copay** Doctor On Demand	\$4 copay** Doctor On Demand
Care	Eligible preventive care	100% covered, no deductible	100% covered, no deductible	100% covered, no deductible	100% covered, no deductible
	Certain serious conditions through Centers of Excellence	100% covered after deductible	100% covered, no deductible	100% covered, no deductible	100% covered, no deductible
	Urgent care	75% covered after deductible	\$75 copay**	75% covered after deductible	\$75 copay
	Emergency	\$300 copay after deductible, then 100% covered	\$300 copay, then 100% covered after deductible	\$300 copay, then 100% covered after deductible	\$300 copay,** then 100% covered after deductible
	Hospitalization	75% covered after deductible	75% covered after deductible	75% covered after deductible	75% covered after deductible
Pharmacy	Generic drugs	\$4 copay*** after deductible	\$4 copay**	\$4 copay**	\$4 copay**
	Brand-name drugs	25% of allowed cost* after deductible	25% of allowed cost*	25% of allowed cost*	25% of allowed cost*
	Specialty drugs	20% of allowed cost* after deductible	20% of allowed cost*	20% of allowed cost*	20% of allowed cost*

*Whichever is greater. The allowed cost of prescription drugs is determined by the plan's pharmacy benefit manager, OptumRx.

**Applies to out-of-pocket maximum, not deductible.

***Certain preventive medications do not apply to deductible.



Scan me to enroll.