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

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
</table>
| **What is the overall deductible?** | HRA High: in-network-$1,750/individual, $3,500/family; out-of-network-$3,500/individual, $7,000/family.  
HRA: in-network-$2,750/individual, $5,500/family; out-of-network-$5,500/individual, $11,000/family.  
Charges for balance billing, healthcare this plan does not cover, out-of-network preventive care, services at out-of-network Walmart Care Clinics, pharmacy copayment/coinsurance, and amounts the plan pays at 100% do not count toward the deductible. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care eligible Centers of Excellence (except bariatric surgery) services and prescriptions drugs are covered before your deductible is met. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits. |
| **Are there other deductibles for specific services?** | No. | You don’t have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | HRA High and HRA: in-network - $6,850/person, $13,700/family. There is no out-of-pocket limit for out-of-network services. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance billing charges, healthcare this plan does not cover, out-of-network preventive care, services at an out-of-network Walmart Care Clinic, out-of-network coinsurance, and amounts the plan pays at 100%. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |

* For more information about limitations and exceptions, see the Summary Plan Description, as supplemented by the 2019 Summary of Material Modifications (SPD) at www.WalmartOne.com/Benefits.
### Will you pay less if you use a network provider?

Yes. See WalmartOne.com or call 1-800-421-1362 for a list of network providers.

This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

### Do you need a referral to see a specialist?

No.

You can see the specialist you choose without a referral.

---

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

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge; Deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>

*Preventive care program section in the SPD for covered preventive services and applicable limitations.*

You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

**If you have a test** |

| Diagnostic test (x-ray, blood work) | 25% coinsurance | 50% coinsurance | There is no charge for preventive services. *See the “Preventive care program” section in the SPD for covered preventive services.* |
| Imaging (CT/PET scans, MRIs) | 25% coinsurance | 50% coinsurance |  |

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* For more information about limitations and exceptions, see the Summary Plan Description, as supplemented by the 2019 Summary of Material Modifications (SPD) at [www.WalmartOne.com/Benefits](http://www.WalmartOne.com/Benefits).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$4 copayment (30 days)</td>
<td><strong>Non-Network Provider (You will pay the most)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$8 copayment (31-60 days)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$12 copayment (61-90 days)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>90-day mail-order is 3 times the cost of a 30-day supply</td>
<td></td>
</tr>
<tr>
<td>More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.expressscripts.com/walmart">www.expressscripts.com/walmart</a></td>
<td>Preferred brand drugs</td>
<td>Greater of $50 or 25% coinsurance (30 days); <strong>Deductible does not apply</strong></td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physician/surgeon fees</td>
<td>Greater of $50 or 20% coinsurance (30 days); <strong>Deductible does not apply</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specialty drug</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>25% coinsurance</td>
<td><strong>Preauthorization may be required.</strong> <em>See the “Preauthorization” section in the SPD.</em></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>Specialty drugs are only available at a Walmart Specialty or ESI/Accredo Specialty pharmacy. Prescriptions for specialty drugs are not covered when purchased at a non-network pharmacy.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the Summary Plan Description, as supplemented by the 2019 Summary of Material Modifications (SPD) at [www.WalmartOne.com/Benefits](http://www.WalmartOne.com/Benefits).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
<td>Care that does not meet your third-party administrator’s definition of “emergency care” is paid at 50% for out-of-network services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Care that does meet the definition of “emergency care” will be considered in-network services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>If you are admitted to the hospital directly from the emergency room, special rules apply. *See the “Your provider network” section of the SPD</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
<td>Care that does not meet your third-party administrator’s definition of “emergency care” is paid at 50% for out-of-network services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Care that does meet the definition of “emergency care” will be considered in-network services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Coverage is limited to the nearest hospital or treatment facility capable of providing care, and only if such transportation is medically necessary as compared to other transportation methods of lower cost and safety.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization may be required. *See the “Preauthorization” section in the SPD.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>For heart, spine, hip or knee replacement evaluation and surgery; breast, lung, prostate, blood and colorectal cancer review; and organ and tissue transplants, coverage may be 100% through the Centers of Excellence (COE) Program; deductible does not apply. Certain weight loss surgeries may be covered with a 25% coinsurance when performed through the COE Program. When not performed through the COE Program, spine and weight loss surgeries and organ and tissue transplants are not covered, even if performed by a network provider, unless an exception applies.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the Summary Plan Description, as supplemented by the 2019 Summary of Material Modifications (SPD) at [www.WalmartOne.com/Benefits](http://www.WalmartOne.com/Benefits).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization may be required. *See the “Preauthorization” section in the SPD.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance or a deductible may apply.</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>Must be provided by a state-approved licensed vocational nurse (L.V.N.), licensed practical nurse (L.P.N.) or registered nurse (R.N.). Limited to 100 visits per year. Other limitations may apply. “See the “When limited benefits apply to the Associates’ Medical Plan” section in the SPD.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the Summary Plan Description, as supplemented by the 2019 Summary of Material Modifications (SPD) at [www.WalmartOne.com/Benefits](http://www.WalmartOne.com/Benefits).
## Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habilitation services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to 20 visits for physical therapy and 20 visits for occupational therapy per calendar year. Certain speech therapy services may be covered, with limitations. *See the “When limited benefits apply to the Associates’ Medical Plan” section in the SPD. Certain other rehabilitation services are limited to 120 days per condition. *See the “When limited benefits apply to the Associates’ Medical Plan” section in the SPD. Coverage is limited to Applied Behavior Analysis therapy.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to 60 days per disability period. *See the “When limited benefits apply to the Associates’ Medical Plan” section in the SPD. Preauthorization may be required. *See the “Preauthorization” section in the SPD. To be covered, doctor must provide diagnosis, type of equipment needed and expected time of usage.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization may be required. *See the “Preauthorization” section in the SPD. To be covered, doctor must provide diagnosis, type of equipment needed and expected time of usage.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization may be required. *See the “Preauthorization” section in the SPD. Limited to 365 days per illness.</td>
</tr>
</tbody>
</table>

### If your child needs dental or eye care

- **Children's eye exam**: No charge, 50% coinsurance. Limited to one exam per year.
- **Children’s glasses**: Not covered, Not covered, None.
- **Children’s dental check-up**: Not covered, Not covered, None.

### Excluded services & Other Covered Services:

- **Services Your Plan Generally Does NOT Cover**: Check your policy or plan document for more information and a list of any other excluded services.
  - Acupuncture
  - Children’s Dental Check-Up
  - Children’s Glasses
  - Chiropractic Care
  - Dental Care (Adult)
  - Non-Preferred Brand Drugs
  - Routine Eye Care (Adult)
  - Weight Loss Programs

For more information about limitations and exceptions, see the Summary Plan Description, as supplemented by the 2019 Summary of Material Modifications (SPD) at [WalmartOne.com/Benefits](http://WalmartOne.com/Benefits).
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Bariatric Surgery (gastric bypass and gastric sleeve surgery only)
- Cosmetic Surgery (for conditions resulting from accidental injuries, tumors, diseases, congenital abnormality or as covered under the Women’s Health & Cancer Rights Act)
- Hearing Aids (hearing screening for children)
- Infertility Treatment (diagnosis and correction of an underlying condition of infertility)
- Long Term Care (60 days/disability period if requirements are met)
- Non-Emergency Care when Traveling Outside The U.S. (as provided by international business medical insurance policy)
- Private-Duty Nursing (limited to 100 visits per year, and must be provided by a licensed or registered nurse)
- Routine Foot Care (limited to 3 visits per year)

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

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

Does this plan provide Minimum essential coverage? Yes.
If you don’t have Minimum essential coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum value standards? Yes.
If your plan doesn’t meet the Minimum value standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-421-1362.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-421-1362.
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-800-421-1362.

* For more information about limitations and exceptions, see the Summary Plan Description, as supplemented by the 2019 Summary of Material Modifications (SPD) at www.WalmartOne.com/Benefits.
About these Coverage Examples:

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

---

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

- The plan’s overall deductible: $1,750
- Specialist coinsurance: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 0%

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

Total Example Cost: $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$20</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$3,100</td>
</tr>
</tbody>
</table>

What isn’t covered:

- Limits or exclusions: $60

The total Peg would pay is: $4,930

---

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

- The plan’s overall deductible: $1,750
- Specialist coinsurance: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 0%

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

Total Example Cost: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$700</td>
</tr>
</tbody>
</table>

What isn’t covered:

- Limits or exclusions: $60

The total Joe would pay is: $3,310

---

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

- The plan’s overall deductible: $1,750
- Specialist coinsurance: 25%
- Hospital (facility) coinsurance: 25%
- Other coinsurance: 0%

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

Total Example Cost: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$150</td>
</tr>
</tbody>
</table>

What isn’t covered:

- Limits or exclusions: $0

The total Mia would pay is: $1,900

---

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

The Associates' Health and Welfare Plan (AHWP) respects the dignity of each individual who participates in the Plan.

The AHWP 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 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.

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 of Civil Rights:

- Phone: 1-800-368-1019 or 1-800-537-7697 (TDD)
- Website: https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf
- Email: OCRCompliant@hhs.gov

Interpreter Services are available at no cost. 1-800-421-1362

Arabic
خدمات الترجمة الفورية مفيدة دون تكلفة. 1-800-421-1362

Burmese
Translated Services are available at no cost. 1-800-421-1362

Chinese
翻译服务免费提供。1-800-421-1362.

Farsi
خدمات مترجم بدون هزینه ای در دسترس می‌باشد. 1-800-421-1362

French
Des services d'interprètes sont disponibles sans frais. 1-800-421-1362.
Haitian Creole
kreyòl ayisyè
Gen Sèvis entèprèt ki disponib gratis. 1-800-421-1362.

Japanese
日本人
通訳サービスは無料でご利用いただけます。1-800-421-1362.

Korean
한국어
통역 서비스를 무료로 이용하실 수 있습니다. 1-800-421-1362.

Polish
Polski
Usługi tłumacza dostępne są bez żadnych kosztów. 1-800-421-1362.

Portuguese
Português
Serviços de interprete estão disponíveis grátis. 1-800-421-1362.

Punjabi
ਪੰਜਾਬੀ
ਟੇਂਗਾਣਭਾਸ਼ਾ ਮੋਹਰਾਂ ਭੁਕ਼ੀ ਵਿਚਲਧਾਰਾ ਵਥਾ। 1-800-421-1362.

Romanian
Română
Serviciile de interpretariat sunt disponibile gratuit. 1-800-421-1362.

Russian
Русский
Переводческие Услуги оказываются бесплатно. 1-800-421-1362.

Somali
Af-Soomaali
Adeegyada Turjumaanka waxaa lagu heli karaa kharash la’aan. 1-800-421-1362.

Spanish
Español
Los servicios de interpretación están disponibles de manera gratuita. 1-800-421-1362.

Swahili
Kiswahili
Huduma za tafsiri zipo bila malipo. 1-800-421-1362.

Vietnamese
Tiếng Việt
Dịch Vũ Thông Dịch có sẵn miễn phí. 1-800-421-1362.