2022 Associate Benefits Book

Summary Plan Descriptions for Puerto Rico Associates

What's inside

Medical plan
Dental plan
Life insurance and disability plans
Associate Stock Purchase Plan
Walmart Puerto Rico 401(k) Plan
...and much more

Effective **January 1, 2022**
Walmart Puerto Rico 401(k) Plan effective **February 1, 2022**

Version 1.1 | October 2021

Welcome to your 2022 Associate Benefits Book

This is where you'll find the Summary Plan Descriptions (SPDs) for Puerto Rico Associates' Health and Welfare Plan (the Plan) and the Walmart Puerto Rico 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 2022 *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!

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

Eligibility and enrollment

If you have Medicare or will become eligible for Medicare in the next 12 months, you have more choices for your prescription drug coverage. See page 128 in the **Legal information** chapter for more details.

Eligibility and enrollment

RESOURCES		
Find What You Need	**Online**	**Other Resources**
• Enroll in Walmart benefits • Notify your HR Representative within 60 days of a status change event	Go to **One.Walmart.com/Enroll**	Call your HR Representative or PR Home Office Benefits Division at **787-653-1065**
Notify your HR Representative if you have questions about the payroll deductions for your benefits		Call your HR Representative or PR Home Office Benefits Division at **787-653-1065**
Pay premiums for benefits while on a leave of absence		See **Continuing benefit coverage if you go on a leave of absence** in this chapter for detailed information. If you are required to pay your premiums to keep coverage current, failure to do so will result in a cancellation of coverage. You may pay by credit or debit card with a Visa, MasterCard, American Express, or Discover card 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.

What you need to know about eligibility and enrollment

- You can enroll for benefits during your initial enrollment period as a newly eligible associate, during Annual Enrollment, or when you have a status change event.
- Your job classification (or changes to your job classification) determines when your initial enrollment period begins.
- Medical, dental, accidental death and dismemberment (AD&D), and long-term disability benefits cannot be changed, added, or dropped outside an initial enrollment period except during Annual Enrollment or after you have a status change event.
- You may enroll in, drop, or change optional life insurance benefits at any time but if you enroll after your initial enrollment period, you will have to provide Proof of Good Health.

The Associates' Health and Welfare Plan

The Associates' Health and Welfare Plan (the Plan) is a comprehensive employee benefit plan that offers medical, dental, AD&D, business travel accident insurance, life insurance, disability, and Resources for Living (employee assistance and wellness) benefits to eligible associates and their eligible dependents. Eligibility for these benefits is described in this chapter, and the terms and conditions for these benefits are described in the applicable chapters of this 2022 *Associate Benefits Book*. The Plan is sponsored by Walmart Inc. (the company).

You are automatically enrolled 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 **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.

Associate eligibility

The benefits you are eligible for depend on a number of factors, which may include your date of hire, average weekly hours, and your job classification in the Walmart Inc. payroll system. In addition, for most benefits, you may be required to meet an eligibility waiting period. See the **Enrollment and effective dates by job classification** section in this chapter for a list of the benefits you are eligible for and for your eligibility waiting period based on your job classification.

Our expectation is that you will use correct and accurate information when applying for or enrolling in benefits. If you do not, you may be subject to the loss of benefits and/or termination of employment. To review Walmart's policy about intentional dishonesty, refer to the Statement of Ethics, which can be found on **One.Walmart.com**. See **Legal documentation for dependent coverage** later in this chapter for information about documents that may be requested of you to verify dependent eligibility.

NOTE: Your eligibility for benefits is determined by the eligibility rules detailed in this *Associate Benefits Book*. To the extent that any information provided to you through other sources conflicts with the *Associate Benefits Book*, the eligibility rules in the *Associate Benefits Book* will control.

MANAGEMENT ASSOCIATE ELIGIBILITY

To be eligible for benefits as a management associate, you must be classified in the company's payroll system as a management associate or management trainee.

FULL-TIME HOURLY ASSOCIATE ELIGIBILITY

To be eligible for benefits as a full-time hourly associate, you must be classified in the company's payroll system as a full-time hourly associate.

PART-TIME HOURLY ASSOCIATE ELIGIBILITY

To be eligible for benefits as a part-time hourly associate, you must be classified in the company's payroll system as a part-time hourly associate.

To be eligible to enroll in medical and/or dental benefits, you must work an average of at least 30 hours per week, with the following exceptions:

- If you were hired prior to January 15, 2011, do not need to work a minimum number of hours per week.
- If you were hired on or after January 15, 2011, and prior to February 1, 2012, you must work an average of at least 24 hours per week.
- If you were hired on or after February 1, 2012, you must work an average of at least 30 hours per week.

If you are a part-time hourly associate, your hours worked will be reviewed to determine your eligibility for medical and dental benefits. For more information, see the section titled **Part-time hourly and temporary associates: eligibility checks for medical and dental benefits**.

TEMPORARY ASSOCIATE ELIGIBILITY

To be eligible for benefits as a temporary associate, you must be classified in the company's payroll system as a temporary associate.

To be eligible to enroll in medical and/or dental benefits, you must work an average of at least 30 hours per week.

If you are a part-time hourly associate, your hours worked will be reviewed to determine your eligibility for medical and dental benefits. For more information, see the section titled **Part-time hourly and temporary associates: eligibility checks for medical and dental benefits**.

ASSOCIATES WHO ARE NOT ELIGIBLE

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, the Puerto Rico Treasury Department, or the Department of Labor as a common-law employee of the company or any participating affiliate:

- A leased employee
- A nonresident alien (except for optional associate life insurance, optional dependent life insurance, accidental death and disability insurance, and business travel accident insurance, and unless covered under a specific insurance policy for expatriates or third-country nationals who are employed by the company)

- An independent contractor
- A consultant
- An associate residing outside Puerto Rico
- An associate who is not classified as an associate of the company or its participating affiliates
- An associate who is enrolled in Medicare Part D (applicable only to eligibility for medical and dental plan options), or
- An associate covered by a collective bargaining agreement, to the extent that the agreement does not provide for participation in the Plan.

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

In this section you'll find descriptions of two eligibility checks conducted to determine initial and ongoing medical and dental (and other benefits) eligibility for part-time hourly and temporary associates, as follows:

- Initial check when you have been employed for 52 weeks to determine initial eligibility
- Annual check to determine eligibility for medical and dental benefits in the next calendar year.

INITIAL ELIGIBILITY CHECK FOR MEDICAL AND DENTAL BENEFITS

If you are a part-time hourly or temporary associate hired prior to January 15, 2011, you do not need to work a minimum number of hours per week to be eligible for medical and dental benefits. If you are a part-time hourly or temporary associate hired on or after January 15, 2011, your initial eligibility for medical and dental benefits is determined during your initial measurement period. Your initial measurement period is the 52 consecutive weeks beginning on your date of hire, during which your average hours worked per week are reviewed.

If you work an average of at least 30 hours a week (24 hours a week for part-time hourly and temporary associates hired on or after January 15, 2011, and prior to February 1, 2012) over the 52-week review period without a break in employment of greater than 13 weeks, you will become eligible for medical and dental benefits at the close of your initial measurement period. Specifically, your eligibility for medical and dental benefits will begin on the first day of the second calendar month following your one-year anniversary date. For example, if your date of hire is April 16, 2021, your average hours worked from that day through April 15, 2022 will be calculated. If you meet the average-hours-worked requirement over this initial measurement period, your coverage would begin June 1, 2022 (assuming you enroll in a timely manner).

Initial medical and dental coverage for associates who meet the average-hours-worked requirement continues through the end of the second calendar year immediately following the calendar year that contains your date of hire. In the example above, your coverage (if you enroll in a timely manner) would continue through the end of 2023. You would then be subject to annual eligibility checks, as described below.

If you leave the company and are rehired

For purposes of the initial eligibility check, if you return to employment as a part-time hourly or temporary associate within 13 weeks after leaving *during* your initial measurement period, you will be treated as if you had not left, for the remainder of the measurement period. All hours worked during the measurement period will be used in the average-hours-worked calculation. For example, if you have a four-week break in service during the 52-week measurement period, your average hours will be calculated using the 48 weeks during which you worked, rather than 52 weeks. If you return to employment as a part-time hourly or temporary associate after 13 weeks or more, you will be treated as a new hire.

If you terminate employment *after* the completion of the initial measurement period and return to employment as a part-time hourly or temporary associate within 13 weeks and before the end of the second calendar year immediately following the calendar year that contains your date of hire (for purposes of this paragraph, this is the "eligibility period"), you will retain your previous eligibility status through the end of the eligibility period. If you are rehired after the eligibility period ends, your eligibility status will be based on the annual eligibility check.

The following rules apply if you are enrolled in medical benefits before you terminate employment, you return to the company within 13 weeks, and you return during your eligibility period:

- If you return during the same calendar year in which you terminated, you will be enrolled automatically in your previous coverage (or the most similar coverage offered under the Associates' Medical Plan [AMP]). If you return within 30 days, your annual deductible and out-of-pocket maximum under the AMP for the calendar year in which you terminate will not be reset. If you return after 30 days, your annual deductible and out-of-pocket maximum will be reset and you will be responsible for meeting the applicable deductible and out-of-pocket maximum in their entirety.
- If you return during the calendar year immediately following the calendar year in which you terminated, you will be enrolled automatically in your previous coverage

(or the most similar coverage offered under the AMP). Your annual deductible and out-of-pocket maximum will be reset and you will be responsible for meeting the applicable deductible and out-of-pocket maximum in their entirety.

You will have 60 days after resuming employment to drop or otherwise change the coverage in which you were automatically enrolled. If you return after 13 weeks, you will be treated as a new associate and will be subject to the 60-day and/or initial eligibility check for medical benefits before you will be eligible.

ANNUAL ELIGIBILITY CHECK FOR MEDICAL AND DENTAL BENEFITS

If you are not eligible for medical coverage for the next calendar year based on the initial eligibility check as described in the section above (or you were not subject to those rules) and you are classified as a part-time hourly or temporary associate, you will be subject to an annual eligibility check to establish your eligibility for medical benefits for the next calendar year. You will also be subject to the annual eligibility check if you were originally hired as a management or full-time hourly associate and were employed one year or more before changing to part-time hourly or temporary status.

The measurement period for the annual eligibility check will be the 52 weeks preceding an annually designated date in early October prior to each calendar year's Annual Enrollment. For example, the annual eligibility check occurring in fall 2022 (for the 2023 calendar year) will review your hours worked from October 5, 2021, through October 4, 2022. If you meet the average hours requirement (24 or 30 hours per week, depending on hire date) over the 52-week period, you will be eligible to enroll in medical and dental benefits during Annual Enrollment for coverage during 2023.

If you do not meet the average weekly hours requirement in the annual eligibility check, your medical and dental coverage may continue for a period of time, as described below under **If you do not meet the annual eligibility check for medical and dental benefits**.

If you have questions about the annual eligibility check, notify your HR Representative or PR Home Office Benefits Division at **787-653-1065**.

If you meet the annual eligibility check for medical and dental benefits

If you are a part-time hourly or temporary associate who is currently enrolled for medical and/or dental coverage and you meet the annual eligibility check in October, you will remain enrolled for medical and/or dental coverage for the remainder of the current year. You will receive Annual Enrollment materials and be eligible to enroll for medical and dental benefits for the following year.

You will be subject to the annual eligibility check each year to determine your eligibility for medical and dental benefits for subsequent years, provided you remain a part-time hourly or temporary associate.

If you do not meet the annual eligibility check for medical and dental benefits

If you are a part-time hourly or temporary associate who is currently enrolled for medical and/or dental coverage, but you do not meet the annual eligibility check in October, your eligibility will continue through the end of the current calendar year, in which the annual eligibility check occurred. You will not be eligible for medical and dental benefits for the following year unless your job classification changes and you meet the eligibility requirements based on your new classification. You will receive a letter describing your options under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue your medical and/or dental coverage when the current calendar year ends. (See the **COBRA** chapter for more information.)

You will be subject to the annual eligibility check each year to determine your eligibility for medical and dental benefits for subsequent years, provided you remain a part-time hourly or temporary associate.

IF YOU TAKE TIME OFF DURING THE ANNUAL MEASUREMENT PERIOD

If you take any type of unpaid time off that is not an approved leave of absence, as described below, the period of unpaid leave will be used to calculate your average hours for the initial and annual measurement periods (even if it is zero) in which the absence occurs.

If your absence is an approved leave granted under federal or local law (including for jury duty, Family and Medical Leave Act of 1993 [FMLA] leave, and military leave, among others), the calculation of your average hours worked will be based on the number of weeks during the 52-week measurement period that you were not on the approved leave. For example, if you take an approved leave during two weeks of the 52-week measurement period, your average hours worked will be calculated over 50 weeks rather than 52.

If you leave the company and are rehired

For purposes of the annual eligibility checks, if you return to employment as a part-time hourly or temporary associate within 13 weeks after leaving *during* your annual measurement period, you will be treated as if you had not left, for the remainder of the measurement period. All hours worked during the measurement period will be used in the average-hours-worked calculation. For example, if you have a four-week break in service during the 52-week measurement period, your average hours will be calculated using the 48 weeks during which you worked, rather than

52 weeks. If you return to employment as a part-time hourly or temporary associate after 13 weeks or more, you will be treated as a new hire.

If you terminate employment *after* the completion of the initial measurement period and return to employment as a part-time hourly or temporary associate within 13 weeks and before the end of the calendar year immediately following the calendar year that contains the latest annual measurement period (for purposes of this paragraph, this is the "eligibility period"), you will retain your previous eligibility status through the end of the eligibility period. If you are rehired within 13 weeks and after the end of the eligibility period, your eligibility status will be based on the annual eligibility check that corresponds with the calendar year in which you return to employment.

If you are enrolled in medical and/or dental benefits before you terminate employment, you return to the company within 13 weeks, and you return during your eligibility period, as defined in the prior paragraph, you will be automatically enrolled in your previous coverage (or the most similar coverage offered under the Plan).

You will have 60 days after resuming employment to drop or otherwise change the coverage in which you were automatically enrolled. If you return after 13 weeks, you will be treated as a new associate and will be subject to the initial eligibility check for medical and/or dental benefits before you will be eligible.

NOTE: If you have questions about the calculation of hours for the eligibility checks, call your HR Representative or PR Home Office Benefits Division at **787-653-1065**.

Dependent eligibility

If you are a management or full-time hourly associate and are eligible for benefits under the Plan, you may also enroll your spouse/partner and dependent child(ren), as defined below. For purposes of the *Associate Benefits Book*, the term "dependent" includes your spouse/partner. If you are a part-time hourly or temporary associate and you are eligible for benefits under the Plan, you may enroll only yourself; you may not enroll any dependents.

EMPLOYMENT CLASSIFICATION	CAN ELECT TO COVER ELIGIBLE DEPENDENTS (AS DEFINED BELOW)
• Management • Full-time hourly	• Spouse/partner • Dependent child(ren)
• Part-time hourly • Temporary	• Cannot enroll dependents

DEFINITIONS: ELIGIBLE DEPENDENTS	
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 your home state 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)	• Your dependent children through the end of the month in which the child reaches age 26. Your dependent children are: – Your natural 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.

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. 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 loss of employment.

If a court order requires you to provide medical and/or dental coverage for your child, the child must be an eligible dependent as defined above. For more information on how the Plan handles a Qualified Medical Child Support Order (QMCSO), see the **Qualified Medical Child Support Orders (QMCSO)** section later in this chapter.

IF YOUR CHILD IS INCAPABLE OF SELF-SUPPORT

If your child is enrolled for coverage under the AMP, you may continue the child's 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 legal support, and
- The child's doctor provides written medical evidence of the child's incapacity.

Additional coverage may be added if your child experiences a valid status change event. For information regarding a status change event, refer to the **Status change events** section of this chapter.

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 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 tax return from the most recent tax season is also required, or both of your tax returns if you file separately.

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*
- 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:

- **Natural 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 tax return from the most recent tax season is also required, or both of your tax returns if you file separately.
- **Child of your domestic partner:** State or county-issued birth certificate and proof of established domestic partnership/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.

Dependents who are not eligible

Your dependent is not eligible for coverage under the Plan if he or she is:

- Residing outside Puerto Rico (not applicable to optional dependent life insurance or AD&D, and not applicable if your dependent is attending college full-time outside Puerto Rico)
- Covered under an expatriate plan
- An undocumented immigrant
- Not an eligible dependent as defined under **Dependent eligibility** on the previous page
- A Walmart associate already enrolled in coverage under the Plan (not applicable to optional dependent life insurance or AD&D)
- A dependent of another Walmart associate and already enrolled in coverage under the Plan (not applicable to optional dependent life insurance or AD&D insurance)
- Enrolled in Medicare Part D (applicable only to eligibility for medical plan options)

When your dependent becomes ineligible

If your dependent is enrolled in coverage under the Plan and becomes ineligible for coverage, you must notify your HR Representative or PR Home Office Benefits Division at **787-653-1065** within 60 days from the date your dependent becomes ineligible. If you notify your HR Representative or PR Home Office Benefits Division within this time frame, the Plan will send an election notice, allowing you 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 your HR Representative or PR Home Office Benefits Division at **787-653-1065** 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 your HR Representative or PR Home Office Benefits Division, you may be responsible for any charges mistakenly paid by the Plan after the date that your dependent became ineligible.

When you enroll for benefits

Once you have completed any applicable eligibility waiting period and have met any other requirements, including the active-at-work requirements described below, you can 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 role 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. If you do not enroll during your initial enrollment period, you will not be able to enroll for the following benefits until the next Annual Enrollment, unless you have a status change event, as described in the **Status change events** section of this chapter:

- Medical (subject to the annual eligibility check described in the **Annual eligibility check for medical and dental benefits** section earlier in this chapter)
- Dental (subject to the annual eligibility check described in the **Annual eligibility check for medical and dental benefits** section earlier in this chapter)
- Accidental death and dismemberment (AD&D)
- Long-term disability (LTD) (see important exception regarding "late enrollees" immediately following)

You may add or drop optional associate life insurance and optional dependent life insurance (or add coverage) at any time. See important information regarding "late enrollees" immediately below.

Late enrollees. If you do not enroll in the long-term disability plan, optional associate life or optional dependent life insurance 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 be subject to Proof of Good Health requirements before coverage is approved and effective. If you enroll in optional associate life or optional dependent life insurance during your initial enrollment period for more than the guaranteed amount or for the guaranteed amount and then increase coverage for you or your spouse/partner, if eligible, at a later date, you will also be subject to Proof of Good Health Requirements. 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 LEVEL

If you enroll your eligible dependents in the Plan, they must have the same coverage you elect for yourself. You may change your coverage during Annual Enrollment or if you have a status change event. See the **Status change events** section later in this chapter.

Under the medical and dental plans, management and full-time hourly associates may elect one of the following coverage levels:

- Associate only
- Associate + spouse/partner
- Associate + child(ren), or
- Associate + family.
- Part-time hourly and temporary associates may elect associate-only coverage but may not elect coverage for any dependents.

CONFIRMING YOUR ENROLLMENT

Once you enroll for coverage, you can view your confirmation statement on **One.Walmart.com/Enroll**. If you see an error regarding the benefits you enrolled in, immediately contact your HR Representative or PR Home Office Benefits Division at **787-653-1065**.

YOUR PLAN ID CARD

When you enroll in medical coverage under the Associates' Medical Plan (AMP), you receive a plan ID card at your home address. Your plan ID card also serves as your pharmacy ID card.

If you enroll in the Associates' Dental Plan (the "dental plan"), you will receive a separate dental plan ID card at your home address.

You can update your address or that of your dependents who are under the age of 21 by contacting your HR Representative If your dependent is age 21 or over, they need to contact your HR Representative or PR Home Office Benefits Division at **787-653-1065** to update their address.

When coverage is effective

See the **Enrollment and effective dates by job classification** section of this chapter for more details about coverage effective dates.

If you are not at work on the day your coverage becomes effective (including for a leave of absence) for medical, dental, accidental death and dismemberment ("AD&D") insurance, Resources for Living, business travel accident insurance, or company-paid life insurance, your coverage is effective on the first day you are "actively at work," as defined below, as long as you are enrolled for the benefit and have paid the applicable premiums. No enrollment or premiums are required for Resources for Living, business travel accident insurance, short-term disability, or company-paid life insurance.

If you are not at work for any reason (including for a leave of absence) other than vacation on the day your coverage becomes effective for optional associate life insurance, optional dependent life insurance, or long-term disability (LTD), your coverage will be effective on the first day you are "actively at work," as defined below, as long as you are enrolled for the benefit and have paid the applicable premiums.

"ACTIVE WORK" OR "ACTIVELY AT WORK"

For medical, dental, AD&D, and Resources for Living coverage, "active work" (or "actively at work") means you are on active status and have reported to your first day of work at the company, even if you are not at work the day coverage begins (for example, due to illness).

For company-paid life insurance, optional associate life insurance, optional dependent life insurance, and business travel accident insurance, being actively at work means you are on active status and not on a leave of absence.

For all types of disability coverage, being actively at work means you have worked hours in the immediately preceding pay period if you are an hourly associate or have earned wages in the immediately preceding pay period if you are a member of management.

AUTOMATIC REENROLLMENT

If you currently have coverage and are eligible for benefits during the following calendar year, but do not actively enroll for those benefits during Annual Enrollment, 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 your HR Representative or PR Home Office Benefits Division at **787-653-1065** for information.

If you do not actively enroll during Annual Enrollment and are automatically enrolled in coverage as described above, you may not change this coverage except during a subsequent Annual Enrollment, unless you experience a status change event.

If you do not actively reenroll during Annual Enrollment, you will be deemed to have consented to automatic re-enrollment and your payroll deductions will be adjusted accordingly.

If you leave the company and are rehired

MANAGEMENT AND FULL-TIME HOURLY ASSOCIATES

If you are enrolled for medical and/or dental benefits before you terminate employment and you return to the company within 13 weeks, you will be automatically reenrolled in your previous coverage (or the most similar coverage offered under the Plan).

You will have 60 days after resuming employment to drop or otherwise change the coverage in which you were enrolled automatically.

If you return after 13 weeks, you will be treated as a new associate.

PART-TIME HOURLY AND TEMPORARY ASSOCIATES

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

Effective dates for benefits under the Plan

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

Enrollment and effective dates by job classification

FULL-TIME HOURLY ASSOCIATES

NOTE: *Don't confuse the initial enrollment period with 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 • Dental • AD&D	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and the day *prior* to the date your coverage is effective. **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 Annual Enrollment for the next calendar year or until you experience a status change event, as described in the **Status change events** 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.	
• Resources for Living • Business travel accident insurance • Short-term disability plan	You are enrolled automatically on your date of hire.	
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck 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 issue 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 issue 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 at your own expense. 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 full-time employment falls. **If you enroll after your initial enrollment period:** You may enroll in, increase, or drop coverage after the initial enrollment period and at any time during the year, but your coverage (including an increase) 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 at your own expense. If approved, your coverage is effective on the date Prudential approves your coverage.	
• Long-term disability (LTD) plan (including enhanced benefits)	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck 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:** 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 coverage following a status change event and are approved, your coverage is effective on the first day of the pay period following the date Lincoln approves your coverage. – If you enroll in coverage during Annual Enrollment and are approved, your coverage will be effective January 1 of the following year. – If you are not approved, you may be eligible to enroll during the next Annual Enrollment or after a status change event but will be subject to the same Proof of Good Health requirements.	

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 AND TEMPORARY ASSOCIATES

NOTE: *Don't confuse the initial enrollment period with 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* • Dental	**Initial enrollment period:** 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.* **When coverage is effective:** Your coverage is effective the first day of the second calendar month following 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 Annual Enrollment for the next calendar year or until you experience a status change event, as described in the **Status change events** section of this chapter. *To be eligible for medical and dental coverage, part-time hourly and temporary associates must work the required number of hours and pass the initial or annual benefits eligibility check (as applicable) described under Associate eligibility earlier in this section. Part-time hourly and temporary associates hired before January 15, 2011, are exempt from this requirement.
• Short-term disability • Resources for Living • Business travel accident insurance	You are automatically enrolled on your date of hire.

NOTE: Part-time hourly and temporary associates may only enroll for associate-only coverage and may not cover any dependents.

MANAGEMENT ASSOCIATES

Includes management trainees

NOTE: *Don't confuse the initial enrollment period with 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 • Dental • AD&D	**Initial enrollment period:** You must enroll between the date of your first paycheck and *prior* to the 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 Annual Enrollment for the next calendar year or you experience a status change event, as described in the **Status change events** section of this chapter.
• Resources for Living • Company-paid life insurance • Business travel accident insurance • Short-term disability plan	You are enrolled automatically on your date of hire.	
• Optional associate life insurance • Optional dependent life insurance	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and *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:** • If you enroll for the guaranteed issue amount, coverage is effective on the date you enroll. • If you enroll for more than the guaranteed issue 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 at your own expense. If approved, your coverage is effective on the date Prudential approves your coverage. **If you enroll after your initial enrollment period:** You may enroll in, increase, or drop coverage after the initial enrollment period and at any time during the year, but your coverage (including an increase) 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 at your own expense. If approved, your coverage is effective on the date Prudential approves your coverage.	
• Long-term disability (LTD) plan (including enhanced benefits)	**Initial enrollment period:** You must enroll in coverage between the date of your first paycheck and the day *prior* to the 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 as of your date of hire. • **If you enroll in 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 coverage following a status change event and are approved, your coverage is effective on the first day of the pay period following the date Lincoln approves your coverage. – If you enroll in coverage during Annual Enrollment and are approved, your coverage will be effective January 1 of the following year. – If you are not approved, you may be eligible to enroll during the next Annual Enrollment or after a status change event but will be subject to the same Proof of Good Health requirements.	

NOTE: Some benefits may 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

When you enroll in the Plan, payroll deductions for the premium amounts are withheld from your paycheck to pay for the coverage you have elected. The first paycheck after your 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.

Your payroll deductions for benefits in any pay period are for the cost of coverage provided to you during that pay period. So, if you are paid biweekly (every other week), your deductions pay for coverage for the two-week period that is the pay period. For example, if a pay period runs from April 1 through April 14, the payroll deductions for benefits taken for that payroll period are deductions for coverage for that pay period, assuming all premiums are current through the end of that pay period. If you are behind on your premiums for any reason, you will have benefits coverage only through the date to which your premiums are current. Deductions are based on biweekly pay periods.

If your payroll deductions are not sufficient to pay any portion of a premium due, you are responsible for paying any unpaid premiums to the extent the premiums would have been paid if withheld as a payroll deduction. If you owe premiums for benefits coverage, any check issued by the company (e.g., paid time off, incentive, etc.), including during or after a leave of absence, will have premiums deducted on an after-tax basis, as permitted by law.

Be sure to check your statement of earnings and deductions on your pay stub to verify that the proper deductions are being taken. You can view your paycheck stub 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 pay stub, call your HR Representative or PR Home Office Benefits Division immediately at **787-653-1065**. Requests for a review of premiums paid are considered if submitted within one year from the date of a possible overpayment. A premium reconciliation up to a maximum of one year will be completed.

WHEN SPECIAL ARRANGEMENTS ARE NECESSARY TO MAINTAIN COVERAGE

If your payroll deductions are not sufficient to pay any portion of a premium due, you are responsible, regardless of your job status, for making arrangements to pay any unpaid premiums to the extent the premiums would have been paid if withheld as payroll deductions. These terms apply to the following benefits:

- Medical
- Dental
- Optional associate life insurance
- Optional dependent life insurance
- Accidental death and dismemberment (AD&D)

Your premium payments for coverage during a pay period are due by the close of that pay period. Your failure to make your premium payments by the due date may result in your coverage being canceled due to nonpayment of premiums.

To avoid interruption or cancellation of coverage, premium payments can be made in advance through the automated system with a VISA, MasterCard, American Express, or Discover credit or debit card or by logging into the payment portal on **One.Walmart.com/Enroll**. You can also call People Services at **800-421-1362** and request a representative who speaks Spanish. To confirm the premium amount owed, call People Services.

Payments of premiums 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 your coverage is canceled due to nonpayment of premiums:

- If you are an active associate, you will not be able to enroll again until the next Annual Enrollment or until you have a valid status change event. However, you may enroll in optional life insurance at any time, provided you remain eligible.
- 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 (or the most similar coverage offered under the Plan). Your coverage will be effective the first day of the pay period that 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 newly eligible associate and will be required to meet any applicable eligibility requirements before you may enroll for coverage.

TAX CONSEQUENCES OF PARTNER BENEFITS

Partners generally do not qualify as spouses or dependents for federal income tax purposes. Therefore, the value of company-provided medical and dental coverage that relates to your partner, or your partner's children, is generally considered imputed income and taxable to you. This value is subject to change from year to year as the underlying benefit values change. Tax and other withholdings are made from your paycheck and the value of those benefits is included in

your Form W-2. During any period in which partner benefits that have an imputed income are maintained by you but you are not receiving a paycheck from the company, the company reserves the right to collect your portion of the FICA tax liability directly from you.

These rules do not apply if your partner satisfies the requirements to be considered your tax dependent under the Internal Revenue Code.

Puerto Rico residents are generally not subject to federal income taxes. Nevertheless, there may be tax consequences under Puerto Rico tax law if you choose to cover a domestic partner. If you are a Puerto Rico employee, you should consult with a tax professional regarding the Puerto Rico tax consequences of including a domestic partner as a dependent for purposes of coverage under the Plan.

Tobacco rates

You can receive lower tobacco-free rates for medical and prescription drug coverage, optional associate life insurance, and optional dependent life insurance for a spouse if:

- You and/or a covered spouse/partner do not use tobacco and are considered to be "tobacco free," or
- You and/or a covered spouse/partner use tobacco and you complete participation in a quit-tobacco program of your choice between the time of Annual Enrollment and December 31, 2022. Alternatively, if you call the Quit Tobacco program available through MCS Solutions at **855-830-9887**, option 3, you can get the first eight visits to a psychologist covered with no copay. The program will work with you (and, if you wish, your doctor) to find a program that is right for you.

"Tobacco free" means that you (and/or your covered spouse/partner) do not use tobacco in any form — cigarettes, cigars, pipes, snuff, or chewing tobacco. For purposes of establishing tobacco-free rates, being "tobacco free" also means that you do not use e-cigarettes or any such nicotine-delivery devices.

You will be asked to attest to your tobacco use at your initial enrollment, to determine your eligibility for tobacco-free rates for your initial eligibility period, and each year at Annual Enrollment, to determine your eligibility for tobacco-free rates for the next 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 the company's policy about intentional dishonesty, please refer to the Statement of Ethics, which can be found on **One.Walmart.com**. If we receive a report of abuse, we will conduct an ethics investigation.

Please note that your eligibility for tobacco-free rates can be established only at your initial enrollment and at Annual Enrollment. If you become tobacco-free during the year, you will not become eligible for tobacco-free rates until the following calendar year.

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.

Continuing benefit coverage if you go on a leave of absence

While you are on a Family Medical Leave Act (FMLA) leave, personal leave, military leave, or other approved leave granted under federal or local law, you retain any medical, dental, optional associate life, optional dependent life, AD&D, and Resources for Living coverage that you had on the day immediately preceding the first day of the leave. Coverage generally is maintained on the same terms and conditions as if you had continued to work during the leave.

During your leave, you are responsible for paying any unpaid premiums to the extent the premiums would have been paid if withheld as a payroll deduction. See **When special arrangements are necessary to maintain coverage** earlier in this chapter for details.

If you cancel your coverage during your FMLA, personal or military leave and return to work, you may contact your HR Representative or PR Home Office Benefits Division at **787-653-1065** within 60 days of returning to work to reinstate your coverage. See the **If you go on a leave of absence** section in the respective chapters for each of the above-named benefits to learn more.

Decisions about leaves of absence are made by the company, not the Plan.

Contact your HR Representative if you have questions about the FMLA, personal, or military leave policy.

PAYING FOR BENEFITS WHILE ON A LEAVE OF ABSENCE

To continue benefit coverage while on a leave of absence, you must pay your premiums on an after-tax basis. For details on making payments while on a leave of absence, refer to **When special arrangements are necessary to maintain coverage** earlier in this chapter.

If you are on a leave of absence and you owe premiums for benefits coverage, any check issued by the company (e.g., paid time off, incentive, etc.) will have premiums deducted on an after-tax basis, as permitted by law.

Continuing benefit coverage while disabled

If you are receiving disability benefits and wish to continue your coverage under other benefits offered under the Plan, this chart describes how your coverage costs are handled:

TO MAINTAIN COVERAGE UNDER THESE BENEFITS	
• Medical • Dental	• Optional associate life • Optional dependent life • AD&D
WHILE YOU ARE RECEIVING...	
• Short-term disability benefits • Long-term disability benefits	Your premiums for the coverage listed above ***will not*** be deducted from your short-term or long-term disability benefit checks because they are not issued through the company payroll system. **NOTE:** You are not required to pay long-term disability plan premiums from any long-term disability benefit payments you receive.*
*If you receive any other earnings, including bonuses, through the company payroll systems while you are receiving disability benefits, your LTD premiums will be withheld from those payments.	

Status change events

Certain benefits can be changed at any time during the year, but others can be changed only during Annual Enrollment or if you have a status change event, as follows:

- Optional associate life insurance and optional dependent life insurance can be added or dropped at any time.
- The AMP, dental, and AD&D insurance can be changed only during Annual Enrollment unless you have a status change event.
- Long-term disability can be added or dropped only at Annual Enrollment unless you have a status change event. If you drop coverage after a status change event, the change becomes effective the day after you drop coverage.

You may make certain coverage changes if you experience a status change event. A status change event for purposes of this SPD 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 impact eligibility. In other words, there must be a logical relationship between the 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 but your other dependents remain eligible for benefits under the Plan. Therefore, you can only drop coverage for your spouse. Changing another dependent's coverage due to this event would not be permitted.

When you have a status change event (including a life event or the loss or gain of other coverage as described below), any changes to your coverage must be made within 60 days from the date of the event.

Status change events include the following 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, or
  - Legal separation.
- Events that change your domestic partnership status:
  - Commencement of domestic partnership
  - Termination of domestic partnership, or
  - 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, or
  - 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 of a dependent
  - Loss of legal custody 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, or
  - 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

  - A change in work location that affects your medical coverage. If the change affects your medical coverage options, 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 benefits are affected and do not submit a request, you will automatically be enrolled in a predetermined plan.

Status change events also include changes in cost or coverage and other events, as detailed in the following section.

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 benefits) 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 coverage in the AMP.
- Additions/improvements of a benefit option under this Plan.
- Eligibility under a governmental plan: If you or your eligible dependents gain eligibility under a governmental plan (other than Medicare, Medicaid, TRICARE, or a state children's health insurance plan), you cannot drop the AMP 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 on the next page in **Changes in your coverage following a status change event**, you can drop coverage in the AMP 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 coverage under the AMP.

LOSS OF COVERAGE

- Loss of coverage under any other employer plan.
- Reduction of coverage under this Plan.
- Significant loss of coverage. The Plan determines when a significant loss of coverage has occurred.
- 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 coverage under the AMP within 60 days of the loss of coverage. (This does not apply to loss of coverage under a Health Insurance Marketplace plan.)
- You may add medical or dental 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 premiums 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, or
  - Employer contributions toward other coverage have terminated.

CHANGE IN COST

If the cost of coverage under this Plan or another Plan changes, 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.

LEGAL ORDER

If an order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order — See **Qualified Medical Child Support Orders (QMCSO)** later in this chapter) requires you to provide medical and/or dental 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 and/or dental 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 the AMP, 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 PR Home Office Benefits Division at **787-653-1065**.

CHANGES IN YOUR COVERAGE FOLLOWING A STATUS CHANGE EVENT

When you have a status 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 will be subject to applicable Plan terms and limitations.

The Plan reserves the right to request additional necessary documentation to show proof of a status 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 are described in the lists of status change events and 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).
- 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.
- 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 status change events or contact PR Home Office Benefits Division at **787-653-1065**.

HOW TO CHANGE YOUR ELECTIONS DUE TO A STATUS CHANGE EVENT

You can make changes online within 60 days of the event on **One.Walmart.com/Enroll** for life event status changes due to:

- Birth
- Commencement of domestic partnership
- Commencement of legal relationship with a person other than your spouse or domestic partner
- Divorce or legal separation
- Gain or loss of coverage by you, your dependent(s), or your eligible spouse/partner
- Marriage
- Termination of domestic partnership, or
- Termination of legal relationship with a person other than a spouse or domestic partner.

For all other types of status changes, call your HR Representative or PR Home Office Benefits Division at **787-653-1065**.

If your status 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 as a dependent under your coverage, so long as the charges are submitted within 60 days of the birth.

If you are seeking to add 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 status change event, the individual will not be added to your coverage as a dependent.

Changes to your coverage are effective on the event date or on the day after the status change event date. If a change is made due to your 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, or long-term disability; see the **Enrollment and effective dates by job classification** charts in this chapter for information about effective dates.

If you do not notify PR Home Office Benefits Division and make a change within 60 days of the status change event, you cannot add or drop coverage until the next Annual Enrollment or until you have a different status change event.

Also, if the status change event is due to your dependent losing eligibility, your dependent will lose the right to elect COBRA coverage for medical and/or dental benefits if you do not notify PR Home Office Benefits Division of the event within 60 days. Similarly, if the status 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 and/or dental benefits if PR Home Office Benefits Division is not notified of the event within 60 days. See the **COBRA** chapter for more information.

If your job classification changes

Transitioning from one job classification to another may affect your eligibility for certain benefits.

If you are classified as a part-time hourly or temporary associate and your classification is changed to full-time, you will be eligible for full-time benefits, as described in the chart below.

If your job classification changes from full-time associate to part-time or temporary associate, your dependents will no longer be eligible for medical, dental, optional dependent life insurance, or AD&D coverage. You will no longer be eligible for company-paid life or optional associate life insurance coverage. If this change results in

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 and/or dental coverage.

NOTE: If your job classification changes to part-time hourly or temporary associate, see the earlier section of this chapter titled **Part-time hourly and temporary associates: eligibility checks for medical and dental benefits**.

Transferring from one job classification to another

PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO A FULL-TIME HOURLY POSITION

Your status at transition	Enrollment details and coverage effective dates
You have been continuously employed for more than 52 weeks and were eligible for medical and dental coverage under the Plan as a part-time hourly or temporary associate immediately prior to your transition	You have 60 days to enroll from the first day of the pay period in which your transition occurs. • If you are currently enrolled in **medical** and/or **dental** coverage (Premium), you can increase your coverage type to associate + spouse/partner or associate + family as a result of your change in job classification. If you are not currently enrolled in medical and/or dental coverage you may enroll only in associate + spouse/partner, associate + child(ren), or associate + family coverage as a result of your change in job classification, until the next Annual Enrollment or until you have a valid status change event. You may not select associate-only coverage as a result of your change in job classification, as you were already eligible for that coverage type as a part-time hourly or temporary associate. – If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in medical and/or dental coverage after your initial enrollment period. • You are eligible to enroll in the Elite plan for **medical** and/or **dental coverage** and the **AD&D plan**. See the respective chapters in this Summary Plan Description for more information. • You are enrolled automatically in **company-paid life insurance** on the first day of the pay period in which your transition occurs. • You are eligible to enroll in **optional associate life insurance** and/or **optional associate life insurance**: – If you enroll within 60 days from the first day of the pay period in which your transition occurs and you enroll for the guaranteed issue amount, coverage is effective on the date you enroll. – If you enroll for more than the guaranteed issue amount, your coverage is subject to Prudential's approval. You will be required to complete Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam at your own expense. If approved, your coverage is effective on the date Prudential approves your coverage. – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in optional associate and dependent life insurance after your initial enrollment period. • You are eligible to enroll in the **long-term disability (LTD) plan** as follows: – If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in the long-term disability plan after your initial enrollment period. *Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: • If you enroll online within 60 days from the first day of the pay period in which your transition occurs, coverage is effective the date you enroll. • If you enroll by completing the enrollment form within 60 days from the first day of the pay period in which your transition occurs, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you complete the enrollment form. If you choose for coverage to be effective on the first day of the pay period in which your transition occurs, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date.

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO A FULL-TIME HOURLY POSITION (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
You have been continuously employed for more than 52 weeks and were not eligible for medical and dental coverage under the Plan as a part-time hourly associate immediately prior to your transition	• You are eligible to enroll in **medical** and/or **dental coverage**. See **The medical plan** and **The dental plan** chapters for information. – If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the Full-time hourly associates chart in the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in medical or dental coverage after your initial enrollment period. • You are eligible to enroll in the **AD&D plan**. See the **Accidental death and dismemberment (AD&D) insurance** chapter in this Summary Plan Description for more information. • You are enrolled automatically in **company-paid life insurance** on the first day of the pay period in which your transition occurs. • You are eligible to enroll in **optional associate life insurance** and/or **optional associate life insurance**: – If you enroll within 60 days from the first day of the pay period in which your transition occurs and you enroll for the guaranteed issue amount, coverage is effective on the date you enroll. – If you enroll for more than the guaranteed issue amount, your coverage is subject to Prudential's approval. You will be required to complete Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam at your own expense. If approved, your coverage is effective on the date Prudential approves your coverage. – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in optional associate and dependent life insurance after your initial enrollment period. • You are eligible to enroll in the **long-term disability (LTD) plan** as follows: – If you enroll within 60 days from the first day of the pay period in which your transition occurs and you have been employed for more than 52 weeks as of that date, your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in the long-term disability plan after your initial enrollment period.
	*Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: • If you enroll online within 60 days from the first day of the pay period in which your transition occurs, coverage is effective the date you enroll. • If you enroll by completing the enrollment form within 60 days from the first day of the pay period in which your transition occurs, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you complete the enrollment form. If you choose for coverage to be effective on the first day of the pay period in which your transition occurs, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date.

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO A FULL-TIME HOURLY POSITION (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
You have been continuously employed for more than 90 days but less than 52 weeks	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • You are eligible to enroll in **medical**, **dental**, and **AD&D**. See the respective chapters in this Summary Plan Description for more information. – If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in medical, dental, or AD&D insurance after your initial enrollment period. • You are enrolled automatically in **company-paid life insurance** on the first day of the pay period in which your transition occurs. • You are eligible to enroll in **optional associate life insurance** and/or **optional associate life insurance**: – If you enroll within 60 days from the first day of the pay period in which your transition occurs and you enroll for the guaranteed issue amount, coverage is effective on the date you enroll. – If you enroll for more than the guaranteed issue amount, coverage for you and your spouse/partner is subject to Prudential's approval. You will be required to complete Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam at your own expense. If approved, your coverage is effective on the date Prudential approves your coverage. – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in optional associate and dependent life insurance after your initial enrollment period. • You are eligible to enroll in the **long-term disability (LTD) plan** as follows: – If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the later of 1) the 12-month anniversary of your date of hire or 2) the date you enroll. – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in the long-term disability plan after your initial enrollment period. *Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: • If you enroll online within 60 days from the first day of the pay period in which your transition occurs, coverage is effective the date you enroll. • If you enroll by completing the enrollment form within 60 days from the first day of the pay period in which your transition occurs, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you complete the enrollment form. If you choose for coverage to be effective on the first day of the pay period in which your transition occurs, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date.

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO A FULL-TIME HOURLY POSITION (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
You have been continuously employed for less than 90 days	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • You are eligible to enroll in **medical**, **dental**, and **AD&D insurance**. See the respective chapters in this Summary Plan Description for more information. – If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in medical, dental, or AD&D insurance after your initial enrollment period. • You are enrolled automatically in **company-paid life insurance** on the first day of the pay period in which your transition occurs. • You are eligible to enroll in **optional associate life insurance** and/or **optional associate life insurance**: – If you enroll within 60 days from the first day of the pay period in which your transition occurs and you enroll for the guaranteed issue amount, coverage is effective on the later of 1) the first day of the calendar month during which your 89th day of continuous employment falls or 2) the date you enroll. – If you enroll for more than the guaranteed issue amount, coverage for you and your spouse/partner is subject to Prudential's approval. You will be required to complete Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam at your own expense. If approved, your coverage is effective on the later of 1) the first day of the calendar month during which your 89th day of continuous employment falls or 2) the date Prudential approves your coverage. – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in optional associate and dependent life insurance after your initial enrollment period. • You are eligible to enroll in the **long-term disability (LTD) plan** as follows: – If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the 12-month anniversary of your date of hire. – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in the long-term disability plan after your initial enrollment period. *Your coverage is effective as follows: • If you enroll online or by completing the enrollment form within 60 days from the first day of the pay period in which your transition occurs, and before the first day of the month during which your 89th day of continuous full-time employment falls, your coverage is effective the first day of the month during which your 89th day of continuous full-time employment falls. • If you enroll online within 60 days from the first day of the pay period in which your transition occurs, and after the first day of the month during which your 89th day of continuous full-time employment falls, your coverage is effective on the date you enroll. • If you enroll by completing the enrollment form within 60 days from the first day of the pay period in which your transition occurs and after the first day of the month during which your 89th day of continuous full-time employment falls, you may choose for coverage to be effective on the first day of the month during which your 89th day of continuous full-time employment falls. In that case, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date.

PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO MANAGEMENT	
Your status at transition	**Coverage effective dates and details**
You have been continuously employed for more than 52 weeks and were eligible for medical and dental coverage under the Plan as a part-time hourly associate immediately prior to your transition	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • If you are currently enrolled in **medical** and/or **dental insurance**, your coverage will be changed from the Premier plan to the Elite plan and you can increase your coverage type to associate + spouse/partner, associate + child(ren), or associate + family as a result of your change in job classification. If you are not currently enrolled in medical and/or dental insurance, you may enroll in the Elite plan but only in associate + spouse/partner, associate + child, or associate + family coverage as a result of your change in job classification, until the next Annual Enrollment or until you have a valid status change event. You may not select associate-only coverage as a result of your change in job classification, as you were already eligible for that coverage type as a part-time hourly or temporary associate. – If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Management associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in medical and/or dental coverage after your initial enrollment period. • You are eligible to enroll in the **AD&D plan**. See the **Accidental death and dismemberment (AD&D) insurance** chapter in this Summary Plan Description for more information. • You are enrolled automatically in **company-paid life insurance** on the first day of the pay period in which your transition occurs. • You are eligible to enroll in **optional associate life insurance** and/or **optional associate life insurance**: – If you enroll within 60 days from the first day of the pay period in which your transition occurs and you enroll for the guaranteed issue amount, coverage is effective on the date you enroll. – If you enroll for more than the guaranteed issue amount, your coverage is subject to Prudential's approval. You will be required to complete Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam at your own expense. If approved, your coverage is effective on the date Prudential approves your coverage. – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Management associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in optional associate and dependent life insurance after your initial enrollment period. • You are eligible to enroll in the **long-term disability (LTD) plan** as follows: – If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Management associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in the long-term disability plan after your initial enrollment period. *Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: • If you enroll online within 60 days from the first day of the pay period in which your transition occurs, coverage is effective the date you enroll. • If you enroll by completing the enrollment form within 60 days from the first day of the pay period in which your transition occurs, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you complete the enrollment form. If you choose for coverage to be effective on the first day of the pay period in which your transition occurs, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date.

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO MANAGEMENT (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
You have been continuously employed for more than 52 weeks and were not eligible for medical and dental coverage under the Plan as a part-time hourly associate immediately prior to your transition	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • You are eligible to enroll in the Elite plan for **medical** and/or **dental coverage**. See **The medical plan** and **The dental plan** chapters for information. – If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Management associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in medical or dental coverage after your initial enrollment period. • You are eligible to enroll in the **AD&D** plan. See the **Accidental death and dismemberment (AD&D) insurance** chapter in this Summary Plan Description for more information. • You are enrolled automatically in **company-paid life insurance** on the first day of the pay period in which your transition occurs. • You are eligible to enroll in **optional associate life insurance** and/or **optional associate life insurance**: – If you enroll within 60 days from the first day of the pay period in which your transition occurs and you enroll for the guaranteed issue amount, coverage is effective on the date you enroll. – If you enroll for more than the guaranteed issue amount, your coverage is subject to Prudential's approval. You will be required to complete Proof of Good Health for yourself and/or your spouse/partner and may be required to undergo a medical exam at your own expense. If approved, your coverage is effective on the date Prudential approves your coverage. – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Management associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in optional associate and dependent life insurance after your initial enrollment period. • You are eligible to enroll in the **long-term disability (LTD) plan** as follows: – If you enroll within 60 days from the first day of the pay period in which your transition occurs and you have been employed for more than 52 weeks as of that date, your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Management associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in the long-term disability plan after your initial enrollment period. *Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: • If you enroll online within 60 days from the first day of the pay period in which your transition occurs, coverage is effective the date you enroll. • If you enroll by completing the enrollment form within 60 days from the first day of the pay period in which your transition occurs, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you complete the enrollment form. If you choose for coverage to be effective on the first day of the pay period in which your transition occurs, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date.

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PART-TIME HOURLY OR TEMPORARY ASSOCIATES TRANSFERRING TO MANAGEMENT (CONTINUED)	
Your status at transition	**Coverage effective dates and details**
You have been continuously employed for less than 52 weeks	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • You are eligible to enroll in the Elite plan for **medical** and/or **dental coverage**. See **The medical plan** and **The dental plan** chapters for information. – If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Management associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in medical or dental coverage after your initial enrollment period. • You are eligible to enroll in the **AD&D** plan. See the **Accidental death and dismemberment (AD&D) insurance** chapter in this Summary Plan Description for more information. • You are enrolled automatically in **company-paid life insurance** on the first day of the pay period in which your transition occurs. • You are eligible to enroll in **optional associate life insurance** and/or **optional associate life insurance**: – If you enroll within 60 days from the first day of the pay period in which your transition occurs and you enroll for the guaranteed issue amount, coverage is effective on the date you enroll. – If you enroll for more than the guaranteed issue amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to complete Proof of Good Health for you and/or your spouse/partner and may be required to undergo a medical exam at your own expense. If approved, your coverage is effective on the date Prudential approves your coverage. – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Management associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in optional associate and dependent life insurance after your initial enrollment period. • You are eligible to enroll in the long-term disability (LTD) plan as follows: – If you enroll within 60 days from the first day of the pay period in which your transition occurs and you have been employed for more than 52 weeks as of that date, your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Management associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in the long-term disability plan after your initial enrollment period.
	*Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: • If you enroll online within 60 days from the first day of the pay period in which your transition occurs, coverage is effective the date you enroll. • If you enroll by completing the enrollment form within 60 days from the first day of the pay period in which your transition occurs, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you complete the enrollment form. If you choose for coverage to be effective on the first day of the pay period in which your transition occurs, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date.

FULL-TIME HOURLY ASSOCIATES TRANSFERRING TO MANAGEMENT	
Your status at transition	**Coverage effective dates and details**
You have been continuously employed for 90 days or more	• The maximum amount of **optional associate life insurance** coverage you can select increases from $200,000 to $1,000,000. – If you increase your coverage amount, 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 at your own expense. If approved, coverage is effective on the date Prudential approves your coverage • Your **long-term disability coverage** will change as follows: – If you elected the **long-term disability (LTD) plan** during your initial enrollment period (when you were a full-time hourly associate) and it is not effective at the time of your transition, your coverage is effective the first day of the pay period in which your transition occurs. – If you did not elect the **long-term disability (LTD) plan** coverage during your initial enrollment period (when you were a full-time hourly associate) see the **Management associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in long-term disability after your initial enrollment period.
You have been continuously employed for less than 90 days	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • You are eligible to enroll in the Elite plan for **medical** and/or **dental coverage**. See **The medical plan** and **The dental plan** chapters for information. – If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* • You are eligible to enroll in the **AD&D** plan. See the **Accidental death and dismemberment (AD&D) insurance** chapter in this Summary Plan Description for more information. • You are enrolled automatically in **company-paid life insurance** on the first day of the pay period in which your transition occurs. • You are eligible to enroll in **optional associate life insurance** and/or **optional associate life insurance**: – If you enroll within 60 days from the first day of the pay period in which your transition occurs and you enroll for the guaranteed issue amount, coverage is effective on your enrollment date. – If you enroll for more than the guaranteed issue amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to complete Proof of Good Health for you and/or your spouse/partner and may be required to undergo a medical exam at your own expense. If approved, your coverage is effective on the date Prudential approves your coverage. – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Management associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in optional associate and dependent life insurance after your initial enrollment period. • You are eligible to enroll in the **long-term eligibility ("LTD") plan**, as follows: – If you enroll within 60 days from the first day of the pay period in which your transition occurs your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Management associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in long-term disability after your initial enrollment period.
	*Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: • If you enroll online within 60 days from the first day of the pay period in which your transition occurs, coverage is effective the date you enroll. • If you enroll by completing the enrollment form within 60 days from the first day of the pay period in which your transition occur, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you complete the enrollment form. If you choose for coverage to be effective on the first day of the pay period in which your transition occurs, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date.

MANAGEMENT ASSOCIATES TRANSFERRING TO FULL-TIME HOURLY	
Your status at transition	**Coverage effective dates and details**
Within 60 days of your date of hire and before you have enrolled for benefits	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • You are eligible to enroll in **medical**, **dental**, and **AD&D insurance**. See the respective chapters in this Summary Plan Description for more information. • If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the first day of the pay period in which your transition occurs or the date you enroll.* • You are eligible to enroll in **optional associate life insurance** and **optional dependent life insurance**: – If you enroll within 60 days from the first day of the pay period in which your transition occurs and you enroll for the guaranteed issue amount, coverage is effective on your enrollment date. – If you enroll for more than the guaranteed issue amount, coverage for you and/or your spouse/partner is subject to Prudential's approval. You will be required to complete Proof of Good Health for you and/or your spouse/partner and may be required to undergo a medical exam at your own expense. If approved, your coverage is effective on the date Prudential approves your coverage. – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in optional associate and dependent life insurance after your initial enrollment period. • You are eligible to enroll in **long-term disability plan** coverage as follows: – If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the first day of the pay period in which your transition occurs. – If you do not enroll within 60 days from the first day of the pay period in which your transition occurs, see the **Full-time hourly associates** chart in the **Enrollment and effective dates by job classification** section earlier in this chapter for rules that apply if you enroll in long-term disability after your initial enrollment period.
	*Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: • If you enroll online within 60 days from the first day of the pay period in which your transition occurs, coverage is effective the date you enroll. • If you enroll by completing the enrollment form within 60 days from the first day of the pay period in which your transition occurs, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you complete the enrollment form. If you choose for coverage to be effective on the first day of the pay period in which your transition occurs, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date.
Within 60 days of your date of hire and after you have enrolled for benefits	**You have 60 days to enroll from the date your transition in status occurs.** • **Optional associate life insurance** coverage amounts selected over $200,000 are reduced to $200,000.
More than 60 days after your date of hire	**If you are currently enrolled for benefits, you have 60 days to make a new enrollment from the date your transition occurs.** • **Optional associate life insurance** coverage amounts selected over $200,000 are reduced to $200,000.

FULL-TIME HOURLY ASSOCIATES TRANSFERRING TO PART-TIME HOURLY OR TEMPORARY	
Your status at transition	**Coverage effective dates and details**
You have met your eligibility waiting period and were eligible for coverage under the Plan immediately prior to your transition	• If you are enrolled in **medical** and/or **dental** under the Elite plan, your coverage will automatically be changed to the Premium plan and adjusted to associate-only coverage effective the first day of the pay period after your transition occurs. Associate + spouse/partner, associate + child(ren), and associate + family coverage are not available to part-time or temporary associates. • All other coverage (**life, AD&D,** and **long-term disability**) will be canceled effective the day prior to the first day of the pay period after your transition occurs. You may be able to convert your and your dependent's life insurance to individual policies.
You have NOT met your eligibility waiting period	**You have 60 days to enroll from the first day of the pay period in which your transition occurs.** • You are eligible to enroll in **medical** and/or **dental** coverage. You are eligible to enroll only in associate-only coverage. See the respective chapters in this Summary Plan Description for more information. – If you enroll within 60 days from the first day of the pay period in which your transition occurs but before the first day of the calendar month during which your 89th day of continuous employment falls, your coverage is effective on the first day of the calendar month during which your 89th day of continuous employment falls. – If you enroll within 60 days from the first day of the pay period in which your transition occurs but after the first day of the month during which your 89th day of continuous employment falls, your coverage is effective on the first day of the calendar month during which your 89th day of continuous full-time employment falls or the date you enroll.* • If you enrolled your spouse/partner in **optional dependent life insurance**, coverage for your spouse/partner is canceled effective the day prior to the first day of the pay period in which your transition occurs. • If you elected **long-term disability plan** coverage, your enrollment is canceled effective the day prior to the first day of the pay period in which your transition occurs.
	*Your coverage is effective as follows: • If you enroll online or by completing the enrollment form within 60 days from the first day of the pay period in which your transition occurs, and before the first day of the month during which your 89th day of continuous full-time employment falls, your coverage is effective the first day of the month during which your 89th day of continuous employment falls. • If you enroll online within 60 days from the first day of the pay period in which your transition occurs, and after the first day of the month during which your 89th day of continuous employment falls, your coverage is effective on the date you enroll. • If you enroll by completing the enrollment form within 60 days from the first day of the pay period in which your transition occurs and after the first day of the month during which your 89th day of continuous full-time employment falls, you may choose for coverage to be effective on the first day of the month during which your 89th day of continuous employment falls. In that case, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date.

MANAGEMENT ASSOCIATES TRANSFERRING TO PART-TIME HOURLY OR TEMPORARY	
Your status at transition	**Coverage effective dates and details**
You are within 60 days of your date of hire but have not enrolled for benefits	**You have 60 days to enroll from the date your transition in status occurs.** • You are eligible to enroll in **medical** and/or **dental** coverage. You are eligible to enroll only in associate-only coverage. See the respective chapters in this Summary Plan Description for more information. – If you enroll within 60 days from the first day of the pay period in which your transition occurs, your coverage is effective on the first day of the pay period in which you enroll or the date you enroll.* • Your enrollment in **company-paid life insurance** is canceled effective the day prior to first day of the pay period in which your transition occurs. You may be able to convert your company-paid life insurance to an individual policy. *Your coverage is effective either the first day of the pay period in which your transition occurs or the date of your enrollment, depending on your choice and on the manner in which you enroll: • If you enroll online within 60 days from the first day of the pay period in which your transition occurs, coverage is effective the date you enroll. • If you enroll by completing the enrollment form within 60 days from the first day of the pay period in which your transition occurs, you may choose for coverage to be effective either the first day of the pay period in which your transition occurs or the date you complete the enrollment form. If you choose for coverage to be effective on the first day of the pay period in which your transition occurs, premiums are deducted from your paycheck on an after-tax basis retroactively to your effective date.
You are within 60 days of your date of hire and you have enrolled for benefits	**You have 60 days to make a new enrollment from the date your transition in status occurs.** • If you are enrolled in **medical** and/or **dental** coverage, your coverage will be adjusted to associate-only coverage effective the first day of the pay period after your transition occurs. Associate + spouse/partner, associate + child(ren), and associate + family coverage are not available to part-time or temporary associates. If you are enrolled for coverage under the Elite plan, your coverage will automatically be changed to the Premium plan. You can find details about benefits for part-time hourly and temporary associates in the **Enrollment and effective dates by job classification** charts earlier in this chapter. • Your enrollment in **company-paid life insurance** coverage is canceled effective the day prior to the first day of the pay period after your transition occurs. You may be able to convert your company-paid life insurance to an individual policy • If you enrolled in **optional associate life**, **optional dependent life**, or **AD&D insurance**, your coverage is canceled effective the day prior to the first day of the pay period in which your transition occurs. You may be able to convert your optional associate life and optional dependent life insurance into individual policies. • If you elected **long-term disability plan** coverage, your enrollment is canceled effective the day prior to the first day of the pay period in which your transition occurs.
More than 60 days have passed since your date of hire	**If you are currently enrolled for benefits, you have 60 days to make a new enrollment from the date your transition occurs.** • If you are enrolled in **medical** and/or **dental** coverage, your coverage will be adjusted to associate-only coverage effective the first day of the pay period after your transition occurs. Associate + spouse/partner, associate + child(ren), and associate + family coverage are not available to part-time or temporary associates. If you are enrolled for coverage under the Elite plan, your coverage will automatically be changed to the Premium plan. You can find details about benefits for part-time hourly and temporary associates in the **Enrollment and effective dates by job classification** charts earlier in this chapter. • Your enrollment in **company-paid life insurance** coverage is canceled effective the day prior to the first day of the pay period after your transition occurs. You may be able to convert your company-paid life insurance to an individual policy. • If you enrolled in **optional associate life**, **optional dependent life**, or **AD&D insurance**, your coverage is canceled effective the day prior to the first day of the pay period in which your transition occurs. You may be able to convert your optional associate life and optional dependent life insurance into individual policies. • If you elected **long-term disability plan** coverage, your enrollment is canceled effective the day prior to the first day of the pay period in which your transition occurs.

You may not drop medical and/or dental coverage for yourself during the Plan year. You may change elections during any future Annual Enrollment or as the result of a status change event.

Qualified Medical Child Support Orders (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 and/or dental benefits to any eligible dependent of a Plan participant required by a court order meeting the qualifications of a QMCSO.

You can obtain the written procedures for determining whether an order meets the federal requirements, free of charge, by contacting your HR Representative or PR Home Office Benefits Division at **787-653-1065**.

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 and/or dental plan and did not elect coverage before the order was received, you will be enrolled in the 2022 default Premium Plan (Elite Plan in case of a management associate) with associate + child(ren) coverage at the tobacco rate, unless the QMCSO specifies otherwise.

If you were enrolled for coverage before the order was received, your child will be added under your existing coverage. You have 60 days to call PR Home Office Benefits Division 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 you satisfying your initial waiting period for medical coverage, the order will be put into effect when your initial waiting period is satisfied.
- 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 and you lose eligibility, and then subsequently regain eligibility, 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 then subsequently regain eligibility, the Plan requires a new QMCSO before coverage for your dependent can take effect.
- 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 PR Home Office Benefits Division at **787-653-1065**.

DROPPING OR CHANGING QMCSO COVERAGE

You may drop the court-ordered QMCSO coverage if the following applies:

- The QMCSO is terminated by a court or administrative agency order — you must request your change within 60 days.
- The QMCSO is rescinded by a court or administrative agency order.
- A child who is the subject of the court order reaches the age identified in the state issuing the court order for termination of coverage. Contact your state child support enforcement agency for details.

If the QMCSO is terminated or rescinded by court or administrative agency order, the court-ordered coverage will end on the date specified in the order or the first day of the pay period in which the Plan receives the order. 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 a QMCSO terminates, you may drop medical and/or dental coverage for the children named in the QMCSO. You may not drop your own coverage or coverage for any dependent voluntarily added after the QMCSO became effective unless there is a change in status for you or your child, or during Annual Enrollment.

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 premiums were paid, if you fail to pay your premiums within 30 days of the date your premium 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, or
- Upon an act of fraud or a misstatement of a material fact.

If you voluntarily drop coverage after a status change event or at Annual Enrollment, coverage ends as follows:

- **After a status change event:** coverage ends on the effective date of the event. See **Status change events** in this chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

Premium deductions are withheld from your final paycheck since those deductions pay for coverage during that pay period.

The medical plan

The medical plan

ASSOCIATES' MEDICAL PLAN RESOURCES			
Find What You Need	**Online**	**By Phone**	**Other Resources**
Third-party administrator: medical benefits MCS Life	Go to **mcs.com.pr**	Customer service: **855-830-9887** or **787-945-1348** (TTY/TDD **866-627-8182**)	**MCS Life** **Customer Service Division** **P.O. Box 3547** **San Juan, Puerto Rico 00919-3547**
Get a network directory		Call the provider locator telephone number on your medical plan ID card	
Get the cost for medical coverage	Go to **One.Walmart.com**	Call PR Home Office Benefits Division at **787-653-1065**	
Employee Assistance Plan (EAP)		Call MCS Life at **855-830-9887** or **787-945-1348** (TTY/TDD **866-627-8182**)	
Third-party administrator: pharmacy benefits			
MC-Rx	**mc-21.com**	**855-252-2292**	**MC-Rx** **Customer Service Department** **Call Box 4908** **Caguas, Puerto Rico 00908**
Request a paper copy of this 2022 *Associate Benefits Book*		Call Cenveo at **888-989-7828**	

What you need to know about medical benefits

- Medical coverage is offered through MCS Life.
- Pharmacy coverage is offered through MC-Rx and included when you elect medical coverage.
- Management associates have the "Elite" plan.
- Full-time associates choose between the "Elite" and the "Premium" plans.
- Part-time and temporary associates have the "Premium" plan.

The Associates' Medical Plan (AMP)

The Associates' Medical Plan is administered in Puerto Rico by a third-party administrator (TPA), MCS Life, which makes medical claim determinations based on the Plan's medical policy, handles your calls and processes claims. The TPA also provides a network of providers who charge discounted rates to Plan participants.

Pharmacy coverage is administered by MC-Rx and included when you elect medical coverage.

The TPA does not insure any medical benefits under the AMP. Please refer to the **Associates' medical plan resources** chart at the beginning of this chapter for the name and address of the TPA. You may also see your medical plan ID card to determine the address and/or Customer Service number to call for information.

The medical benefit is described in a separate booklet you will receive from the TPA. That booklet, the Certificate of Benefits, along with the additional provisions set out here and in the **Claims and appeals** and **Legal information** chapters, the WRAP Document, and the **Eligibility and enrollment** chapter, constitute the Plan Document and the Summary Plan Description for the medical benefit.

For detailed information on what is covered, see the Certificate of Benefits provided by MCS Life.

What is covered by the AMP

The AMP pays benefits for covered expenses, which are charges for procedures, services, equipment and supplies that are defined under the Plan as:

- Not in excess of the maximum allowable charge, which is determined by the TPA
- Medically necessary (as defined below), and
- Not in excess of Plan limits.

MEDICALLY NECESSARY

Medically necessary generally means the AMP has determined the procedure, service, equipment or supply to be:

- Appropriate for the symptoms, diagnosis or treatment of a medical condition
- Provided for the diagnosis or direct care and treatment of the medical condition
- Within the standards of good medical practice and within the organized medical community
- Not primarily for the convenience of the patient or the patient's doctor or other provider, and
- The most appropriate (as defined in the next column) procedure, service, equipment or supply that can be safely provided.

"Most appropriate" means:

- There is valid scientific evidence (e.g., through MCG, formerly Milliman Care Guidelines) 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 to be ineffective or are otherwise unsuitable, and
- For hospital stays, acute care as an inpatient is necessary due to the kind of services the Plan 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.

Filing a medical claim

If you use a network provider, the provider will generally file the claim for you. If you see a non-network provider, you may need to file a claim. If you need to file a claim, the claim should include the following information:

- Patient's name
- Provider's name, address and tax identification number
- Associate's insurance ID (see your medical plan ID card)
- Date of service
- Amount of charges
- Medical procedure codes (these should be found on the bill), and
- Diagnosis.

Please see your medical plan ID card or the inside back cover of this book for the correct address to mail your claim. Failure to mail your claim to the correct address may result in the denial of your claim.

In addition, you may complete a claim form at any MCS Life office.

Failure by you or the provider to file a claim within 12 months from the date of service will result in denial of your claim.

There are laws that govern the review of your claims. Claims will be determined under the same time frames and requirements set out in the **Claims and appeals** chapter. See the **Claims and appeals** chapter for details.

When you incur medical expenses and a claim is filed, benefits will be paid directly to the provider for network services. Payment to the provider discharges the Plan's obligation to you for the benefit.

If you use a non-network provider, payment may be made directly to you, upon your showing proof of payment in full to the provider. This payment will be the lesser of the full cost of the service provided and the fee that would be payable to a network provider for the same service, after applying the appropriate copayment or coinsurance. Payment may also be made to a non-network provider that accepts assignments, if you expressly authorize such payment. 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, except as required by state Medicaid law or required under a Qualified Medical Child Support Order. Please note that any direct payment to a provider is undertaken by the Plan solely for your convenience.

You have the right to appeal a claim denial. See the **Claims and appeals** chapter for details.

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 will 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 ACAA 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, and
- 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 those benefits payable under "other plans" and may limit the benefits it pays.

You must follow the primary plan's terms in order 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.

If you reside in Puerto Rico, where automobile ACAA 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.

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%	80%
The AMP's total benefit is:	0%	20%	80%

DETERMINING WHICH PLAN IS THE PRIMARY PLAN

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 ACAA coverage and any personal injury protection and medical payment coverage available to you. If the AMP pays benefits as a result of injuries or illnesses you sustained 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. Please 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, the 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 also 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 OR ENROLLED IN MEDICARE

If you are enrolled in Medicare Part D, you are not eligible to enroll in the AMP. If your dependent is enrolled in Medicare Part D 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 the 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 currently employed by the company and are age 65 or older
- You are currently employed by the company 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 the company, or
- 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 the company.

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, or
- You or your dependent is an active participant or COBRA participant entitled to 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 the company, 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.

STATE-MANDATED AUTOMOBILE, PERSONAL INJURY OR MEDICAL PAYMENT COVERAGE

If you reside in Puerto Rico, where automobile ACAA 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.

Break in coverage

There may be occasions in which you must make special arrangements to pay your medical premiums 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 make your premium 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 the impact a break in coverage may have, and on how to make personal payments to continue your coverage, see the **Eligibility and enrollment** chapter and refer to the section titled **When special arrangements are necessary to maintain coverage**.

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 either before the leave begins or during the leave. For information about making payments while on a leave of absence, see the **Eligibility and enrollment** chapter.

When 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 and enrollment** chapter). You and/or your enrolled family members 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 required premiums, coverage ends on the cancellation date. See **Paying for your benefits** in the **Eligibility and enrollment** chapter for information. There is no right to continue coverage under COBRA when coverage is canceled due to non-payment of required contributions.

If you voluntarily drop coverage after a status change event or at Annual Enrollment, coverage ends as follows:

- **After a status change event:** coverage ends on the effective date of the event. See **Status change events** in the **Eligibility and enrollment** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave the company and are rehired

If you terminate employment and return to work for the company within 13 weeks, you will automatically be reenrolled in your previous coverage (or the most similar plans offered under the AMP). If you return after 30 days but within 13 weeks, you will have 60 days after resuming work to drop the coverage in which you were automatically reenrolled.

If you return and reenroll after 13 weeks, treated as a new associate and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you drop coverage and reenroll

If you drop coverage and reenroll within 30 days, you will automatically be reenrolled for the same coverage you had prior to leaving the company (or the most similar plans offered under the AMP).

If you drop coverage and reenroll after 30 days, you will be treated as a new associate and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

IF A DEPENDENT IS DROPPED FROM COVERAGE AND REENROLLED

If your dependent child is dropped from coverage and then determined to be eligible for coverage within 30 days, the dependent will automatically be reenrolled in the same coverage you elect for yourself.

If your dependent regains eligibility and is reenrolled after 30 days, they will be treated as a newly eligible dependent. The associate may enroll them for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

Other information about the medical plan

THE 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 physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the Plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. For additional information, please call **855-830-9887** or **787-945-1348**.

The dental plan

The dental plan

Your teeth are an important part of your overall health. The dental plan provides coverage for a wide range of dental services, to help you protect one of your most valuable personal and professional assets — your smile.

DENTAL PLAN RESOURCES			
Find What You Need	**Online**	**Online**	**Other Resources**
Get a listing of network dentists	**deltadentalpr.com**	Customer service: **855-359-6409**	**Delta Dental of Puerto Rico** **P.O. Box 9020992** **San Juan, Puerto Rico 00902-0992**
Get answers to questions about your dental claims and to contact Delta Dental Customer Service	Go to **deltadentalpr.com** or see your HR representative	Call the provider locator telephone number on your medical plan ID card: **855-359-6409**	
Get a claim form if you use a nonparticipating dentist		Call the provider locator telephone number on your medical plan ID card: **855-359-6409**	Contact your HR representative

What you need to know about the dental plan

- Dental coverage is offered through Delta Dental of Puerto Rico.
- Management associates have the “Elite” plan.
- Full-time associates choose between the “Elite” or the “Premium” plans.
- Part-time and temporary associates have the “Premium” plan.

Administration of the dental plan

The dental plan is administered in Puerto Rico by a third-party administrator (TPA), Delta Dental of Puerto Rico, which makes dental claim determinations based on the Plan's dental policy, handles your calls and processes claims. The TPA also provides a network of providers who charge discounted rates to Plan participants.

The TPA does not insure any dental benefits under the Plan. Please refer to the **Dental plan resources** chart at the beginning of this chapter for the name and address of the TPA.

The dental benefit is described in a separate booklet you will receive from the TPA. That booklet, the Certificate of Benefits, along with the additional provisions set out here and in the **Claims and appeals** and **Legal information** chapters, the WRAP Document and the **Eligibility and enrollment** chapter, constitute the Plan Document and the Summary Plan Description for the dental benefit.

For detailed information on what is covered see the Certificate of Benefits provided by Delta Dental.

As a full-time hourly associate, you are eligible to enroll in the Elite or Premium dental plan. As a part-time hourly or temporary associate, you are eligible to enroll in the Premium dental plan. As a management associate you are eligible to enroll in the Elite dental plan. For a detailed information on covered benefits and maximum coverage per member please refer to the 2022 Certificate of Benefits.

When you enroll in the dental plan, you also select the eligible family members you wish to cover:

- Associate-only
- Associate + spouse/partner
- Associate + child(ren), or
- Associate + family.

For information on dependent eligibility and when dependents can be enrolled, see the **Eligibility and enrollment** chapter.

Filing a dental claim

If you use a network dentist, your dentist will often 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 network dentist. If you use a non-network dentist, the payment will be made to you.

You or your dental provider must file a claim within 12 months or your claim will be denied. Please mail your claim to:

Delta Dental of Puerto Rico
P.O. Box 9020992
San Juan, Puerto Rico 00902-0992

Failure to mail your claim to the correct address may result in the denial of your claim.

FILING A DENTAL PRESCRIPTION CLAIM

If you do not have medical coverage with the Plan, any dental prescription will not be covered by the Plan. If you have medical coverage with the Plan, your dental prescriptions would be covered as any medical prescription.

IF YOU HAVE COVERAGE UNDER MORE THAN ONE DENTAL PLAN

If you or a family member 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.

Break in coverage

There may be occasions in which you must make special arrangements to pay your medical premiums 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 make your premium 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 the impact a break in coverage may have, and on how to make personal payments to continue your coverage, see the **Eligibility and enrollment** chapter and refer to the section titled **When special arrangements are necessary to maintain coverage**.

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 either before the leave begins or during the leave. For information about making payments while on a leave of absence, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

When 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 and enrollment** chapter). You and/or your enrolled family members 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 required premiums, coverage ends on the cancellation date. See **Paying for your benefits** in the **Eligibility and enrollment** chapter for information. There is no right to continue coverage under COBRA when coverage is canceled due to non-payment of required contributions.

If you voluntarily drop coverage after a status change event or at Annual Enrollment, coverage ends as follows:

- **After a status change event:** coverage ends on the effective date of the event. See **Status change events** in the **Eligibility and enrollment** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be reenrolled for the same coverage you had prior to leaving the company (or the most similar coverage offered under the Plan). If your break is greater than 30 days but less than 13 weeks, you will have 60 days after resuming work to drop the coverage in which you were automatically enrolled.

If you return to work after 30 days, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you return to work after 13 weeks, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you drop coverage and reenroll

If you drop coverage and reenroll within 30 days, you will automatically be reenrolled for the same coverage you had prior to leaving the company (or the most similar plans offered under the Plan).

If you drop coverage and re-enroll after 30 days, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

IF A DEPENDENT IS DROPPED FROM COVERAGE AND REENROLLED

If your dependent child is dropped from coverage and then determined to be eligible for coverage within 30 days, the dependent will automatically be reenrolled in the same coverage you elect for yourself.

If your dependent regains eligibility and is reenrolled after 30 days, they will be treated as a newly eligible dependent. The associate may enroll them for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

COBRA

COBRA

If you and/or your covered dependents lose medical or dental 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.

COBRA RESOURCES	
Find What You Need	**Other Resources**
Contact PR Home Office Benefits Division within 60 calendar days of a divorce, termination of a relationship with a partner (as defined in this chapter) or ineligibility of dependent(s)	Call **787-653-1065**
Contact Alight Solutions, the third-party administrator for COBRA	Call **877-660-6630**
Pay your COBRA premium	Call **877-660-6630**

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 or dental coverage. Qualifying events are described in this chapter. The Plan extends COBRA continuation coverage to you and all your covered dependents.
- For medical and dental 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 Resources for Living benefits automatically continue 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 Resources for Living benefits.
- The Plan contracts with Alight Solutions, 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 **877-660-6630**.

COBRA continuation coverage

If medical or dental 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 the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

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 or dental coverage under the Plan on the day before the date of your qualifying event date to be eligible for COBRA coverage, unless coverage ended during a leave of absence, as described below. You are able to continue the same medical or dental coverage you had on the day prior to your qualifying event. You may choose a lesser tier level and/or select an alternate medical plan, if applicable. COBRA continuation coverage applies to medical and dental coverage; it does not apply to other benefits described in this *Associate Benefits Book*.

The Plan also provides continuation coverage for Resources for Living. See the **Resources for Living** chapter for more information.

IF YOU ARE ON LEAVE OF ABSENCE

Generally, if your leave ends and you do not return to work, you and any eligible dependents enrolled in medical or dental coverage under the Plan during your leave will be offered COBRA, which will run from the date following your employment termination date. You or your eligible dependents must call PR Home Office Benefits Division at **787-653-1065** within 60 calendar days of your employment termination date to make your request for COBRA coverage.

If you and any eligible dependents were enrolled in medical or dental coverage under the Plan on the day before your leave of absence 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. You or your eligible dependents must call Home Office Benefits Division at **787-653-1065** within 60 calendar days of your employment termination date to make your request for COBRA coverage. 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 or dental coverage ends because:

- Your employment with Walmart ends for any reason, or
- You are no longer eligible for medical or dental 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 or dental 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 and enrollment** chapter for the definition of "partner")
- You enroll in Medicare benefits Part D, causing your medical coverage to terminate (you must call Home Office Benefits Division at **787-653-1065** within 60 days of enrolling in Medicare Part D), or
- 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 or dental 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 call PR Home Office Benefits Division at **787-653-1065** within 60 days of enrolling in Medicare Part D)
- Your dependent child no longer meets eligibility requirements (e.g., the end of the month in which a dependent turns age 26), or
- You die.

NOTIFICATION

In general, Walmart will notify Alight Solutions, 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 PR Home Office Benefits Division if you enroll in Medicare Part D. Walmart will generally make this notification to the COBRA administrator within 30 days after the qualifying event.

Under the law, you or your eligible dependent is responsible for notifying PR Home Office Benefits Division of your divorce, legal separation, termination of your relationship with a partner, or a child's loss of dependent status. 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 behalf of yourself as well as any eligible dependent affected by the qualifying event. Provide notice of the qualifying event to PR Home Office Benefits Division by calling **787-653-1065**.

Federal law places responsibility upon you or your eligible dependent to notify PR Home Office Benefits Division 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 PR Home Office Benefits Division 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.

The notice must include the following information:

- Name and address of the covered associate
- Address of the covered associate
- Type of qualifying event
- Date of qualifying event
- Name of dependent losing coverage, and
- Address of the dependent losing coverage (if different from the covered associate's address).

If you do not contact PR Home Office Benefits within the 60-day period, you will lose your right to elect COBRA continuation coverage. To protect your family's rights, let PR Home Office Benefits Division know about any changes in addresses of family members. You should keep a copy of any notices you send to PR Home Office Benefits Division or Alight Solutions for your records.

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 will describe your right to continue medical or dental coverage under COBRA. (If you do not receive this notification, please call the COBRA administrator at **877-660-6630**). To receive COBRA continuation coverage, you must elect such coverage through the COBRA administrator within 60 calendar days from the date you lose coverage or the date of the election notice, if later. You can contact the COBRA administrator by calling **877-660-6630**. If you elect COBRA, notify the COBRA administrator of any change of address. If you do not elect COBRA continuation coverage within the 60-day period, you will lose your right to elect COBRA coverage.

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 family members 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 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**.

STATUS CHANGE EVENTS WHILE ON COBRA CONTINUATION COVERAGE

After the COBRA election period, you or your eligible dependent may not change or add to the elected COBRA coverage without a status change event outside Annual Enrollment or a subsequent qualifying event. For information about status change events, see **Status change events** in the **Eligibility and enrollment** chapter. If a status 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 period during the time you are on COBRA.

Unless otherwise provided in the Plan, if you add a spouse or partner or other eligible dependent due to a status change event while on COBRA, each person is subject to any applicable Plan limitations.

In the event of a status change, 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 status change event.

Paying for COBRA coverage

You and/or your eligible dependents are responsible for both the associate portion of the premium and the portion previously paid by the company, 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 payment will be due 45 days after you elect COBRA and must cover the cost of COBRA coverage from the date of the qualifying event through the end of the month before the month in which you make your first payment. (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, 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 will also be due 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 without any break.

You are allowed a 30-day grace period from the premium due date before coverage is canceled. However, if you make your payment later than the first day of the month, 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 will 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. Premium payments are due regardless of your receipt of a payment invoice. If you are paying by mail, attach your payment to the invoice and mail to:

Centro de Servicio Unidad COBRA
P.O. Box 194926
San Juan, Puerto Rico 00919-4926

If your 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.

If you do not want to continue coverage, you may cancel COBRA coverage at any time by ceasing to pay the premiums. No further action is required.

How long COBRA coverage may last

The maximum duration of your COBRA coverage depends on the reason for the COBRA coverage, as shown in the chart below.

MAXIMUM DURATION OF COBRA COVERAGE		
Event	**Associate**	**Dependents**
• Your employment with the company 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 the associate enrolled in Medicare
You enroll in Medicare Part D	Not applicable	36 months from the date the associate enrolled in Medicare Part D
Disability extension is obtained	29 months from the date of the original event	29 months from the date of the original 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 event

IF YOU ARE ENTITLED TO MEDICARE

If you are eligible for Medicare Parts A and/or B and terminate employment with the company (or lose coverage under the Plan), 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 until the next Medicare annual enrollment period to enroll in Medicare Parts A and/or B and may have to pay a higher Medicare premium when you do enroll. The eight-month special enrollment period runs from the date that you are no longer employed by the company (or lose coverage under the Plan, whichever occurs first), even if you elect COBRA continuation coverage (e.g., following termination of employment). For additional information, please 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 eligible dependents can elect COBRA for a period of not more than 36 months from the date you became eligible for Medicare.

If you are entitled to Medicare prior to your COBRA election date, you or your eligible dependents must notify the COBRA administrator at **877-660-6630** of your Medicare status in order to ensure your maximum coverage period is properly calculated.

IF YOU OR AN ELIGIBLE DEPENDENT IS DISABLED

If you're a qualified beneficiary who has COBRA coverage because of termination of employment or reduction in hours, you and each enrolled member of your family may be entitled to an extra 11 months of COBRA coverage if you or other enrolled members of your family 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, and

- 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 in order 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.

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 the company 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 family member is not enrolled in COBRA coverage, the COBRA premium for the covered family members 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 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 or dental coverage (e.g., a dependent turns age 26), or
- 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 COBRA coverage ends

COBRA coverage usually ends after the 18-month, 29-month or 36-month 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:

- The company no longer provides medical or dental coverage to any of its associates
- After the initial 45-day 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 or dental 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), or
- You or your eligible dependent submit 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.

Resources for Living®

Resources for Living®

Resources for Living (RFL) gives you confidential counseling and well-being information. It's available at no cost to you and your family members from your date of hire. Call a professional counselor anytime for help with stress management, family relationships, career issues, and other daily challenges. RFL also has lots of information and help with childcare, eldercare, education, finances, wellness, and more.

RESOURCES		
Find What You Need	**Online**	**Other Resources**
Speak with a counselor or work-life specialist to identify resources and solutions for everyday needs		Call **800-825-3555**
Access articles, tools, and resources across a wide range of topics	Go to **One.Walmart.com** or **rfl.com**: User ID: **Walmart** Password: **Associate**	
Access monthly healthy living tips and webinars on a variety of topics	Go to **One.Walmart.com** or **rfl.com**: User ID: **Walmart** Password: **Associate**	

What you need to know about Resources for Living

- RFL is available 24 hours a day, seven days a week, 365 days a year.
- You and your household members can find counseling, information, and work-life assistance.
- There is no cost to you for RFL benefits. You are automatically enrolled in RFL as of your date of hire.

Using Resources for Living (RFL)

If you are a U.S. associate, you, your household family members, and your benefit-eligible dependents are automatically enrolled in RFL as of your first day of employment. You can call RFL any time at **800-825-3555** or log into **rfl.com** to find tools for:

- Stress management
- Budgeting and saving money
- Legal assistance
- Relationships at home and in the workplace
- Emotional and physical well-being
- Family life and more

RFL provides access to services and support by telephone, televideo, and chat-based counseling, videos, webinars, web-based articles, and through a resource team that can help support your everyday needs and well-being.

RFL counseling services

Whether you need help working through an issue or just someone to talk to, RFL offers you 24/7/365 telephone counseling support for a variety of common questions and stressors. You can call and get help with:

- Managing stress
- Coping with depression, anxiety, or substance misuse
- Building healthy relationships with family, friends, and co-workers
- Balancing the demands of work and home life
- Working through emotionally difficult situations

In addition to unlimited in-the-moment telephone counseling, you and your eligible family members may receive up to 10 televideo counseling sessions per person, per issue, per year, with an RFL licensed therapist, or via app-based chat through Talkspace, at no cost to you. If your situation calls for therapeutic counseling and you elect to use the Talkspace chat-based counseling, the 10 sessions equate to 10 weeks of chat support per person, per issue, per year. Call RFL toll-free at **800-825-3555** for support and to learn more about therapeutic counseling.

RFL legal and financial services

RFL gives you access to legal and financial experts. Whether you're creating a budget or a will, RFL can help you:

- Meet your financial goals and save for the future
- Explore your options related to legal issues
- Create a personal budget
- Make your money go further
- Pay down debt
- Recover from identify theft, and more

You can receive a half-hour consultation for each legal or financial 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.

RFL daily life assistance

You can reach out to RFL for help in meeting the demands of work and home life. Call for help with everyday needs such as:

- Care for your child or an older adult
- Military resources
- Pet care
- Adoption resources
- Home repair services
- Support groups
- Educational options and resources for children and adults
- Accessing tools to support your well-being, including healthy eating, exercise, improved sleep, and stress management

RFL's work-life consultants can help you find options for meeting your needs and research details like cost, services, and availability.

CALLING RFL

Call **800-825-3555** for personalized support at any time. Services are available in English and Spanish (other languages available upon request). Calls are confidential, except as required by law.

RFL ON THE WEB

Visit **rfl.com** for articles, webinars, tools, and resources on a variety of topics to help you live well. To log on to **rfl.com**, enter the following:

User ID: **Walmart**
Password: **Associate**

You can also access **rfl.com** by clicking on the single sign-on link found on the RFL page of **One.Walmart.com**.

When RFL benefits end

If you experience a qualifying event and become eligible for COBRA benefits, your Resources for Living benefits automatically continue 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 Resources for Living benefits.

Filing a claim for RFL benefits

You do not have to file a claim for RFL benefits. You may access the RFL website or contact RFL 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:

People Services
508 SW 8th Street
Bentonville, Arkansas 72716-3500

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.

Company-paid life insurance

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	Go to **One.Walmart.com**	Beneficiary changes cannot be made over the phone
Get more coverage details		Call Prudential at **877-294-7026**
• File a claim • Request an accelerated benefit • Get details about continuing your insurance		Call Prudential at **877-294-7026**

What you need to know about company-paid life insurance

- If you are a full-time hourly or management associate, Walmart provides you with life insurance coverage at no cost to you (for details about eligible job classifications, see the **Enrollment and effective dates by job classification** charts in the **Eligibility and enrollment** chapter). 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 death, 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.

Company-paid life insurance

If you are a full-time hourly or management associate, Walmart provides you with life insurance coverage at no cost to you (for details about eligible job classifications, see the **Enrollment and eligibility dates by job classification** charts in the **Eligibility and enrollment** chapter). No enrollment is necessary.

Your company-paid coverage amount is equal to your annualized rate of pay, including overtime and bonuses, during the one-year period prior to your death, rounded to the nearest $1,000, to a maximum of $50,000.

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 do this by going to **One.Walmart.com**. Note that only beneficiary designations made online are accepted.

You can name anyone you wish. If the beneficiary(ies) you list with Walmart differs from the beneficiary(ies) named in your will, the list that Walmart has prevails. If you have not designated 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** later in this chapter.

The following information is needed for each beneficiary:

- Name
- Current address and phone number
- Relationship to you
- Social Security number
- Date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated 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. 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 on **One.Walmart.com**. Any change in beneficiary must be completed and submitted to Walmart before your death and can be submitted only by you, the covered associate.

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 go to whoever is listed on your beneficiary form with Walmart, regardless of your current relationship with that person, unless state law says otherwise. You can change your beneficiary(ies) at any time on **One.Walmart.com**.

When your company-paid life insurance coverage begins

Company-paid life insurance coverage begins on the date specified in the **Enrollment and effective dates by job classification** charts in the **Eligibility and enrollment** chapter. You must be actively at work for your coverage to become effective. You are considered actively at work if you are on active status and not on a leave of absence. See the **Eligibility and enrollment** chapter for details.

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 amount your beneficiary(ies) would have received upon your death (measured on the date you provide proof of your terminal illness). Payment is made in a lump sum. Upon your death, your beneficiary(ies) receives the greater of (a) 100% of your annual earnings, based on the most recent average salary for the last 26 pay-periods, reduced by the amount of any terminal illness proceeds paid under the option to accelerate payment of death benefits, or

(b) the amount of insurance in effect prior to payment of any terminal illness proceeds, reduced by the amount of any terminal illness proceeds paid under the option to accelerate payment of death benefits.

If you terminate from the company 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 **Continuing your company-paid life insurance after you leave Walmart** 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 claim

The following information must be provided to Prudential regarding the deceased associate:

- Name
- Social Security number
- Date of death, and
- Cause of death (if known).

An original or certified copy of the death certificate is 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 8517
Philadelphia, Pennsylvania 19176

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 **877-294-7026**.

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, a coffin, and transportation of your remains. The benefit is the lesser of the cost to return your remains or $10,000.

When benefits are not paid

Benefits are not paid to any beneficiary(ies) who engaged in an illegal act that resulted in the associate's death. The benefit in this circumstance would go to another eligible designated beneficiary or, if there is no other surviving beneficiary, to a beneficiary in the default list, as specified under **If you do not name a beneficiary** earlier in this chapter.

When coverage ends

Your company-paid life insurance coverage ends:

- At termination of your employment
- On the last day of the pay period when 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), or
- When the benefit is no longer offered by the company.

This policy is term life insurance. It has no cash value.

Continuing your company-paid life insurance after you leave Walmart

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.

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 in the next column.

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 the company 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 your death occurs during the 31-day conversion period, the death benefit will be payable up to the amount that could have been converted.

To request information on portability or conversion, call Prudential at **877-294-7026**.

If you leave the company and are rehired

If you return to work for the company as a full-time hourly or management associate within 13 weeks, you will automatically be reenrolled for coverage.

If you return to work after 13 weeks, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period. See the **Eligibility and enrollment** chapter for details.

Company-paid life insurance

Optional associate life insurance

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	Go to **One.Walmart.com**	Beneficiary changes cannot be made over the phone
Get more details		Call Prudential at **877-294-7026**
• File a claim • Request an accelerated benefit • Get details about continuing your insurance		Call Prudential at **877-294-7026**

What you need to know about optional associate life insurance

- If you are a full-time hourly or management associate, you can enroll in optional associate life insurance when you are eligible, as described in the **Eligibility and enrollment** chapter.
- Depending on the amount of coverage you choose and when you enroll, you may be required to provide Proof of Good Health.
- You can enroll in, change, or drop optional associate life insurance at any time, but if you enroll at any time other than your initial enrollment period, you will have 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.

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.

If you are a full-time hourly or management associate you can enroll in optional associate life insurance when you are eligible, as described in the **Eligibility and enrollment** chapter.

Your coverage choices for optional associate life insurance depend on your job classification, as reflected in the company's payroll system. The coverage amounts you can choose are shown in the chart below.

FULL-TIME HOURLY ASSOCIATES		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 eligibility dates by job classification** section in the **Eligibility and enrollment** 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.

If you are a full-time hourly or management associate, you can enroll in optional associate life insurance at any time once you are eligible. Proof of Good Health may be required when you enroll, depending on the coverage amount you choose and when you enroll.

You can change or drop coverage at any time. However, you will be required to provide Proof of Good Health if you want to increase your coverage or reenroll for any amount of coverage after dropping coverage.

See the **Company-paid life insurance** chapter for information about other life insurance coverage available to full-time hourly and management associates.

PROOF OF GOOD HEALTH

Proof of Good Health is required for optional associate life insurance if:

- The coverage amount selected is above $25,000 during your initial enrollment period
- You enroll after your initial enrollment period for any amount, or
- You increase your coverage after your initial enrollment period.

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.

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 do this by going to **One.Walmart.com**. Any change in beneficiary must be completed and submitted to Walmart before your death and can be submitted only by you, the covered associate. Note that only beneficiary designations made online are accepted.

You can name anyone you wish. If the beneficiary(ies) you list with Walmart differs from the beneficiary(ies) named in your will, the list that Walmart has prevails. If you have not designated 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 needed for each beneficiary:

- Name
- Current address and phone number
- Relationship to you
- Social Security number
- Date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated 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 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 on **One.Walmart.com**. Any change in beneficiary must be completed and submitted to Walmart before your death and can be submitted only by you, the covered associate.

> Be sure to keep your beneficiary information up to date. Proceeds will go to whoever is listed on your beneficiary form with Walmart, regardless of your current relationship with that person, unless state law says otherwise. You can change your beneficiary(ies) at any time on **One.Walmart.com**.

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.

When your optional associate life insurance coverage begins

When Proof of Good Health is required (as described on the previous page), your coverage becomes effective the day the company receives approval from Prudential or at the end of your eligibility waiting period, whichever is later.

If you should die before Prudential approves coverage, no optional associate life insurance benefit will be paid to your beneficiary(ies).

When Proof of Good Health is not required, your coverage becomes effective on the date you enroll or at the end of your eligibility waiting period, whichever is later.

In either case, you must be actively at work for your coverage to become effective. You are considered actively at work if you are on active status and not on a leave of absence. See the **Eligibility and enrollment** chapter for details.

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 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 the company 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** 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 **877-294-7026** for details.

Please consult a tax professional to assess the impact of this benefit.

Filing a claim

The following information must be provided to Prudential regarding the deceased associate:

- Name
- Social Security number
- Date of death, and
- Cause of death (if known).

An original or certified copy of the death certificate is 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 8517
Philadelphia, Pennsylvania 19176

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 **877-294-7026**.

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 re-examine 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
- Premiums paid may be refunded.

Break in coverage

There may be occasions in which you must make special arrangements to pay your optional associate life insurance premiums 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 make your premium 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 the impact a break in coverage may have, and on how to make personal payments to continue your coverage, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** 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 **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

When coverage ends

Your optional associate life insurance coverage ends:

- At termination of your employment
- On 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 of your death
- On the last day of an approved leave of absence (unless you return to work)
- When the benefit is no longer offered by the company, or
- On the day after you drop coverage.

This policy is term life insurance. It has no cash value.

Continuing your optional associate life insurance after you leave Walmart

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.

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 the company 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 not be more than the amount of coverage you elected under the plan (and not more than five times your annual earnings), and 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 have 31 days from the termination date of coverage to request to convert your coverage to an individual policy. If your death occurs during the 31-day conversion period, the death benefit will be payable up to the amount that could have been converted.

To request information on portability or conversion, call Prudential at **877-294-7026**.

If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be reenrolled for the same coverage in effect prior to leaving the company (or the most similar coverage offered under the Plan). You can drop or otherwise change your coverage at any time.

If you return to work after 13 weeks, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period. Proof of Good Health is required for coverage plans above $25,000 (or for any amount if you enroll after your initial enrollment period). See the **Eligibility and enrollment** chapter for details.

If you drop or decrease your coverage and reenroll

If you drop or decrease your coverage and reenroll within 30 days, you may reenroll for the same coverage in effect prior to dropping or decreasing coverage.

If you reenroll more than 30 days after dropping or decreasing your coverage, Proof of Good Health will be required.

Optional dependent life insurance

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	Go to **One.Walmart.com**	Call Prudential at **877-294-7026**
File a claim		Call Prudential at **877-294-7026**

What you need to know about optional dependent life insurance

- If you are a full-time hourly or management associate, you can enroll your eligible dependents in optional dependent life insurance when you are eligible, as described in the **Eligibility and enrollment** chapter. Full-time hourly and management associates can enroll their spouse/partners and/or their children.
- 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 at any other time. Proof of Good Health is not required for your children.
- Coverage is provided through the Prudential Insurance Company of America (Prudential).
- This policy is term life insurance. It has no cash value.

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. If you are a full-time hourly or management associate, you can enroll in optional dependent life insurance when you are eligible, as described in the **Eligibility and enrollment** chapter.

All full-time hourly and management associates can enroll their spouses/partners and/or children.

For details about eligible job classifications, see the **Enrollment and eligibility dates by job classification** charts in that chapter.

When you enroll in optional dependent life insurance, if your covered spouse/partner and/or legal 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		CHILD COVERAGE
$5,000	$75,000	$5,000
$15,000	$100,000	$10,000
$25,000	$150,000	$20,000
$50,000	$200,000	

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. Premiums from optional dependent life coverage do not subsidize coverage under company-paid life insurance.

You can enroll in optional dependent life insurance at any time. Proof of Good Health is required for your spouse/partner if you enroll after your initial enrollment period. Also, you can change or drop coverage at any time. However, if you want to increase your spouse/partner's coverage or reenroll after dropping coverage, you will be required to provide Proof of Good Health for your spouse/partner.

PROOF OF GOOD HEALTH

Proof of Good Health is required for your spouse/partner's optional dependent life insurance coverage if:

- The coverage amount selected is above $5,000 during your initial enrollment period
- You enroll after your initial enrollment period for any amount, or
- You increase your coverage after your initial enrollment period.

However, within 60 days of marriage/partnership, 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. Proof of Good Health is not required for children.

When your optional dependent life insurance coverage begins

When Proof of Good Health is required (as described above), coverage for your spouse/partner becomes effective the day the company receives approval from Prudential or at the end of your eligibility waiting period, whichever is later. Proof of Good Health is not required for children.

If your spouse/partner should die before Prudential approves coverage, no optional dependent life insurance will be paid to you.

When Proof of Good Health is not required, coverage for your spouse/partner or child becomes effective on the date you enroll or at the end of your eligibility waiting period, whichever is later.

If your spouse/partner or dependent child is confined for medical treatment (at home or elsewhere), coverage is delayed until the spouse/partner or child has a medical release (does not apply to a newborn child).

You must be actively at work for your dependent coverage to become effective. You are considered actively at work if you are on active status and not on a leave of absence. See the **Eligibility and enrollment** 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 and enrollment** 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 a claim

The following information must be provided to Prudential regarding the deceased dependent:

- Name
- Social Security number
- Date of death, and
- Cause of death (if known).

An original or certified copy of the death certificate is required as proof of death. Mail the death certificate to:

The Prudential Insurance Company of America
Group Life Claim Division
P.O. Box 8517
Philadelphia, Pennsylvania 19176

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 **877-294-7026**.

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 re-examine 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
- Premiums paid may be refunded.

Break in coverage

There may be occasions in which you must make special arrangements to pay your optional dependent life insurance premiums 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 make your premium 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 the impact a break in coverage may have, and on how to make personal payments to continue your coverage, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** 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 **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

When coverage ends

Your optional dependent life insurance coverage ends:

- At termination of your employment
- On 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 of your death
- On the date that you or a dependent spouse/partner or child loses eligibility (see the **Eligibility and enrollment** chapter)
- On the last day of an approved leave of absence (unless you return to work)
- When the benefit is no longer offered by the company, or
- The day after you drop your coverage.

In addition, if you have optional dependent life coverage and your job status changes to part-time hourly associate or temporary associate, your coverage and your dependents' coverage will end on the last day of the pay period when your job status changes.

This policy is term life insurance. It has no cash value.

Continuing spouse/partner coverage after you leave Walmart

If you are a full-time or management associate and carry optional dependent life insurance for your spouse or 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 or 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.

You must apply for portability or conversion within 31 days of the date your spouse/partner coverage ends. If your spouse or 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 or partner could have converted, even if your dependent did not apply for portability or conversion of coverage.

Portability enables you to maintain similar term life insurance for your spouse or partner with Prudential after your associate coverage ends or your spouse or 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 premiums 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 or 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 or partner may also apply for term life coverage under the portability feature if they meet all of these conditions:

- Your spouse or partner's coverage ends due to divorce or termination of partnership.
- Your spouse or partner is less than age 80.
- Your spouse or 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 or partner provides Proof of Good Health, and Prudential accepts such proof, you may increase the amount of your spouse or 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 life insurance coverage to an individual policy if coverage would end for any reason other than failure to pay premiums 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 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.

To request information on portability or conversion, call Prudential at **877-294-7026**.

If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be reenrolled for the same coverage you had prior to leaving the company (or the most similar coverage offered under the Plan). You can drop or otherwise change this coverage at any time.

If you return to work after 13 weeks, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period. Proof of Good Health is required for spouse/partner coverage plans above $5,000 (or for any amount if you enroll after your initial enrollment period). See the **Eligibility and enrollment** chapter for details.

If you drop or decrease your coverage and reenroll

If you drop or decrease your coverage and reenroll within 30 days, you may reenroll for the same coverage in effect you had prior to dropping or decreasing coverage.

If you reenroll more than 30 days after dropping or decreasing coverage, Proof of Good Health will be required for spouse/partner coverage plans.

IF A DEPENDENT IS DROPPED FROM COVERAGE AND REENROLLED

If your dependent child is dropped from coverage and then determined to be eligible for coverage within 30 days, the dependent will automatically be reenrolled in the same coverage you elect for yourself.

If your dependent regains eligibility and is reenrolled after 30 days, they will be treated as a newly eligible dependent. The associate may enroll them for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

Accidental death and dismemberment (AD&D) insurance

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	Go to **One.Walmart.com**	Beneficiary changes cannot be made over the phone
Get more details		Call Prudential at **877-294-7026**
File a claim		Call Prudential at **877-294-7026**

What you need to know about AD&D insurance

- If you are a full-time hourly or management associate, you can enroll in AD&D insurance when you are eligible, as described in the **Eligibility and enrollment** chapter.
- 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).

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.

If you are a full-time hourly or management associate, you can enroll in AD&D insurance when you are eligible, as described in the **Eligibility and enrollment** chapter. For details about eligible job classifications, see the **Enrollment and effective dates by job classification** charts in that 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

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

You can enroll in or make changes to your AD&D insurance during your initial enrollment period, Annual Enrollment, or when you have a status change event. For more information, see the **Eligibility and enrollment** chapter.

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 do this by going to **One.Walmart.com**. Note that only beneficiary designations made online are accepted. You (the associate) will receive any benefits payable for your covered dependents.

You can name anyone you wish. If the beneficiary(ies) you list with Walmart differs from the beneficiary(ies) named in your will, the list that Walmart has prevails. If you have not designated a beneficiary(ies) under the AD&D benefit, payment will be made to your surviving family surviving family members as described under **If you do not name a beneficiary** later in this chapter.

The following information is needed for each beneficiary:

- Name
- Current address and phone number
- Relationship to you
- Social Security number
- Date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated 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 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 beneficiary(ies) at any time on **One.Walmart.com**. Any change in beneficiary must be completed and submitted to Walmart before your death and can be submitted only by you, the covered associate.

Be sure to keep your beneficiary information up to date. Proceeds go to whoever is listed on your beneficiary form with Walmart, regardless of your current relationship with that person, unless state law says otherwise. You can change your beneficiary(ies) at any time on **One.Walmart.com**.

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.

When your AD&D coverage begins

If you enroll during Annual Enrollment, your coverage becomes effective on January 1 of the next year.

If you enroll outside of Annual Enrollment, your coverage becomes effective on the date of the status change event or the end of your eligibility waiting period, whichever is later.

Your AD&D coverage begins when you have enrolled for the benefit and are actively at work. For AD&D coverage, "actively at work" means you are on active status and have reported for your first day of work, even if you are not at work the day coverage begins (for example, due to illness). See the **Eligibility and enrollment** chapter for details.

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.

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

- 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.
- 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.
- Spouse/partner education 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.
- Child education and care 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) or 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.
Education benefit 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. *Full-time hourly and management associates only.*
Education benefit 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.
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.
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 only 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 a claim

The following information must be provided to Prudential regarding the claimant:

- Name
- Social Security number
- Date of death or injury, and
- 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 8517
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, or
- 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 your AD&D insurance premiums 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 make your premium 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 the impact a break in coverage may have, and on how to make personal payments to continue your coverage, see **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** 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 **When special arrangements are necessary to maintain coverage** in the **Eligibility and enrollment** chapter.

When coverage ends

Your AD&D coverage ends:

- At termination of your employment
- On 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 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), or
- When the benefit is no longer offered by the company. 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 or temporary associate, your coverage and your dependents' coverage will end on the last day of the pay period when your job status changes.

If you voluntarily drop coverage after a status change event or at Annual Enrollment, coverage ends as follows:

- **After a status change event:** coverage ends on the effective date of the event. See **Status change events** in the **Eligibility and enrollment** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave the company and are rehired

If you return to work for the company within 13 weeks, you will automatically be reenrolled for the same coverage in effect prior to leaving the company (or the most similar coverage offered under the Plan). If your break is greater than 30 days but less than 13 weeks, you will have 60 days after resuming employment to drop or otherwise change the coverage in which you were automatically reenrolled.

If you return to work after 13 weeks, you will be considered newly eligible and will be required to complete the applicable eligibility waiting period.

See the **Eligibility and enrollment** chapter for details.

If you drop or decrease your coverage and reenroll

If you drop or decrease your coverage and reenroll within 30 days, you may reenroll for the same coverage in effect prior to dropping or decreasing coverage.

If you reenroll more than 30 days after dropping or decreasing coverage, you may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

IF A DEPENDENT IS DROPPED FROM COVERAGE AND REENROLLED

If your dependent child is dropped from coverage and then determined to be eligible for coverage within 30 days, the dependent will automatically be reenrolled in the same coverage you elect for yourself.

If your dependent regains eligibility and is reenrolled after 30 days, they will be treated as a newly eligible dependent. The associate may enroll them for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

Business travel accident insurance

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	Go to **One.Walmart.com**	Beneficiary changes cannot be made over the phone
Get more details		Call Prudential at **877-294-7026**
File a business travel accident insurance claim		Call Prudential at **877-294-7026**
Get more details about international business travel medical insurance through GeoBlue	Go to **geo-blue.com**	Call GeoBlue at **888-412-6403**

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 GeoBlue.

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. Coverage is effective on your first day of active work. You are considered actively at work if you are on active status and not on a leave of absence. See the **Eligibility and enrollment** chapter for details.

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.

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 do this by going to **One.Walmart.com**. Note that only beneficiary designations made online are accepted. You (the associate) will receive any benefits payable for the injuries listed in **When business travel accident insurance benefits are paid** later in this chapter.

You can name anyone you wish. If the beneficiary(ies) you list with Walmart differs from the beneficiary(ies) named in your will, the list that Walmart has prevails. If you have not designated 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** later in this chapter.

The following information is needed for each beneficiary:

- Name
- Current address and phone number
- Relationship to you
- Social Security number
- Date of birth, and
- The percentage you wish to designate per beneficiary, up to 100%.

If two or more beneficiaries are designated 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 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 on **One.Walmart.com**. Any change in beneficiary must be completed and submitted to Walmart before your death and can be submitted only by you, the covered associate.

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 your 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 on your beneficiary form with Walmart, regardless of your current relationship with that person, unless state law says otherwise. You can change your beneficiary(ies) at any time on **One.Walmart.com**.

Filing a 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, and
- Cause of injury or death (if known).

An original or certified copy of the death certificate is 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 8517
Philadelphia, Pennsylvania 19176

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 **877-294-7026**.

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 the company. 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 the company
- Commission or attempted commission of an assault or felony
- Operating a land, water, or air vehicle while being legally intoxicated, or
- 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 coverage ends

Your business travel accident insurance coverage ends on your last day of employment.

If you leave the company and are rehired

Your business travel accident insurance coverage (or the most similar coverage offered under the Plan) will be reinstated.

International business travel medical insurance

International business travel medical insurance is available through a policy with GeoBlue for associates who travel internationally for business.

GeoBlue 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.

GEOBLUE SERVICES

Business travel medical insurance through GeoBlue provides coverage for emergency medical treatment including hospitalization, doctor visits, and prescription drug coverage (not including over-the-counter medication).

GeoBlue 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 GeoBlue Customer Service at **888-412-6403** before obtaining medical treatment to ensure that the treatment is covered.

GeoBlue 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), and
- Repatriation of remains.

If you incur eligible medical expenses, submit them to GeoBlue 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 **geo-blue.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, and
- Information about health and security risks.

Downloading the GeoBlue app: Once you've registered, download the GeoBlue 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 GeoBlue's self-service tools including mapping to your nearest approved medical facility/provider, making appointments, etc.

GeoBlue 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 **geo-blue.com**.

Claims: Claim forms are generally not required for GeoBlue services. However, if you have a question about your benefits or disagree with the benefits provided, you may contact GeoBlue or file a claim. To submit a claim via email or fax, download a claim form and view detailed instructions in the Member Hub at **geo-blue.com**. Submit your claim by email to **claims@geo-blue.com** or by fax to **610-482-9623**.

You may also submit claims by post. Download a claim form from the Member Hub at **geo-blue.com** and send your completed form to:

GeoBlue
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 GeoBlue policy. Contact GeoBlue at any time by calling **888-412-6403**.

Short-term disability

Short-term disability

If a scheduled surgery, unexpected illness or injury, or complications of pregnancy keeps you off the job for an extended period, the Walmart short-term disability plan can protect part of your paycheck. When you can't work, the Walmart short-term disability plan works for you.

SHORT-TERM DISABILITY RESOURCES	
Find What You Need	**Other Resources**
Get more details about short-term disability	Call Multinational at **787-764-1279** or contact your HR Representative
File a claim within 90 days of the date your disability began	Contact your HR Representative

What you need to know about salaried short-term disability

- All associates are automatically enrolled in short-term disability coverage (SINOT) on the first day of employment. Enrollment in short-term disability is required by Puerto Rico law.
- The short-term disability plan replaces 65% of your average weekly wage, up to a maximum benefit of $113 per week, if you are unable to work due to a covered disability.
- Please note that under Puerto Rico law, maternity benefits are covered separately under the Working Mothers Protection Act. If a disability arises out of complications of pregnancy, short-term disability benefits may become payable.

Enrolling in short-term disability and when coverage is effective

As a Walmart associate, you are automatically enrolled in short-term disability coverage on your first day of employment. Short-term disability coverage is an insurance required by Puerto Rico law. For Walmart associates, this insurance is administered by Multinational Life Insurance Company (Multinational). For information on coverage, call the phone number listed in **Short-term disability resources** at the beginning of this chapter.

Short-term disability provides 65% of your average weekly wage for a maximum benefit period of up to 26 weeks after a seven-day waiting period if you become disabled as defined by the Plan. If you are hospitalized, benefits begin the first day of hospitalization. The maximum weekly benefit under the short-term disability plan is $113. For more information about your average weekly wage, see **Your short-term disability benefit** later in this chapter.

Your coverage beings the first day of employment.

YOUR SHORT-TERM DISABILITY BENEFIT	
If you...	**Your benefit is:**
• Are completely disabled to work for more than seven days because of a covered disability (the waiting period does not apply if you are hospitalized) • Are under medical treatment • Received a salary of $150 or more during a base year	65% of your average weekly income, up to a maximum benefit of $113 per week. For example, 65% of $400 is a $260 weekly benefit, but you will receive the maximum benefit of $113.
NOTE: A "base year" means the first four of the last five calendar year quarters which begin immediately prior to the date you file an application for benefits.	

When you qualify for short-term disability benefits

To qualify for short-term disability benefits, you must:

- Submit medical evidence provided by a qualified doctor that you are disabled as defined by the Plan, and
- Receive approval by Multinational of your claim.

Multinational may require written proof of your disability or additional information before making a decision on your claim. A statement by your physician that "you are unable to work" does not in and of itself qualify you for short-term disability benefits. Also note that approval of a medical leave of absence does not constitute approval for short-term disability benefits.

As defined by the Plan, "disability" or "disabled" or means:

- You are unable to perform the essential duties of your occupation according to the medical evidence provided by a qualified doctor other than you or a family member (failure to meet requirements necessary to maintain a license to perform the duties of your occupation does not mean you are totally disabled)
- You are under the continuous care of a qualified doctor, and
- The disability is due to injury, sickness or complications of pregnancy.

If your disability is the result of more than one cause, you will be paid as if they were one. The maximum benefit for any one period of disability is limited to 26 weeks.

When benefits are not paid

Short-term disability benefits will not be paid for:

- Any illness or injury that is not treated by a qualified doctor or chiropractor
- Any loss caused by war or act of war (declared or not), insurrection, rebellions or taking part in a riot or civil disorder
- Any loss caused by illness or injury while in the armed services of any country engaged in war or other armed conflict
- Any injury caused by your commission of or attempt to commit an unlawful act
- Any illness or injury connected with employment
- Any injury caused by you being engaged in a motor vehicle accident or any loss caused by any illness or injury for which Automobile Accident Social Protection Act benefits are paid, or may be paid, if properly claimed
- Any loss caused by any illness or injury for which workers' compensation benefits are paid, or may be paid, if properly claimed
- Any injury or loss for which Chauffeur's Insurance benefits are paid or may be paid, if properly claimed, and/or
- Any other injury or loss that is excluded from coverage under the terms of the policy.

The policy can be obtained by calling PR Home Office Benefits Division at **787-653-1065**.

Filing a claim for short-term disability

You must submit your short-term disability claim within 90 days of the date your disability begins to assure benefits. If you submit your short-term disability claim after 90 days following the date your disability begins, you must provide a reasonable justification for the delay.

If you experience a disabling illness or injury, follow these steps:

STEP 1: Notify your supervisor as soon as you know you will be absent from work due to an illness or injury.

STEP 2: On or after your last day worked, call your HR Representative to report the disability and to obtain the claim form to complete. Processing of your claim cannot begin until you have stopped working.

STEP 3: Complete the claim form with your personal information and give it to your HR Representative when completed. Your HR office is responsible for completing the company information requested on the form.

STEP 4: Ask your doctor to provide complete medical information, including:

- Diagnosis, and
- Disability date and expected duration of disability.

STEP 5: Once the form is completed with your personal, medical, and company information, you are responsible for sending it to the claims division of Multinational.

Claims will be determined under the time frames and requirements set out by Multinational. You have the right to appeal a claim denial.

Multinational may require written proof of your disability or additional medical information before your benefit payments begin.

When short-term disability benefits begin

If you are approved for short-term disability benefits, the benefit will begin after a seven-day waiting period on the eighth calendar day after your short-term disability begins. If you are hospitalized, benefits begin the first day of hospitalization. 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.

Any sick or vacation days you have may be used to substitute for the benefit waiting period.

You will not accumulate sick, vacation, or other types of benefit hours while you are receiving short-term disability benefits.

Your short-term disability benefit

The amount of your short-term disability benefit is based on your average weekly wage.

The maximum weekly benefit under the short-term disability plan is $113.

Total gross pay includes:

- Overtime
- Bonuses, except Christmas bonus
- Vacation, and
- Sick pay.

Your short-term disability benefit is equal to 65% of your average weekly wage, up to the $113 weekly maximum.

Your weekly benefit will be reduced by other benefits or income that you (or your family) receive or are eligible to receive. Examples include, but are not limited to, income from the following:

- Workers' compensation or any other governmental program that provides disability or unemployment benefits as a result of your job with the company
- Employer-related individual policies
- Automobile Accident Social Protection Act (ACAA) automobile insurance, and
- Lump-sum payments or settlements related to the disability.

The short-term disability benefit includes a death benefit in the amount of $4,000 and shall pay in addition up to $3,000 for funeral expenses.

Please refer to the policy for a complete list of offsets. The policy can be obtained by calling PR Home Office Benefits Division at **787-653-1065**.

Multinational has the right to recover from you any amount that is overpaid to you for short-term disability benefits under this plan.

AVERAGE WEEKLY WAGE	
Length of employment	**How average weekly wage is determined**
Employed 12 months or more	Total gross pay ÷ prior 52 weeks For example, the average weekly wage for an associate with a total gross pay of $20,800 is $4700 ($20,800 ÷ 52)
Employed less than 12 months	Total gross pay ÷ number of weeks worked For example, the average weekly wage for an associate with a total gross pay of $4,800 for 12 weeks of work is $400 ($4,800 ÷ 12)

Continuing benefit coverage while disabled

If you wish to continue medical, dental, AD&D, optional associate and dependent life insurance while you are receiving short-term disability benefits, you must make premium payments each pay period for each of these benefits. These amounts will not be deducted from your short-term disability benefit payments. If you fail to pay your premiums for these benefit plans, they may be canceled. See the **Eligibility and enrollment** chapter for details.

Your short-term disability and long-term disability coverage will not be canceled if you are receiving payments under this policy. You will not be required to pay long-term disability premiums while you are receiving short-term disability benefits.

When short-term disability benefit payments end

Short-term disability benefit payments from the Plan will end on the earliest of:

- The date you are no longer disabled
- The date you fail to furnish proof that is satisfactory to Multinational that you are disabled
- The date you are no longer under the regular care of a physician
- The date you refuse to be examined, if Multinational requires an examination
- The last day of the maximum period for which benefits are payable (end of 26 weeks), or
- The date of your death.

IF YOU RETURN TO WORK AND BECOME DISABLED AGAIN

If you return to work for 90 calendar days or less of active work and become disabled again from the same or a related condition that caused the first period of disability, 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. The combined benefit duration will not exceed 26 weeks.

If you have returned to active work 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 26 weeks of benefits. A new benefit waiting period of seven calendar days will apply. If you are hospitalized, benefits begin the first day of hospitalization.

Coverage during a leave of absence or temporary layoff

Once your short-term disability coverage has begun, if you are not actively at work due to an approved leave of absence or a temporary layoff, you will continue to be eligible for short-term disability benefits for 180 days from your last day of work. Your coverage will end on the 181st day. Coverage will be reinstated if you return to active work within one year.

When coverage ends

Your short-term disability coverage ends:

- At termination of your employment, or
- On the date of your death.

Long-term disability

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 Lincoln.

Long-term disability

If you become disabled and can't work, the company'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.

LONG-TERM DISABILITY RESOURCES		
Find What You Need	**Online**	**Other Resources**
Get more details or file a claim	Go to **One.Walmart.com/LOA > Me > My Time > Disability**	Call Lincoln at **888-778-9251**

What you need to know about long-term disability

- Walmart offers a long-term disability (LTD) plan and also an LTD enhanced plan. If you are an employee of Walmart and classified as a full-time hourly or management associate in Walmart's payroll system, you are eligible to enroll in either plan.
- The LTD plans work with certain other benefits you receive while disabled to replace 50% of your average monthly wage under the LTD plan or 60% of your average monthly wage under the LTD enhanced plan.
- If you enroll in either plan after your initial eligibility period, you will be required to submit Proof of Good Health and may be required to undergo a medical exam at your own expense before you can be approved for coverage.

The LTD plans

You are eligible to enroll in LTD coverage if you are a full-time hourly or management associate. For details about eligible job classifications, see the **Enrollment and effective dates by job classification** section in the **Eligibility and enrollment** chapter.

You can choose one of two available plans:

- **The LTD plan.** Provides 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 by the plan.
- **The LTD enhanced plan.** Provides 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 if you become disabled as defined by the plan.

Both plans are insured by Lincoln. For information about your waiting period, see **When LTD 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 LTD benefits** later in this chapter.

The date your coverage begins depends on when you enroll for coverage:

- If you enroll during your initial enrollment period, your coverage begins on your effective date, as detailed in the **Eligibility and enrollment** chapter.
- If you enroll upon transferring from one eligible job classification to another, your coverage begins on your effective date. See the **Eligibility and enrollment** chapter for information on your transition enrollment period and your effective date.
- 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 approved, your coverage will be effective the first day of the following pay period after approval is received from Lincoln. If you are not approved, you will only be eligible to enroll in the LTD plan or LTD enhanced plan during the next Annual Enrollment or after a status change event.

If you are enrolled in the LTD plan or LTD enhanced plan, you will be able to drop coverage only at Annual Enrollment or after a status change event. If you later reenroll, you will be treated as a late enrollee, as described above.

To receive benefits under the LTD plan or the LTD enhanced plan, you must be actively at work at the time of your disability unless you are not actively at work in certain cases of leave of absence or layoff, as described later in this chapter under **Coverage during a leave of absence or temporary layoff**. Being actively at work means you have worked hours in the immediately preceding pay period if you are an hourly associate or have earned wages if you are a member of management. See the **Eligibility and enrollment** chapter for details.

THE COST OF LTD COVERAGE

Your cost for LTD coverage is based on your biweekly earnings, your age, and whether you select the LTD plan or the LTD enhanced plan. Premiums are deducted from all wages, including bonuses. Premium payments are waived for LTD coverage during any period in which LTD benefits are payable but premiums for other benefits will not be affected. Walmart will not withhold premiums for such other benefits from your LTD benefits. If, however, you receive any other earnings, including bonuses, through the Walmart payroll systems while you are receiving LTD benefits, your premiums for all benefits will be withheld from those payments.

When you qualify for LTD benefits

Under the terms of the LTD plan and LTD enhanced 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, 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.

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 LTD 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.

PRE-EXISTING CONDITION EXCLUSION

You will not receive LTD benefits for any disability or partial disability which begins in your first 12 months after your effective date of coverage if such disability or partial disability is caused, partially or entirely, or results from a pre-existing condition. A "pre-existing 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 pre-existing 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 LTD plan (50% benefit) to the LTD enhanced plan (60% benefit), the pre-existing condition exclusion will apply to the additional coverage amount. If you had satisfied the pre-existing condition requirement of the LTD plan (50% benefit) and then suffer a disability before you satisfy the pre-existing condition exclusion of the LTD enhanced plan (60% benefit), you will only receive benefits under the LTD plan (50% benefit).

Filing an LTD claim

Call Lincoln at **888-778-9251** as soon as you know you will need to use your LTD benefit. Lincoln will provide you with information on how to file your claim.

Associates receiving State Insurance Fund Corporation benefits (workers' compensation) and enrolled in the LTD plan or LTD enhanced plan may be eligible for disability benefits after their benefit waiting period has expired. Call Lincoln at **888-778-9251** to report your LTD 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 LTD 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, or
- 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 LTD benefits begin

If you are approved by Lincoln for LTD benefits, they will begin after your waiting period:

- **For full-time hourly associates:** Your waiting period is 26 weeks or the end of your short-term disability benefits, whichever is longer.
- **For management associates:** Your waiting period is 90 days or the end of your employer-sponsored salary continuation program, 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 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 LTD benefits. The "specified number of calendar days" means (i) 60 days for hourly associates, and (ii) 180 days for salaried associates.

Calculating your benefit

The amount of your LTD benefit is based on:

- Your average monthly wage, and
- If you are enrolled in the LTD plan or the LTD enhanced plan.

AVERAGE MONTHLY WAGE	
Length of employment	**How average monthly wage is determined**
Employed 12 months or more	Your earnings for the 26 pay periods immediately prior to your last day worked ÷ 12 For example, the average monthly wage for an associate with pre-disability earnings of $36,000 for the prior 26 pay periods is $3,000 ($36,000 ÷ 12).
Employed less than 12 months	Pre-disability earnings ÷ number of months worked For example, the average monthly wage for an associate with pre-disability earnings of $21,000 for seven months of work is $3,000 ($21,000 ÷ 7).

Average monthly wage includes:

- Overtime
- Bonuses
- Vacation
- Sick pay (not including any previous disability benefits), and
- Regular earnings for the 26 pay periods (52 if paid weekly) prior to your last day worked. Any pay periods in which you have no earnings are excluded, decreasing the number of pay periods used for the calculation.

Commissions or any other extra compensation or fringe benefits are not included.

If you have been employed less than 12 months, an annualized average of earnings will be used.

Your LTD benefit is shown below:

YOUR LTD BENEFIT	
If you are enrolled	**Your coverage is**
In the LTD 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)*
In the LTD 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)*
*See **Other benefits or income that reduces LTD benefits** for more information.	

Your benefit will be no less than $50, for any month that you are eligible to receive LTD benefits. The total of your monthly disability payment, plus all earnings, cannot exceed 100% of your average monthly wage prior to your disability.

LTD benefits are paid biweekly, as long as you continue to be disabled as defined by the LTD plans.

Lincoln has the right to recover, and you must repay, any amount overpaid to you for LTD benefits under the LTD plan or LTD enhanced plan.

TAXES AND YOUR LTD BENEFIT

You pay 100% of the costs of your LTD coverage with after-tax contributions. As such, benefits payable to you under the LTD plans are not subject to income taxes.

OTHER BENEFITS OR INCOME THAT REDUCES LTD BENEFITS

Your LTD 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 LTD benefit relates. 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 LTD 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
- 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 LTD benefits are subsequently adjusted by cost-of-living increases, your LTD benefit will not be further reduced. Refer to the policy for a complete list of offsets. You may obtain a copy of the LTD policy by calling Lincoln at **888-778-9251**.

REDUCTION OF LTD BENEFIT EXAMPLE		
Annual salary: $36,000	**LTD Plan (50%)**	**LTD 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
LTD 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 LTD 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.

Failure to file for Social Security disability benefits could result in your Social Security retirement benefits being reduced when you reach the age of retirement. If you qualify for Social Security disability or retirement benefits while you are receiving benefits under the LTD plan and your Social Security disability claim is approved retroactively, you must reimburse Lincoln for any LTD 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 pre-disability earnings.

"Pre-disability monthly earnings" means your regular monthly rate of pay in effect for the 26 regular pay periods immediately prior to your last day worked, divided by 12. Pre-disability earnings include overtime, bonuses, vacation, illness protection, and personal pay, but not commissions or other fringe benefits or extra compensation. If you have worked for less than 12 months with the company, your regular monthly rate of pay will be based on the total earnings you actually received while working for the company immediately prior to the date you became disabled, annualized and divided by 12.

"Indexed pre-disability monthly earnings" means your pre-disability earnings increased annually by 7% or the percentage change in the Consumer Price Index, whichever is less.

Lincoln offers a work incentive benefit for the first three months that you are partially disabled and working. You will continue to receive the full amount of your monthly benefit for the first three months if you are partially disabled, unless your benefit and current monthly earnings exceed your pre-disability basic monthly earnings. Your monthly benefit will be reduced by the excess amount so that the monthly benefit plus your earnings do not exceed 100% of your pre-disability basic monthly earnings.

After the first three months 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 pre-disability monthly earnings
B	Your current partial monthly earnings
C	The monthly benefit payable if you were qualified as disabled, less other income earnings
D	The disabled and working benefit payable

IF YOU PASS AWAY WHILE RECEIVING LTD BENEFITS

Coverage under the LTD plans ends upon your death. However, if you pass away while receiving LTD benefits, a lump-sum payment of $5,000 or three times your gross monthly LTD 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 LTD benefit payments end

LTD 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 pre-disability earnings
- 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 chart below), or
- The date of your death.

MAXIMUM DURATION OF LTD BENEFITS	
Age when you become disabled	**Benefits duration**
Prior to age 62	Until 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 LTD 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, and
- 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/recurrent claim," the recurrent disability will be part of the same disability.

Your LTD 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 to the left.

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.

Coverage during a leave of absence or temporary layoff

Once your LTD coverage is effective and you are eligible to file a claim for benefits, if you are not actively at work due to an approved non-disability leave of absence or temporary layoff, you will continue to be eligible for LTD benefits for 90 days from your last day of work. Your eligibility for LTD benefits ends on the 91st day after your approved non-disability leave or temporary layoff begins, but is reinstated if you return to active work status within one year. See **Continuing benefit coverage if you go on a leave of absence** in the **Eligibility and enrollment** chapter for more information, including details on paying for benefits while on leave.

When coverage ends

Your LTD coverage ends:

- 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 when 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 an approved leave of absence
- When the benefit is no longer offered by the company, or
- On the date of your death.

In addition, coverage under the long-term disability plan would end when you drop your coverage, as follows:

- **After a status change event:** coverage ends on the effective date of the event. See **Status change events** in the **Eligibility and enrollment** chapter for information.
- **At Annual Enrollment:** coverage ends on December 31 of the current year.

If you leave the company and are rehired

If you leave the company and return to full-time work for the company within 13 weeks, you will automatically be reenrolled for the same coverage plan you had prior to leaving the company (or the most similar coverage offered under the Plan). If you are automatically reenrolled in LTD plan or LTD enhanced plan coverage and choose to drop it after you return, you may do so within 60 days of resuming employment.

If you return to full-time work after 13 weeks, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

If you lose and then regain eligibility or drop coverage and reenroll

If you lose eligibility and then regain eligibility or drop coverage and reenroll within 30 days, you will automatically be reenrolled for the same coverage you had prior to losing eligibility or dropping coverage (or the most similar coverage offered under the Plan).

If you lose eligibility and then regain eligibility or drop coverage and reenroll after 30 days, you will be considered newly eligible and may enroll for coverage under the time periods and conditions described in the **Eligibility and enrollment** chapter.

Claims and appeals

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 claim that has been partially or fully denied in the areas of eligibility, medical, dental, life insurance, AD&D, and disability.

RESOURCES	
Find What You Need	
Submit a claim for benefits	Submit claims to the Plan's third-party administrators as shown later in this chapter.
Appeal a denied claim	Submit appeals within the deadlines provided in this chapter for: • Medical claims to MCS Life • Pharmacy claims to MC-Rx • Dental claims to Delta Dental of Puerto Rico, Inc. • Life insurance, business travel accident insurance and AD&D to Prudential • Short-term disability to Multinational, and then to the Secretary of Labor • Long-term disability to Lincoln All addresses are listed later in this chapter.
Appeal a decision on eligibility for coverage or enrollment status	Write to: **Walmart Total Rewards Benefits** **Attn: Internal Appeals** **508 SW 8th Street** **Bentonville, Arkansas 72716-3500** **Or fax to 888-715-4154** Or for COBRA appeals, write to: **Alight Solutions** **Centro de Beneficios COBRA para Walmart** **P.O. Box 194926** **San Juan, Puerto Rico 00919-4926**
Designate an authorized representative to submit claims or appeals on your behalf	Call PR Home Office Benefits Customer Service at **787-653-1065**.

What you need to know about claims and appeals

- You have the right to appeal an adverse eligibility decision affecting your or a family member's coverage.
- You have the right to appeal an adverse preauthorization decision regarding your requested benefits.
- You must submit claims for benefits directly to the third-party administrator or provider of the Plan.
- You have the right to appeal a benefit claim that has been partially or fully denied.
- You can appoint another party to appeal on your behalf. The Plan will provide the appropriate form for you to complete and sign. This is the only authorization form that will be accepted for another party to appeal on your behalf.
- After a final decision of an appeal of a medical or pharmacy claim is made by the third-party administrator or the Plan, you may have the right to request an independent external review of the decision.
- Decisions regarding enrollment, eligibility status, and claims for the following plans are not eligible for external review, but will be eligible for voluntary review under the Plan: dental, life insurance, AD&D, disability and business travel accident.

Deadlines to file a claim or bring legal action

You must submit your claim to the Plan within six months. Unless otherwise specified in the chapter describing the applicable benefit, initial claims for benefits under the Plan must be filed within six months from the date of service (180 days for pharmacy claims) or other date on which the right to make a claim first arises. Since procedures for filing a claim or an appeal of a decision are different for different benefit plans and third-party administrators, be sure to review the relevant section of this chapter for more 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, behavioral health, or dental claims, 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 claims procedures of the Plan. 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 appeals and you want to file a lawsuit, you must file any lawsuit for benefits within 180 days after the final decision on appeal (whether by the Plan or after external review). 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 by the Plan 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 or 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, if authorized by you or your dependents, but only as a convenience to you. 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 dependents under any circumstances.

Appealing an enrollment or eligibility status decision

This section describes the appeal process that applies to enrollment and eligibility only.

If you disagree with the Plan Administrator's determination regarding your enrollment or eligibility status, you have 365 days from your eligibility enrollment event to appeal in writing to the address in the **Resources** chart at the beginning of this chapter.

COBRA participants should send the appeal, in writing, to Alight at the address in the 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 will be eligible for voluntary review.

Medical, pharmacy, and dental claims process

This section describes the claims process that will be used for the following benefits only:

- Medical
- Pharmacy
- Dental, and
- A rescission of coverage, which is a cancellation of coverage that has a retroactive effective date, except where cancellation of coverage is due to failure to pay required contributions or premiums in a timely manner.

If you voluntarily choose to prenotify the third-party administrator of a scheduled medical service before you receive treatment, and prenotification is not required, the third-party administrator's response is nonbinding on the Plan and not subject to appeal. However, if the Plan terms or policies, as applied by your third-party administrator, require you or your provider to preauthorize services, and your request for prior authorization is denied, that decision is subject to appeal.

Your initial claims for medical claims will be determined by MCS Life. Your initial claims for pharmacy claims will be determined by MC-Rx. Your initial claims for dental claims will be made by Delta Dental of Puerto Rico.

TIME PERIODS FOR CLAIM DETERMINATIONS

The time period in which your claim will be determined depends on the type of claim.

Pre-service claims. The Plan requires prior authorization for certain services. For these benefits, you or your provider must file a claim for approval before you receive treatment, or your claim may not be paid. These are called pre-service claims.

Urgent care claims. If your pre-service claim is urgent, your claim will be decided under the urgent care time frames. A claim is urgent 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.

Post-service claims. If you are filing a claim after you have already received services, your claim is a post-service claim. If your claim arises when there is a reduction in ongoing care, your claim is a concurrent care claim.

Concurrent care claims. If your claim arises when there is a reduction in ongoing care, such as a reduction in the length of a previously approved hospital stay or a reduction in the number of previously approved physical therapy visits, or if you request an extension of an ongoing course of treatment, your claim is a "concurrent care claim."

The chart titled **Claims process and timing** on the following page shows deadlines for making claims determinations for these types of claims.

CLAIMS PROCESS AND TIMING	
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 exigencies, 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 prior authorization.	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 rendered, or where the Plan does not require prior authorization.	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 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.

***With respect to dental care and services:** If the total cost of a treatment plan for you, your spouse/domestic partner, or your covered dependents in the Delta Dental plan exceed $300, a predetermination is recommended for the approval of charges and services to ensure that both you and your dentist know which benefits and amounts the Plan will cover before beginning the treatment. Delta Dental will promptly return a predetermination voucher to both you and the dentist, which will include a verification of eligibility and the definition and extent of the benefits in a period of twelve months to complete the services. Refer to your dental plan certificate of coverage for more information.

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 provisions of the Plan 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), and
- Notice regarding your right to bring legal action following a denial on appeal.

For medical, pharmacy, and dental benefits, the denial also will 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, and
- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist participants 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 third-party administrator or when a non-network provider disputes a payment from the third-party administrator 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 third-party administrator or Plan, but it is not a claim for your Plan benefits under these procedures.

Internal appeal process

APPEALING A CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED: MEDICAL, PHARMACY, OR DENTAL APPEALS

NOTE: Information in this section addressing medical appeals includes a summary of benefits and conditions of MCS Life and is subject to the terms and conditions of the main MCS certificate. For additional information, please refer to the main MCS certificate.

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 (with respect to medical appeals, oral requests may be accepted upon being transferred into writing, as described on the following page)
- Be sent to the correct address (see **Mailing addresses for appeals** on the following page)
- Be submitted within 180 days of the date of the initial denial, and
- Contain any additional information/documentation you would like considered (and, in the case of dental appeals, your enrollee ID number).

If your appeal involves an urgent claim, please contact your third-party administrator for information about how to file your claim orally.

When making an appeal, you must send your written request for review of the initial claim to the third-party administrator that administers your claims, as listed in the chart that follows.

MAILING ADDRESSES FOR APPEALS

MEDICAL SERVICES *Refer to your plan ID card for the name of your third-party administrator.*	
MCS-LIFE	**MCS LIFE** **Customer Service Division** **P.O. Box 3547** **San Juan, Puerto Rico 00919-3547** A properly completed MCS Appeals Submission Form can also be sent to: **Grievances and Appeals Unit** **MCS Plaza** **P.O. Box 195429** **San Juan, Puerto Rico 00919-5429**
Alternatively, you or your representative may visit any MCS Service Center to submit your appeal. If your visit is in reference to an appeal, it will be documented in writing, or you may use the MCS Appeals Submission Form. The form will be transferred to the Grievance and Appeals Unit the same day it is filed. You may submit your request orally. You, your representative, or your provider may contact MCS at **888-758-1616** (TTY/TDD **866-627-8182**). MCS documents all oral requests in writing and maintains the documentation in a case file, following these procedures: Your request is recorded in your own words, repeated back to you to verify accuracy, and placed into a tracking system. If a department other than the Grievance and Appeals Unit receives your request, it forwards the request to the Grievance and Appeals Unit the same day by email or fax to open the case and meet established time frames.	
PHARMACY	
MC-Rx	**MC-Rx** **Customer Service Department** **Call Box 4908** **Caguas, Puerto Rico 00908**
DENTAL	
Delta Dental of Puerto Rico	**Delta Dental of Puerto Rico, Inc.** **Grievance and Appeals** **14 Calle 2 Suite 200** **Guaynabo, Puerto Rico 00968-1735**

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 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.

(With respect to dental appeals, you can review records that deal with your request from 8:00 a.m. to 4:30 p.m., Monday through Friday, at Delta Dental of Puerto Rico facilities. Since many records are electronically filed, please call in advance so copies can be ready for you. Certain cases may be referred to one of Delta Dental's consultants, to a review committee of the dental society in your area, or to the state dental association for evaluation.)

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 the chart that follows, depending on the type of claim:

APPEAL PROCESS AND TIMING	
Urgent claims	You will be notified of the determination as soon as possible, taking into account the medical exigencies, but not later than 48 hours after receipt of the claim (72 hours for pharmacy claims).
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 15 days from the date your request is received (30 days for dental claims).
Post-service claims	You will be notified of the determination within a reasonable period of time, but no later than 30 days from the date your request is received (60 days for dental claims).

If your claim is denied on appeal, you will receive a denial notice that includes:

- The specific reasons for the denial
- Reference to provisions of the Plan on which the denial was based, and, with medical claims, titles and credentials of the persons who participated in the review of the appeal
- 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, and
- Notice regarding your right to bring legal action following a denial on appeal.

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 appeals (and external appeals with medical and pharmacy claims), including how to initiate an appeal, and
- The availability of any contact information for an applicable office of health insurance consumer assistance or ombudsman to assist participants with the internal and external appeals process.

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

You are entitled to appeal a denied dental claim. The instructions on how, when, and where to submit your request for an additional voluntary review will be included with the decision that is issued as part of the review of your initial appeal.

Upon a receipt of a request for an additional voluntary review, we will send a notice to you or your authorized representative concerning your rights and the rules governing the voluntary review process.

Even if a claim has not been denied, you may file a grievance with Delta Dental if you have a complaint concerning the availability, delivery, or quality of covered dental services; regarding claims payment, handling, or reimbursement for dental services; or related to other matters pertaining to your relationship with the Delta Dental plan.

You may file your grievance by submitting written materials that you want to be considered when conducting a review of your complaint to the address indicated in the previous section. Upon receiving your grievance, Delta Dental will designate one or more persons to conduct the review of your grievance and provide you with his or her contact information. Within 30 days of receiving your request, Delta Dental will send you a written decision and indicate any action we have taken.

REQUESTING A VOLUNTARY REVIEW OF YOUR DENIED APPEAL FOR 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 of the date on the appeal denial letter. The same criteria and response times that applied to your appeal are generally applied to this voluntary level of review.

The claimant must send a written request for a voluntary appeal for enrollment or eligibility status to:

Walmart Total Rewards Benefits
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

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 YOUR DENIED APPEAL FOR ADMINISTRATIVE REASONS: MEDICAL APPEALS

You may request a voluntary review of the decision on your appeal of a denied medical benefit if your appeal was denied for an administrative reason, such as exceeding the number of allowed visits, and not for a medical judgment reason. You must file your request within 180 days of the date on 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:

Walmart Total Rewards Benefits
Attn: Voluntary Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

External appeal process for medical, pharmacy, and dental benefits

EXTERNAL APPEALS FOR MEDICAL BENEFITS

If MCS affirms its initial decision in whole or in part and you disagree with MCS's determination, or if MCS fails to provide you with a written appeal determination within the appeal time frame, you, your authorized representative, or your physician may request an external review within 120 days from the date of the determination of the first appeal.

The external review is performed by an Independent Review Organization (IRO) contracted by MCS, but with independent judgment.

If you have a medical condition for which following the standard time frame may be harmful to you, or if your appeal is related to an experimental procedure that should be started urgently, you may request an urgent appeal even if the internal process has not been exhausted. The Independent Review Organization (IRO) conducting the review may then request that you go through the internal process.

MCS will receive your request for external review and determine within one business day if your request is eligible for an external review based on whether:

- You are or were covered at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, were enrolled in MCS at the time the health care service or treatment was provided.
- It can be reasonably understood that the health care service is a covered service under the benefit Plan, except when MCS has determined that it is not covered because it does not meet MCS's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of the service.
- You have exhausted the Plan's internal appeal process.
- You have provided all the information and forms required to process an external review.
- For reviews of appeal denials of experimental or investigational treatment, whether the treatment is a covered benefit under the Plan except for MCS's determination that the service or treatment is experimental or investigational for a particular medical condition, and is not explicitly listed as an excluded benefit under the Plan.

Send your written request for external review to the third-party administrator that administers your claims:

MCS LIFE
Customer Service Division
P.O. Box 3547
San Juan, Puerto Rico 00919-3547

A properly completed MCS Appeals Submission Form can also be sent to the following address:

Grievances and Appeals Unit
MCS Plaza
P.O. Box 195429
San Juan, Puerto Rico 00919-5429

You may withdraw a request for appeal may either verbally or in writing at any time before a decision regarding the appeal is made.

EXTERNAL APPEALS FOR PHARMACY AND DENTAL BENEFITS

If your internal appeal for pharmacy or dental benefits under the Plan is denied, you may have the right to further appeal your claim pursuant to an independent external review process.

Your external appeal will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn the Plan's decision, and the independent review organization's decision will be binding on the Plan. Your internal appeal denial notice will include more 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.

Send a written request for external pharmacy or dental appeals to:

PHARMACY BENEFITS
MC-Rx **Customer Service Department** **Call Box 4908** **Caguas, Puerto Rico 00908**
DENTAL BENEFITS
Delta Dental of Puerto Rico, Inc. **Grievance and Appeals** **14 Calle 2 Suite 200** **Guaynabo, Puerto Rico 00968-1735**

Other rights related to medical, pharmacy, and dental benefits

THE PLAN'S RIGHT TO REQUEST MEDICAL RECORDS

The Plan has the right to request medical records for any associate or 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. 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 and/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.

YOUR RIGHT TO RECOVER OVERPAYMENT

If you overpay your contributions or premiums for any coverage under the Plan (except COBRA), the Plan will refund excess contributions or premiums to you upon request. In this circumstance, any refunds you receive may be offset by any benefits paid during this period by the Plan if you or a dependent was not eligible for such coverage. If you overpay your premiums for COBRA coverage under the Plan, a request for refund of those excess premiums should be made to the Plan's COBRA administrator.

THE PLAN'S RIGHT TO AUDIT

The Plan has the right to audit your and your dependents' 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 and/or future claims with the provider made on behalf of you or your dependent, or 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 and/or future claims filed by you or a dependent based on the results of an audit.

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, you shall be deemed, by virtue of your enrollment in the Plan, to have agreed that the company 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 and enrollment** chapter, including the applicable payroll deductions.

RIGHT TO REDUCTION, REIMBURSEMENT, AND SUBROGATION

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 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, 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, 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 but not limited to, uninsured/underinsured motorist coverage
  - Business medical and/or liability insurance coverage or payments, and
  - Attorney's 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 in time 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 but not limited to 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 Plan's right to 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, and
- The Plan's right to first priority 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
- Total and permanent physical or mental disability, or
- Death.

In addition to the exceptions listed above, 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. 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 in this chapter, 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 persons and their representatives to cooperate in order to guarantee reimbursement to the Plan from third-party benefits. Failure to comply with this request will entitle the Plan to withhold benefits due to you or your dependents under the Plan. A covered person and their representatives must not do anything to hinder reimbursement of overpayment to the Plan after benefits have been accepted by the covered person or their representatives.

The Plan's rights to reduction, reimbursement, and subrogation apply regardless of whether such payments are designated as payment for, but not limited to:

- Pain and suffering, or
- Medical benefits.

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 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 in order to recover benefits paid or to be paid by the Plan.

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, or
- 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. The claimant may also designate an authorized representative to submit claims for benefits or appeals on the claimant's 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 of the date of the 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, and
- 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:

Walmart Total Rewards Benefits
Attn: Subrogation Review
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Within a reasonable time, but no later than 30 days after the initial claim for benefits is made, 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 the claimant's 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, and
- 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 notified 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 a claimant's appeal to be considered, it must:

- Be in writing
- Be sent to the correct address
- Be submitted within 180 days of the date of the initial denial, and
- Contain any additional information/documentation the claimant would like considered.

The claimant must send a written request for an appeal to:

Walmart Total Rewards Benefits
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

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 claimant's 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, and
- 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 the claimant can request the Plan not to reduce benefits 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 after the decision on appeal. A claimant may not file suit after that 180-day period expires.

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 insurance, business travel accident, and AD&D insurance can be initiated by calling Prudential at **877-294-7026**.

See the applicable insurance chapter for details on the information required to file each type of claim. When you submit a claim to Prudential and your claim is denied, a notice will be sent within a reasonable time period, but not longer than 90 days from receipt of the claim. If Prudential determines that an extension is necessary due to matters beyond Prudential's control, this time may be extended for an additional 90-day period. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which Prudential expects to render a determination.

If your claim is in part or wholly denied, you will receive notice of an adverse benefit determination that will:

- State the specific reasons for the adverse benefit determination
- Reference the specific plan provisions on which the determination is based
- Describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary, and

- Describe Prudential's 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 an adverse benefit determination on review.

APPEALING A PRUDENTIAL CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for benefits is denied and you would like to appeal, you must send a written appeal to Prudential at the address below within 180 days of the denial. Your appeal should include any comments, documents, records, or any other information you would like considered.

Send your written appeal to:

Prudential Insurance Company of America
Prudential Group Life Claim Division
P.O. Box 8517
Philadelphia, Pennsylvania 19176

You will have the right to request copies, free of charge, of all documents, records or other information relevant to your claim. Your appeal will be reviewed without regard to your initial determination by someone other than the party who decided your initial claim. Prudential 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 Prudential determines 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 from Prudential 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 statement describing your right to request copies, free of charge, of all documents, records or other information relevant to your claim
- 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, and
- A statement describing any appeals procedures offered by the Plan and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

VOLUNTARY SECOND APPEAL OF LIFE INSURANCE, AD&D, OR BUSINESS TRAVEL ACCIDENT CLAIMS

If your appeal 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 voluntary second appeal of your denial in writing to Prudential. You must submit your second appeal within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. 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 are generally applied to this voluntary second appeal.

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

Claims and appeals process for disability coverage claims

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 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 policy provisions on which the decision is based
- 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 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 after you appeal the decision, if you receive a written denial on appeal, and

- If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the denial, either:
  - The specific rule, guideline, protocol or other similar criteria, or
  - A statement that such a rule, guideline, protocol or other similar criteria was relied upon in making the denial and that a copy will be provided free of charge to you upon request.

APPEALING A DISABILITY CLAIM THAT HAS BEEN FULLY OR PARTIALLY DENIED

If your claim for benefits is denied and you would like to appeal, you must send a written appeal to Multinational or Lincoln (as applicable) at the address shown later in this chapter within 180 days of the denial. Your appeal should include any comments, documents, records or any other information you would like considered.

You will have the right to request copies, free of charge, of all documents, records or other information relevant to your claim. Your appeal will be reviewed, without regard to your initial determination, by someone other than the party who decided your initial claim.

Multinational 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 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, and
- A statement describing any appeals procedures offered by the Plan and your right to bring a civil suit under ERISA.

See **Deadlines to file a claim or bring legal action** earlier in this chapter regarding the deadline to bring legal action.

Short-term disability appeals should be sent to:

Multinational Life Insurance
P.O. Box 366107
San Juan, Puerto Rico 00936-6107

If you are denied short-term disability benefits by Multinational on appeal, you may file an appeal before the Puerto Rico Department of Labor, SINOT Division, within 10 days of the notice of the decision by Multinational on appeal.

Long-term disability appeals should be sent to:

Group Benefits Claims
Lincoln Financial Group
Group – Charlotte WM
P.O. Box 2578
Omaha, Nebraska 68172-9688

Resources for Living benefits

You do not have to file a claim or appeal for Resources for Living benefits. You may access the Resources for Living website or call Resources for Living at **800-825-3555** at any time.

However, if you have a question about your benefits, or disagree with the benefits provided, you may contact Total Rewards Benefits or file a claim or appeal by writing to the following address:

Walmart Total Rewards Benefits
Attn: Internal Appeals
508 SW 8th Street
Bentonville, Arkansas 72716-3500

Any claims or appeals will be determined under the time frames and requirements applicable to medical benefits.

International business travel medical insurance

Claim forms are generally not required for GeoBlue services. However, if you have a question about your benefits or disagree with the benefits provided, you may contact GeoBlue or file a claim. To submit a claim via email or fax, download a claim form and view detailed instructions in the Member Hub at **geo-blue.com**. Submit your claim by email to **claims@geo-blue.com** or by fax to **610-482-9623**.

You may also submit claims by post. Download a claim form from the Member Hub at **geo-blue.com** and send your completed form to:

GeoBlue
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 GeoBlue policy. Contact GeoBlue at any time by calling **888-412-6403**. Outside the U.S. call collect: **610-254-5830**.

Legal information

Legal information

The 2022 *Associate Benefits Book* for Puerto Rico associates 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 includes the following chapters:

- Eligibility and enrollment
- The medical plan
- The dental plan
- COBRA
- Resources for Living
- Company-paid life insurance
- Optional associate life insurance
- Short-term disability
- Long-term disability
- Claims and appeals

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.

LEGAL INFORMATION RESOURCES		
Find What You Need	**Online**	**Other Resources**
Contact the Plan Administrator		Write to: **Walmart** **Plan Administrator** **Associates' Health and Welfare Plan** **508 SW 8th Street** **Bentonville, Arkansas 72716-3500** Call **479-621-2058**
Answers to questions about the HIPAA Privacy Notice	Email your question to privacy@wal-mart.com	Call People Services at **800-421-1362**
Answers to questions about Medicare Part D	Visit **medicare.gov** for personalized help	**800-MEDICARE** (**800-633-4227**) TTY users should call **877-486-2048**
Answers to your questions about Medicaid/CHIP	Visit **insurekidsnow.gov**	**877-KIDSNOW** (**877-543-7669**)

What you need to know about the legal information for the Associates' Health and Welfare Plan

- As a participant in the Associates' Health and Welfare 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:

- Medical benefits, including pharmacy
- Self-funded dental benefits
- Associate assistance programs
- Company-paid life insurance
- Optional associate life insurance
- Accidental death and dismemberment insurance
- Business travel accident insurance
- Short-term disability benefits
- Long-term disability insurance

Each component benefit program is summarized in the respective chapter of this SPD. These summaries are also part of the Plan's SPD.

The terms and conditions of the Associates' Health and Welfare Plan are set forth in this book, 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 Associates' Health and Welfare Plan is established and maintained. An amendment to an incorporated document, including this SPD, is considered an amendment to the Plan.

Plan identifying information

Plan Sponsor:
Walmart Inc.
702 SW 8th Street
Bentonville, Arkansas 72716-0295

Plan Sponsor's EIN: 71-0415188

Plan Number: 501

Type of Plan: Welfare, including medical, dental, associate assistance program, company-paid life insurance, optional associate and dependent life insurance, accidental death and dismemberment (AD&D), business travel accident insurance, short-term disability, and long-term disability insurance.

Type of Administration: The Plan is administered by the Plan Administrator. 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. Each chapter in this SPD identifies the specific third party, including insurers, which 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, 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:
Senior Vice President, U.S. Benefits
Walmart Inc.
Associates' Health and Welfare Plan
508 SW 8th Street
Bentonville, Arkansas 72716-3500
479-621-2058

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 vision, critical illness, accident, company-paid life, optional associate life, optional dependent life, AD&D, business travel accident, long-term disability, and medical 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 employees, in an amount determined by Walmart Inc. 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.

Neither the Plan nor the benefits described in this 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 the company, or the benefits call center. Only written statements by the Plan Administrator shall bind the Plan.

Your rights under ERISA

As a participant in the Associates' Health and Welfare 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 Summary Plan Description 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 your group health 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 pre-existing 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 employee benefit plan. The people who operate your 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 your 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**.

HIPAA notice of privacy practices

This notice was updated August 1, 2019

THIS NOTICE APPLIES TO THE ASSOCIATES' MEDICAL PLAN (AMP), DENTAL PLAN, AND RESOURCES FOR LIVING (RFL), REFERRED TO COLLECTIVELY AS THE "PLANS"

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, and RFL 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, and RFL.

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), a fully insured PPO Plan and a fully insured international business travel medical plan. For these benefit options, the insurer of the HMO or PPO Plan 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 the benefits website on One.Walmart.com.

HOW THE AMP, DENTAL PLAN, AND RFL 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. T**o 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. T**o 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 Plan 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 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 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 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 Lawsuits and Disputes.** The Plans may use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we receive satisfactory assurances from the party seeking the information that reasonable efforts have been made to inform you of the request and given you the opportunity to raise an objection to the court or obtain an order protecting the information the party has requested.
5. T**o 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 health information 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 release your health information for workers' compensation and 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 Plan will not condition your eligibility to participate in the Plan or payment of benefits under the Plan 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.

STRICTER STATE PRIVACY LAWS

Under the HIPAA Privacy Regulations, the Plan is 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 Plan maintains 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, or RFL'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 Plan. 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 Plan at the address on the following 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, or RFL, 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, or RFL, 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 People Services
Attn: HIPAA Compliance Team
508 SW 8th Street
Mail Stop #3500
Bentonville, Arkansas 72716-3500

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' Health and Welfare Plan (the Plan) 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. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

There are 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.
- The Walmart prescription drug plans (as described later in this notice under the heading **Which Walmart plans are considered creditable coverage?**) are, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and are therefore considered creditable coverage. If you are a participant in one of these plans, you may keep your current coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

CREDITABLE AND NON-CREDITABLE COVERAGE

What is the meaning of the term "creditable coverage"? Creditable coverage means that your current prescription drug coverage is, on average for all Plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Prescription drug coverage that does not satisfy this requirement is not creditable coverage.

WHICH WALMART PLANS ARE CONSIDERED CREDITABLE COVERAGE?

Walmart has determined that the Elite and Premium prescription drug coverages are considered creditable according to Medicare guidelines.

If your coverage is creditable, you can keep your existing coverage and not pay extra if you later decide to enroll in Medicare coverage.

If you are enrolled in the Elite or Premium Plan, you can choose to join a Medicare prescription drug plan later without paying extra because you have existing prescription drug coverage that, on average, is as good as Medicare's coverage.

If you are enrolled in Medicare Part D, you are not eligible to enroll in the Elite or Premium Plan. If your dependent is enrolled in Medicare Part D and you are not, you are eligible to enroll in a Walmart medical plan, but your dependent would not be eligible for coverage.

If you drop your medical coverage with Walmart and enroll in a Medicare prescription drug plan, you and your eligible dependents will have the option of re-enrolling in the Walmart plan during annual enrollment or with a valid status change event. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

WHICH WALMART PLANS ARE CONSIDERED NON-CREDITABLE COVERAGE?

No prescription drug coverage offered by the Plan is considered non-creditable according to Medicare guidelines.

WHEN CAN I ENROLL FOR MEDICARE PRESCRIPTION DRUG COVERAGE?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7.

If you have creditable prescription drug coverage and you lose it through no fault of your own, you will be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you have non-creditable prescription drug coverage and you drop coverage under the Plan, because your coverage is employer-sponsored group coverage, you will be eligible for a two-month SEP to join a Medicare drug plan. However, you may pay a higher premium (a penalty) because you did not have creditable coverage under the Plan.

WHEN WILL I PAY A HIGHER PREMIUM (A PENALTY) TO JOIN A MEDICARE DRUG PLAN?

If you have creditable coverage and drop or lose your coverage under the Plan and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join the Medicare drug plan later.

If you have non-creditable coverage, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan.

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 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 Associates' Medical Plan (AMP) will be affected. Plan guidelines restrict you from enrolling in the Elite and Premium plans if you are enrolled in Medicare Part D. If your dependent is enrolled in Medicare Part D 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 Walmart AMP, be aware that you and your dependents will be able to get your AMP coverage back, but only during annual enrollment or due to a status change event.

If you enroll in a Medicare Part D plan and decide within 60 days to switch back to a plan under the Walmart AMP, you will automatically be re-enrolled for the same coverage you had prior to the status change event.

FOR MORE INFORMATION ABOUT MEDICARE AND YOUR PRESCRIPTION DRUG COVERAGE

- You will get this notice each year before your Medicare enrollment period.
- If we make a plan change that affects your creditable coverage, you will receive another notice.
- If you need a copy of this notice, you can request one from Benefits Customer Service at **800-421-1362**.

ADDITIONAL INFORMATION AVAILABLE

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-approved prescription drug plans. You will get a copy of the handbook in the mail every year from Medicare. You can also get more information about Medicare prescription drug plans from these sources:

- Visit medicare.gov.
- Call your state health insurance assistance 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**.

For people with limited income and resources, extra help paying for the Medicare prescription drug plan is available. For more information about this resource, visit the Social Security Administration online at **socialsecurity.gov**, or call **800-772-1213** (TTY **800-325-0778**).

REMEMBER

Keep this notice. If you enroll in one of the Medicare prescription drug plans, you may need to provide a copy of this notice when you join to show whether or not you have 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 below, 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

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:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: **http://myarhipp.com**
Phone: **855-MyARHIPP** (**855-692-7447**)

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program
https://www.dhcs.ca.gov/hipp
Phone: **916-445-8322**
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://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service:
800-359-1991 / State Relay **711**
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: **855-692-6442**

FLORIDA – Medicaid
Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: **877-357-3268**

GEORGIA – Medicaid
Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: **678-564-1162** ext **2131**

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: **http://www.in.gov/fssa/hip**
Phone: **877-438-4479**
All other Medicaid
Website: **https://www.in.gov/medicaid**
Phone: **800-457-4584**

IOWA MEDICAID AND CHIP (Hawki)
Medicaid website: **https://dhs.iowa.gov/ime/members**
Medicaid phone: **800-338-8366**
Hawki website: **http://dhs.iowa.gov/Hawki**
Hawki phone: **800-257-8563**
HIPP website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp

KANSAS – Medicaid
Website: **http://www.kancare.ks.gov**
Phone: **800-792-4884**

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://kidshealth.ky.gov/Pages/index.aspx**
Phone: **877-524-4718**
Medicaid website: **https://chfs.ky.gov**

LOUISIANA – Medicaid
Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp**
Phone: **888-342-6207** (Medicaid hotline) or **855-618-5488** (LaHIPP)

MAINE – Medicaid
Enrollment website: **https://www.maine.gov/dhhs/ofi/applications-forms**
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: **http://www.mass.gov/info-details/masshealth-premium-assistance-pa**
Phone: **800-862-4840**

MINNESOTA – Medicaid
Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**
Phone: **800-657-3739**

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: **573-751-2005**

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: **800-694-3084**

dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial **877-KIDS NOW** or **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, 2021. Contact your state for more information on eligibility.

NEBRASKA – Medicaid
Website: **http://www.ACCESSNebraska.ne.gov**
Phone: **855-632-7633**
Lincoln: **402-473-7000** Omaha: **402-595-1178**

NEVADA – Medicaid
Website: **http://dhcfp.nv.gov**
Phone: **800-992-0900**

NEW HAMPSHIRE – Medicaid
Website: **https://www.dhhs.nh.gov/oii/hipp.htm**
Phone: **603-271-5218**
Toll-free for HIPP program: **800-852-3345**, ext **5218**

NEW JERSEY – Medicaid and CHIP
Medicaid website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid**
Medicaid phone: **609-631-2392**
CHIP website: **http://www.njfamilycare.org/index.html**
CHIP phone: **800-701-0710**

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:
http://www.nd.gov/dhs/services/medicalserv/medicaid
Phone: **844-854-4825**

OKLAHOMA – Medicaid and CHIP
Website: **http://www.insureoklahoma.org**
Phone: **888-365-3742**

OREGON – Medicaid
Website: **http://healthcare.oregon.gov/Pages/index.aspx**
http://www.oregonhealthcare.gov/index-es.html
Phone: **800-699-9075**

PENNSYLVANIA – Medicaid
Website: **https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx**
Phone: **800-692-7462**

RHODE ISLAND – Medicaid and CHIP
Website: **http://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: **http://dss.sd.gov**
Phone: **888-828-0059**

TEXAS – Medicaid
Website: **http://gethipptexas.com**
Phone: **800-440-0493**

UTAH – Medicaid and CHIP
Medicaid website: **https://medicaid.utah.gov**
CHIP website: **http://health.utah.gov/chip**
Phone: **877-543-7669**

VERMONT – Medicaid
Website: **http://www.greenmountaincare.org**
Phone: **800-250-8427**

VIRGINIA – Medicaid and CHIP
Website: **https://www.coverva.org/en/famis-select**
https://www.coverva.org/en/hipp
Medicaid/CHIP phone: **800-432-5924**

WASHINGTON – Medicaid
Website: **https://www.hca.wa.gov**
Phone: **800-562-3022**

WEST VIRGINIA – Medicaid
Website: **http://mywvhipp.com**
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, 2021, 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 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.

عربي
خدمات الترجمة الفورية متاحة دون تكلفة. 1-800-421-1362.

မြန်မာ
စကားပြန်ဝန်ဆောင်မှုများကို အခမဲ့ ရရှိနိုင်ပါသည်။ 1-800-421-1362

汉语普通话
翻译服务免费提供。1-800-421-1362.

فارسی
خدمات مترجم بدون هیچ هزینه ای در دسترس می باشد. 1-800-421-1362

Français
Des services d'interprètes sont disponibles sans frais.
1-800-421-1362.

kreyòl ayisye
Gen Sèvis entèprèt ki disponib gratis. 1-800-421-1362.

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.

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

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

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: **OCRComplaint@hhs.gov**

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

Português (Brasil)
Serviços de interprete estão disponíveis grátis.
1-800-421-1362.

ਪੰਜਾਬੀ
ਦੋਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। 1-800-421-1362.

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

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

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

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

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

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

The Associate Stock Purchase Plan (ASPP)

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 $1,000 withheld from your biweekly paycheck ($1 to $500 if you are paid weekly) to buy stock. 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	Complete an online enrollment session on **One.Walmart.com/ASPP**	
• Access your account information • Get your account statement • Get a Form 1099	Go to the Computershare website at **computershare.com/walmart** or the Associate Stock app	Call Computershare at **800-438-6278** (hearing impaired: **800-952-9245**) or get the Associate Stock app (available for Apple or Android devices)
Send money directly to Computershare		Send check to: **Computershare** **Attn: Walmart ASPP** **P.O. Box 505042** **Louisville, Kentucky 40233** (Company matching contributions will not be made on money sent directly to Computershare)

What you need to know about the Associate Stock Purchase Plan

- All eligible associates can purchase Walmart stock through convenient payroll deductions and direct payments to Computershare.
- 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. You only pay a fee when you sell shares of stock.
- Your shares will be credited to an account that is maintained in your name at Computershare. 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 legal age of majority in your payroll state to participate (19 is the legal age of majority in Alabama and Nebraska). If you live in Puerto Rico, you must be 21 years of age to participate. If you have questions about the age requirement, review your state laws on legal age of majority.

Enrolling in the Associate Stock Purchase Plan

You can enroll in the Plan by completing an online benefits enrollment session on **One.Walmart.com/ASPP**. Before you enroll in this plan, you should carefully review this Associate Stock Purchase Plan brochure 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 Associate Stock Purchase Plan allows all eligible associates to buy Walmart stock conveniently through payroll deductions. You can have any whole dollar amount from $2 to $1,000 withheld from your paycheck to buy stock ($1 to $500 for associates with a weekly paycheck).

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 in 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.

In addition to your payroll deductions, you can also contribute to the Associate Stock Purchase Plan by sending money directly to Computershare, the Plan's administrator, at:

Computershare
Attn: Walmart ASPP
P.O. Box 505042
Louisville, Kentucky 40233

Money sent directly to Computershare will not receive the Walmart matching contribution. The total of your payroll deductions and money sent directly to Computershare cannot exceed $125,000 per Plan year. Dividends paid on the stock you hold as of each dividend record date are automatically reinvested to buy additional shares of stock for you, but do not count against the $125,000 maximum.

The value of the stock you purchase can fluctuate and may decline. There is no way to guarantee that your stock will have the same value in the future that it had when you made the purchase or that the value of the stock will increase.

When making a decision 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 that is incorporated by reference in the Plan Prospectus.

WALMART'S CONTRIBUTION TO YOUR COMPANY STOCK OWNERSHIP

If you contribute	Your Plan year payroll deduction contribution is	Walmart's matching contribution* 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

*Company contributions will be made only on stock purchased through payroll deductions. Company contributions will not be made on money sent directly to Computershare.

Selling stock through the Plan

No fees are charged to you for buying stock; however, when you sell stock you will be charged a fee. The fees charged by Computershare as described in this section are subject to change from time to time.

If you choose to sell your stock, your stock will be sold pursuant to a market order. Your stock will be sold as soon as your request can reasonably be processed. Generally, market orders 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 New York Stock Exchange (NYSE). If the NYSE is closed when your order is ready to be processed, your order will be processed as early as possible on the next NYSE trading day. The fee is $25.50 per sale plus $0.05 (five cents) per share sold for each sell you execute.

You can sell stock from **computershare.com/walmart**, from the Associate Stock app (available for Apple and Android devices), or by calling Computershare at **800-438-6278** (hearing impaired: **800-952-9245**). 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 Computershare. 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 two business days from the date of sale. If you select to receive your 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.

The sale fee is automatically deducted from the amount deposited or reported on your check for the net proceeds of the sale. Each time you sell stock, you will receive a transaction summary form. For tax reporting purposes, you'll receive appropriate tax documents (1099B and/or 1099DIV) enclosed with your annual statement in the first quarter of the following year (January through March). Depending on delivery preference, these documents will be either mailed to your address on file with Computershare or you will be notified via email when they 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 Computershare account

You will receive a statement from Computershare at least annually (first quarter) that shows the activity in your account. However, 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 **computershare.com/walmart**.

The annual statement you receive will 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 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 **computershare.com/walmart**, by the Associate Stock app (available for Apple and Android devices), or by phone at **800-438-6278** (hearing impaired: **800-952-9245**).

If you request replacement statements from Computershare, there is a $5 charge per statement for previous years' statements. Or, you can obtain copies free of charge through the website at **computershare.com/walmart**.

Ending your participation and closing your account

To cancel your payroll deductions to the Associate Stock Purchase Plan, complete an online benefit enrollment session on **One.Walmart.com/ASPP**.

After you cancel your payroll deductions, you can close your account by selling or transferring the remaining stock in your account. To avoid paying a sales transaction fee twice, cancel your payroll deductions before closing your account. You also have the option to stop payroll deductions and to continue to hold your shares through the Plan at Computershare.

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 the company match. You can make voluntary cash purchases and benefit from having no broker's fee. There is an annual maintenance fee of $35 per year, which will be automatically deducted from your account through the sale of an appropriate number of shares or portion of a share of stock to cover the fee during the first quarter of the year.
- You can close your account and transfer your shares to another brokerage.
- You can close your account and sell some or all of the shares in your account.

In order to prevent any residual balances and to avoid paying a sales transaction fee twice, wait until you receive your final paycheck before closing your account.

It is very important that you update Computershare 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.

50,935,077 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 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 Securities and Exchange Commission 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 June 30, 2021

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 stockholders of Walmart at our Annual Stockholders' Meeting held on June 3, 2016. As of June 30, 2021, up to 50,935,077 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; 20,000,000 shares of Stock were available for purchase from the company under the Plan; and 30,000,000 shares of Stock were available for purchase on the open market under the Plan. On November 30, 2018, 50,000,000 shares were registered with the United States Securities and Exchange Commission for offer and sale on Registration Statements on Form S-8. Shares of the Stock are listed for trading on the New York Stock Exchange. 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. 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 Mr. Steve Reinemund, Ms. Carla Harris, Ms. Marissa Mayer, and Mr. Randall Stephenson.

The Committee has selected a Third-Party Administrator, currently Computershare Trust Company, N.A. ("Computershare"), to establish and maintain accounts under the Plan. Computershare also serves as the company's stock transfer agent and provides other stock-related services to the company and its shareholders.

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/ASPP** 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 or employment 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 must be approved by the Committee.

Plan contributions — Associate Stock Purchase Program

To make payroll deduction contributions, you need to complete an online benefits enrollment session at **One.Walmart.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 an online benefits enrollment session at **One.Walmart.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 $1,000 per biweekly payroll period. Payroll deductions for associates paid on a weekly basis can be as little as $1 or as much as $500 per weekly payroll period. The amount of any biweekly or weekly 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 15 percent 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 participate or have participated in payroll deductions under the Plan and your Plan account has not been closed as described below, 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 in 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 Computershare. Instructions for making such voluntary contributions are available from Computershare. Neither the Company nor your Participating Employer will make matching contributions on amounts you contribute directly to Computershare. 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 Computershare.

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 consistently 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 from time to time.

Your Stock under the Outstanding Performance Award component will be given to you through an account maintained for your benefit by Computershare.

STOCK PURCHASES

Your employer will send all of your payroll deductions along with any matching contributions to Computershare as soon as practicable following each pay period. Computershare will purchase Stock for your Plan account no later than five business days after it receives the funds. If you make a voluntary cash contribution outside of payroll deductions, Computershare will purchase your Stock with that voluntary cash contribution no later than five business days after it receives the funds.

Computershare may purchase Stock for the Plan accounts on a national stock exchange, from the company, or from a combination of these places. However, the Committee reserves the right to direct Computershare to purchase from a particular source, consistent with applicable securities rules and the applicable rules of any national stock exchange.

Typically, when Computershare 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 Computershare. A participant is not permitted to direct an order for Computershare to purchase shares of Stock solely for himself or herself that are part of the bundled group.

If Computershare 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 New York Stock Exchange — 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 NYSE on the date of 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 and used to fund such purchases, 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, 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 Computershare, but that may not be practicable in all circumstances. All voluntary cash contributions must be converted to U.S. dollars before being sent to Computershare to purchase shares of Stock.

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 Computershare's name until you request to have your shares deposited into a "General Shareholder" account, have your Stock certificates delivered to you from the Plan 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, just like any other stockholder of the company. You may not transfer or assign your Plan account to another person who is not an eligible participant in the Plan. There is no 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 do with other shares of Stock you may own, subject to compliance with our Insider Trading Policy.

DIVIDENDS AND VOTING

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 stockholders. To vote the shares of Stock held in your Plan account, you must deliver signed voting instructions, also known as proxy instructions, in a timely manner 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. However, 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 New York Stock Exchange 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). However, you must pay any commissions or charges resulting from other Computershare services you request, for example, brokerage commissions and other fees applicable to the sale of Stock. Computershare can tell you if a particular request would cause you to incur a charge. The fees charged by Computershare described in this Prospectus are subject to change from time to time.

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 period of time covered by the statement. You may elect to receive your statements online. If you elect to do so, you will receive an email informing you that your statement is ready and can be found on **computershare.com/walmart**. 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 your income taxes.

You may also access information regarding your account at any time by logging on to **computershare.com/walmart** or the Associate Stock app. You can access your account information by phone at **800-438-6278** (hearing impaired **800-952-9245**).

If you request replacement statements from Computershare, there is currently a $5 charge per statement for statements for years preceding the most recently completed plan year. Or, you can obtain copies free of charge through the website at **computershare.com/walmart**.

RISKS

Many of your risks of Plan participation are the same as those of any other stockholder 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 Computershare 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 certificate delivery and Stock sales

Computershare will send you, on request, 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 continue to have in effect and the dividends those shares will not be reinvested under the Plan.

You may also have Computershare transfer any or all of 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 request that Computershare sell all or a portion of the shares of Stock (including any fractional interests) credited to your Plan account at any time, 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 Computershare sell shares of Stock held in your Plan account. Any brokerage commission or fees will be at the rates posted by Computershare from time to time. These rates are available upon request from Computershare. A current schedule of Computershare's fees applicable to the Plan can be found at **computershare.com/walmart**. The company negotiated the amount of such fees with Computershare.

If you choose to sell your Stock, your Stock will be sold pursuant to a market order. Although the Plan permits sales of shares of Stock held in Plan accounts to be made through batch orders and such sales have been made through batch orders in the past, sales of shares of Stock under the Plan are now made solely pursuant to market orders. As a result, if you direct Computershare to sell any shares of Stock credited to your Plan account, Computershare will sell those shares in the open market at the then current best available price. However, 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 Computershare sells shares credited to your Plan account in the open market, we could be the purchaser of such shares. However, 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 New York Stock Exchange (the "NYSE"), but orders for those sales need not be executed over the NYSE. If the NYSE is closed when your order is ready to be processed, your sale transaction will be processed as early as practicable on the next NYSE trading day. Orders for the sale of shares of Stock under the Plan may be executed by or through an affiliate of Computershare 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 Computershare 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 Computershare. Specifically:

- You may keep your Plan account open (without the weekly or biweekly payroll deduction and your employer's matching contributions). If you keep your account open, you may continue to make voluntary cash contributions and no brokerage commissions will be charged on the purchase of Stock. If you cease to be employed by the company or one of its affiliates, an annual maintenance fee will be charged to your account. Computershare has the option to collect such maintenance fee either in the form of quarterly installments, or in an annual lump sum payment, which is due in the first quarter of each calendar year and will be paid by means of the sale of an appropriate number of shares or portion of a share of Stock by Computershare. (If you are transferred to a company affiliate that is not a Participating Employer, the company may continue to pay the maintenance fee for you.)
- If you own at least one full share of Stock, you may close your Plan account by moving your Stock into a "General Shareholder" account maintained on your behalf by Computershare. You may accomplish this move either by receiving all full shares in certificate form with a check for any fractional share ownership or by re-depositing the shares in the General Shareholder account, or Computershare can move the shares electronically at your request. You should contact Computershare for more information about the fees associated with a General Shareholder account.
- You may close your Plan account by having all shares of Stock in your account sold and the proceeds paid to you, or you can have certificates for full shares (and cash proceeds of any fractional shares paid to you) delivered to you instead. The proceeds of any sale of full or fractional shares will be net of brokerage commissions, sales fees and other applicable charges. Your account will be closed automatically if you terminate employment and there are no shares or fractional shares in your account.

If you die before your Plan account has been closed, your Plan account will be distributed per the legal documentation submitted to Computershare or to your estate, unless you had previously arranged with Computershare 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 Computershare to move your shares into a General Shareholder account maintained by Computershare at his or her own expense or to have the Stock (or proceeds from the sale thereof) distributed, less any applicable fees or commissions.

If you established a joint tenant account prior to April 1, 2018, you may contact Computershare at **800-438-6278** (hearing impaired: **800-952-9245**) to remove a joint tenant from your account.

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 stockholder 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. 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, as the case may be, 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 for 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 to you 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 the same 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 of the shares of Stock held in your Plan account. However, when you sell or otherwise dispose of your shares of Stock—whether through Computershare 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 at **800-421-1362**. You can also write to:

Walmart People Services
Walmart Inc.
508 SW 8th Street
Bentonville, Arkansas 72716-0295

Computershare may be contacted by calling **800-438-6278** (**800 GET-MART**) (hearing impaired: **800-952-9245**), online at **computershare.com/walmart**, or by writing to the following address for all correspondence, including transactions, Stock certificate requests, Stock powers, voluntary purchases and any customer service inquiries:

Computershare
Attn: Walmart ASPP
P.O. Box 505042
Louisville, Kentucky 40233

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 over **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, 2021;
- The company's Quarterly Reports on Form 10-Q for the fiscal quarter ended April 30, 2021;
- The company's Current Reports on Form 8-K filed with the Commission on June 4, 2021;
- The company's definitive Proxy Statement for the 2021 Annual Shareholders' Meeting, filed with the Commission on April 22, 2021; 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 Stockholders 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
508 SW 8th Street
Bentonville, Arkansas 72716-0295

Or you may call People Services at **800-421-1362**.

The Walmart Puerto Rico 401(k) Plan

Este documento contiene un resumen en inglés de los derechos y beneficios bajo el Plan 401(k) de Walmart Puerto Rico. Si necesitas asistencia para aclarar cualquier duda relacionada a este documento, comunícate con tu Representante de Recursos Humanos o a la División de Beneficios llamando al **787-653-1065** de lunes a viernes de 8:00 a.m. a 5:00 p.m. (hora estándar del Atlántico).

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 Puerto Rico 401(k) Plan

THE WALMART PUERTO RICO 401(K) PLAN RESOURCES		
Find What You Need	**Online**	**Other Resources**
Enroll in or change your 401(k) contribution and your catch-up contribution	Go to **One.Walmart.com** or the Plan's website at **benefits.ml.com**	Call the Customer Service Center at **888-968-4015**
• Request a rollover packet 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 hardship withdrawal or a withdrawal after you reach age 59½ • Request a withdrawal of your rollover contributions • Request a loan from your Plan account • Change your investment options • Request a payout when you leave Walmart Puerto Rico • Get information about your Plan investment options	Go to **benefits.ml.com**	Call the Customer Service Center at **888-968-4015**
• Designate a beneficiary		Fill in the Beneficiary Designation Form for the Walmart Puerto Rico 401(k) Plan – contact your Human Resources representative

What you need to know about the Walmart Puerto Rico 401(k) Plan

- You are generally eligible to participate in the Plan on the first day of the calendar month following your first anniversary of employment if you are credited with at least 1,000 hours of service during that first year.
- You can contribute from 1% up to 50% of each paycheck to the Plan once you are eligible.
- Walmart Puerto Rico will make matching contributions each payroll period. The matching contribution will be a dollar-for-dollar match on each dollar you contribute to the Plan after you become eligible for matching contributions, up to 6% of your eligible annual pay.
- You will always be 100% vested in the money you contribute to your 401(k) Account and the money Walmart Puerto Rico contributes to your Company Match Account.
- You choose how to invest all contributions to your Plan account
- If you do not choose how your current contributions to the Plan will be invested, they will be automatically invested in the Plan's default investment option, currently the BlackRock® LifePath Index Funds.
- You pay no Puerto Rico income tax on contributions or any investment earnings until you receive a payout from the Plan.
- The Plan accepts rollover contributions from other eligible retirement plans. You can withdraw your rollover contributions at any time.
- You may request a loan from your Plan account, subject to Plan rules.
- You can access and monitor your account at any time at **benefits.ml.com**.

This is a summary of benefits offered under the Plan as of December 1,2021. Should any questions ever 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 Puerto Rico 401(k) Plan eligibility

ASSOCIATES WHO ARE ELIGIBLE TO PARTICIPATE IN THE PLAN

All associates of Walmart Puerto Rico who are residents of Puerto Rico are eligible to participate in the Plan, except:

- Leased employees; non-resident aliens with no income from Puerto Rico sources; independent contractors or consultants
- Anyone not treated as an employee of Walmart Puerto Rico
- 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 Puerto Rico has negotiated in good faith to impasse with the representative on the question of benefits.

WHEN PARTICIPATION BEGINS

If you are an eligible associate, you will begin participating in the Walmart Puerto Rico 401(k) Plan on the first day of the calendar month following your first anniversary of employment with Walmart Puerto Rico if you are credited with at least 1,000 hours of service during that first year. For example, if your date of hire is December 15, 2020, and you are credited with 1,095 hours by December 15, 2021 (your first anniversary), then you will become a participant in the Plan on January 1, 2022. This means you can choose to contribute to the Plan from your pay and are eligible to receive company matching contributions.

If you are not credited with 1,000 hours of service during that first year, your eligibility will be determined on hours worked during the Plan year, which runs from February 1 to January 31. You will be eligible to participate in the Plan on 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, 2020, and you are credited with only 595 hours by December 15, 2021 (your first anniversary), but you work 1,095 hours during the February 1, 2021–January 31, 2022 Plan year, you will become a participant in the Plan on February 1, 2022.

HOW HOURS OF SERVICE ARE CREDITED UNDER THE PLAN

For hourly associates, the hours counted toward the 1,000-hour requirement are credited as follows:

- Hours, including overtime hours, worked by hourly associates for Walmart Puerto Rico or any related company 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 management associate, 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 Puerto Rico or any related company.
- In general, you must work at least six months of the Plan year to have 1,000 hours credited for the year. (Vacation pay after you leave Walmart Puerto Rico does not give you additional service for this purpose.)

If you become an associate of Walmart Puerto Rico 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 Puerto Rico or a related company 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 before you become eligible to participate in the Plan, you will receive an enrollment packet at your home address on file. This packet tells you how you can make contributions from your pay on a pretax basis into your 401(k) 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.

When making elections regarding your contributions to the Plan, keep in mind that Walmart Puerto Rico will match all of your contributions dollar-for-dollar up to 6% of eligible annual pay in any Plan year. You will always be 100% vested in your 401(k) Account and the Company Match Account.

To begin making contributions to the Plan once you are eligible, you can enroll online on **One.Walmart.com** or at **benefits.ml.com** or by calling 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 (see **Making contributions to your 401(k) account** later in this summary), and

- How to invest your account among the Plan's investment options. The Plan's investment options and procedures are described in the 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 and the investment option(s) you have elected. You should review the confirmation to make sure your enrollment information is correct.

Your contributions to the Plan will be effective as soon as administratively feasible, normally within two pay periods after you enroll. No contributions will be taken from your pay before you become an eligible participant in the Plan. Only participants who elect to contribute their own funds to the Plan will have those contributions matched by Walmart Puerto Rico.

It is your responsibility to review your paychecks to confirm that your election was implemented correctly. If you believe your election was not 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 Puerto Rico 401(k) Plan accounts

The Walmart Puerto Rico 401(k) Plan consists of several accounts. You will have some or all of the following accounts:

- **401(k) Account:** This account holds your contributions to the Plan (including your catch-up contributions, if any) as adjusted for earnings or losses on those contributions.
- **Company Match Account:** This account holds Walmart Puerto Rico's matching contributions, as adjusted for earnings or losses on those contributions.
- **401(k) Rollover Account:** This account holds any contributions that you rolled over to this Plan from another eligible retirement plan that is qualified under Puerto Rico Internal Revenue Code Section 1081.01(a), as adjusted for earnings or losses on those contributions.
- **Company Funded 401(k) Account:** This account holds the discretionary Company 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 Company contributions to the Plan made for Plan years ended on or before January 31, 2011, as adjusted for earnings or losses on those contributions.

The chart on the following page provides a summary of some of the differences between these accounts. These differences are discussed in more detail throughout this summary.

Note that if you become an associate of Walmart Puerto Rico 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

When you come to work for Walmart Puerto Rico, you may have pretax funds owed to you from a previous employer's retirement plan that is qualified under Puerto Rico Internal Revenue Code Section 1081.01(a). If so, you may be able to roll over that money to this Plan. If you roll over funds to this Plan, keep these points in mind:

- If you are an eligible associate, you may go ahead and roll over money to the Plan even though you have not yet satisfied the 1,000 hour and 12-month waiting period requirement to become a participant in the Plan
- Once you roll funds into the Walmart Puerto Rico 401(k) Plan, those funds will be subject to the rules of this Plan, including payout rules, and not the rules of your former employer's plan
- Your rollover contribution will be placed in your 401(k) Rollover Account 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, you can make your request at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015** to obtain a rollover packet.

Making contributions to your 401(k) account

After you become a participant in the Plan, you may choose to contribute from 1% up to 50% (in whole percentages) of each paycheck to your 401(k) Account. Your contributions in any calendar year, however, may not exceed a limit set by law. For 2022, the limit is $15,000. You are always 100% vested in all amounts contributed into your 401(k) Account.

Contributions to your 401(k) Account are deducted from your pay before Puerto Rico income taxes are withheld. This means that you don't pay Puerto Rico income taxes on amounts you contribute to the Plan. Earnings on these contributions continue to accumulate tax-free and are not taxed until your 401(k) Account is actually distributed to you from the Plan. 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.

HOW YOUR 401(K) CONTRIBUTION IS DETERMINED

The percentage of pay you elect to contribute to the Plan will be applied to the following types of pay:

- Regular salary or wages, including bonuses and any pretax dollars you use for your 401(k) contributions or to purchase benefits available under the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan
- Overtime, paid time off (used and paid out), bereavement, jury duty and premium pay
- Most incentive plan payments
- Holiday bonuses
- Special recognition awards, such as the Outstanding Performance Award
- Differential wage payments you receive from Walmart Puerto Rico 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
- Approved disability pay
- Equity 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).

Only pay earned after you become eligible to participate in the Plan will be considered when determining 401(k) and company matching contributions.

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 was implemented correctly. If you believe your election was not implemented correctly, you must 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.

WALMART PUERTO RICO 401(K) PLAN ACCOUNT DIFFERENCES

	Source of contributions	May participants choose investments?	Vesting percentage	Are hardship withdrawals available?	Are in-service withdrawals available after age 59½?
401(k) Account	You	Yes	100%	Yes	Yes
Company Match Account	Walmart	Yes	100%	No	Yes
All Rollover Accounts	You	Yes	100%	Yes	Yes
Company Funded 401(k) Account	Walmart	Yes	100%	No	Yes
Company Funded Profit Sharing Account	Walmart (except for rollovers you made to the Profit Sharing Plan)	Yes	2 years – 20% 3 years – 40% 4 years – 60% 5 years – 80% 6 years – 100% (Rollovers are immediately 100% vested)	No	Yes (to the extent vested)

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. These are called catch-up contributions and are made by payroll deduction just like your normal contributions. For 2021, your catch-up contributions may be any amount up to the lesser of $1,500 or 75% of your eligible annual pay. This amount may be adjusted from time to time. Your catch-up contributions will be credited to your 401(k) Account.

For example, if you elect to contribute the maximum amount in the 2022 calendar year, which is the lesser of $15,000 or the maximum percentage of your eligible annual pay allowed under the Plan, you could elect to contribute up to an additional $1,500 during the 2022 calendar year. If you are interested in making catch-up contributions, you can enroll online on **One.Walmart.com** or at **benefits.ml.com**, or by calling the Customer Service Center at **888-968-4015**.

CONTRIBUTING TO MORE THAN ONE PLAN DURING THE YEAR

The maximum total amount you can contribute to this Plan and to any other Puerto Rico qualified plan is $15,000 for the 2022 calendar year, or $16,500 if you are eligible for catch-up contributions. This amount may be increased from time to time. 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 must be included in your income for that year and will be taxed. 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 People Services at **800-421-1362** no later than April 1 following the calendar year in which the excess contributions were made. 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 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 Puerto Rico). For more information, contact People Services at **800-421-1362**.

Walmart Puerto Rico's contributions to your Company Match Account

Once you are eligible to receive matching contributions, Walmart Puerto Rico will make matching contributions to your Company Match Account equal to 100% of your subsequent contributions to your 401(k) Account, including catch-up contributions, up to 6% of your eligible annual pay for the Plan Year. The company matching contribution will be made into your Company Match Account each pay period and will continue 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 participate in the Plan.

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 ($15,000 for 2022) 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 $15,000 in 401(k) contributions in January of 2022, 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, 2022.

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 Puerto Rico 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 Puerto Rico'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 Puerto Rico 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 Puerto Rico and its related companies. 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 Puerto Rico and its related companies as follows:

PROFIT SHARING VESTING SCHEDULE*	
Years of service	**Vested percentage**
Less than two	0%
Two	20%
Three	40%
Four	60%
Five	80%
Six or more	100%

*Applies to participants actively employed on or after January 31, 2008.

NOTE: If you terminated employment before February 1, 2007, your payout was based on the prior vesting schedule and not the vesting schedule shown above.

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. (Please note that years of service for this purpose are not determined by your anniversary date.)

If you leave Walmart Puerto Rico 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 Puerto Rico's contributions to your Company Funded 401(k) Account.

Investing your account

YOUR INVESTMENT OPTIONS

You decide how your accounts will be invested. You can choose:

- **The BlackRock LifePath® Index Funds.** The BlackRock LifePath Index Funds are a series of investment options commonly known as "target retirement date" funds. The BlackRock LifePath Index Funds are diversified investment options that automatically change their asset allocation over time to become more conservative as a participant gets closer to retirement. This is done by shifting the amount of money that is invested in more aggressive investments, such as stocks, and allocating those amounts to more conservative investments, such as bonds and money market funds, as a participant gets closer to 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 purchase 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 will depend upon 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 BlackRock LifePath Index Funds based on your age. For more information, refer to the Qualified Default Investment Alternative (QDIA) notice and the Investment Guide. These documents can both 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, profit-sharing assets, as a whole, are significantly invested in Walmart stock. For Plan years ending prior to January 31, 2006, all or a significant portion of Walmart Puerto Rico's profit-sharing contribution was invested in Walmart stock. 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 Puerto Rico's profit-sharing contribution was not invested in Walmart stock.

A description of all investment options, including the BlackRock LifePath Index 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 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., Walmart Puerto Rico, the Benefits Investment Committee and the trustee

are not responsible for losses to your accounts that are the 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 Puerto Rico 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.

HOW TO OBTAIN MORE INVESTMENT INFORMATION

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 are in line with your objectives and your risk tolerance. For more sources of information 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 enter "investing and diversification" in the search field.

You may obtain more specific information regarding your investment rights and investment options under the Plan at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

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 Plan materials. It is your responsibility to make sure your change is made. If you don't 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 at **888-968-4015** 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 "put your eggs in more than one basket."

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. Therefore, you should keep in mind your rights to diversify your Plan account and carefully consider how you choose to invest your Plan account. You can obtain information about your right to diversify your accounts and all of the investment options available under the Plan by accessing your account online at **benefits.ml.com** or by calling 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. If you would like more sources on individual investing and diversification, you may go to the website of the Department of Labor's Employee Benefits Security Administration at **www.dol.gov/agencies/ebsa** and enter "investing and diversification" in the search field.

More about owning Walmart stock

VOTING

If any part of your account is invested in Walmart stock through the Plan, each year you will receive all of the materials generally distributed to the shareholders of Walmart, including an instruction card telling the trustee how you would like the shares in your Plan account to be voted. The materials will be mailed to your home address or sent electronically, based on your electronic delivery election.

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 send 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 about 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., Walmart Puerto Rico 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 Walmart Inc. with respect to your rights as shareholder (through your Plan accounts), 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 401(k) 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 will also be reinvested as determined by the Benefits Investment Committee.

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 Puerto Rico, if any, the performance of your investment options, and the values of your accounts and fees assessed to your accounts during the quarter. 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 account. You can find information on fees in the Annual Participant Fee Disclosure Notice and online at **benefits.ml.com**.

Receiving a payout while working for Walmart Puerto Rico

Generally, you are not entitled to a payout from the Walmart Puerto Rico 401(k) Plan until you stop working for Walmart Puerto Rico and its related companies. However, in the following limited situations you may be entitled to receive a payout of some or all of your accounts while you're still working:

- In the case of a financial hardship (as defined by the Puerto Rico Treasury Department).
- After you attain age 59½.
- Rollovers can be withdrawn at any time.
- You may request a loan from your Plan account.

It's important to understand how any type of payout or loan from the Walmart Puerto Rico 401(k) Plan affects your tax situation. For more information, see **The income tax consequences of a payout** later in this summary.

FINANCIAL HARDSHIP WITHDRAWALS

You may withdraw some or all of your 401(k) Account (other than earnings on those contributions) and Rollover Account as necessary to meet a "financial hardship."

Under government guidelines, a financial hardship may exist if the request is for:

- Payment of medical care expenses not covered by insurance for you, your spouse or your dependents
- Costs directly related to the purchase (excluding mortgage payments) of your primary residence (home)
- 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 or dependents
- Payments necessary to prevent eviction from, or foreclosure on, your primary residence, or
- Payment for burial or funeral expenses for your deceased parent, spouse, children or dependent.

You must have already obtained all in-service payouts available at age 59½, including a loan, before you can request a financial hardship payout.

Also, Puerto Rico tax laws will not allow you to contribute to this Plan and certain other retirement or stock purchase plans (including the Associate Stock Purchase Plan) for 12 months after the date of your financial hardship payout. If you are a management associate with stock options,

you may not exercise options during this 12-month period. Further, you will not be able to make contributions to your 401(k) Account during the calendar year immediately following the year of your hardship payout which are in excess of the applicable annual contributions limit under the Puerto Rico Internal Revenue Code applicable for such calendar year ($15,000 for 2020) less the amount of your contributions for the year of the hardship payout.

A financial hardship payout is immediately taxable to you. For more information, see **The income tax consequences of a payout** later in this chapter.

You can make a request for a financial hardship payout online at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

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 Puerto Rico. You can make a request for a withdrawal online at **benefits.ml.com** or by calling the Customer Service Center at **888-968-4015**.

WITHDRAWALS OF ROLLOVER CONTRIBUTIONS

You may withdraw all or any portion of your 401(k) Rollover Account and your Profit Sharing Rollover Account at any time even if you are still working for Walmart Puerto Rico or its related companies. (Note that, prior to February 1, 1998, the Plan accepted rollovers to a profit sharing rollover account, but this option is no longer available.)

PLAN LOANS

You may apply for a loan from the vested portion of your Plan account while you are still working for Walmart Puerto Rico. 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 Plan 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 accessed 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 is taxable to you as ordinary and subject to a 10% withholding rate.

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. Effective February 1, 2020, your beneficiary choices must be made on **One.Walmart.com**. Since your spouse or partner 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 Alternate Beneficiary Form for Married Participants Form B and your spouse must complete the Spousal Consent portion of that form. The Spousal Consent form must be notarized and must accompany the Form B in order for Form B to be valid.

Form B and the Spousal Consent form can be found on **One.Walmart.com**, or you may talk to the Human Resource Representative at your facility. Any beneficiary designation you make will be effective for all of your Plan accounts in the Plan.

If you do not designate a beneficiary, your death benefit will be distributed in accordance with the Plan's default provisions in the following order as stated below:

- Spouse or partner (as defined below); if none, then
- Living children (stepchildren are not included); if none, then
- Living parents; if none, then
- Living siblings; if none, then
- Your estate, to be distributed per the terms of your will or as a court determines.

Please note that if you designate your spouse as your beneficiary and you later divorce, your designation will not be effective after the divorce unless you complete a new designation form. Similarly, if you do not have a spouse and you later marry, your prior beneficiary designation will not be effective after the marriage unless you complete a new designation form with your spouse's consent.

Also, note that if you designate a beneficiary and your beneficiary dies before the benefit check is issued, the benefit will be paid to your contingent beneficiary 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 or partner is your beneficiary, the benefit will always be paid to the spouse's or partner's estate if he or she dies after you but before the benefit is paid. Again, it is very important for you to keep your beneficiary information up to date. Beneficiary choices should be made on **One.Walmart.com**.

Your same-sex spouse will be 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 June 23, 2013, any beneficiary designation you had in effect that designated someone other than your spouse as your beneficiary immediately 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 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 to continue indefinitely
  - 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.

BENEFICIARY DESIGNATIONS MADE 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 401(k) Account, your Company Funded 401(k) Account, your Company Match Account and your 401(k) Rollover Account. Similarly, if you made a beneficiary designation under the Profit Sharing Plan before October 31, 2003, that designation will continue to apply to your Company Funded Profit Sharing 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. To make a beneficiary designation, you will need to complete an Online Beneficiary session on **One.Walmart.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 Plan account or as directed in the Order.

If you leave Walmart Puerto Rico

When you stop working for Walmart Puerto Rico and its related companies, you are entitled to receive a payout of all of your vested accounts in the Plan.

It is important to understand how any type of payout from the Walmart Puerto Rico 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 Walmart Puerto Rico's payroll system. For example, if your termination is entered into and processed by the payroll system on July 20, 2021, you may elect your payout on or after August 19, 2021.

A notice informing you that you are entitled to payment will normally be mailed to your home address or sent electronically, based on your electronic delivery elections, after you leave Walmart Puerto Rico and its related companies. Please make sure that your address is correct on your payroll check when you leave Walmart Puerto Rico or a related company 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, you should 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 Walmart Puerto Rico's payroll system, unless you consent to an earlier payout. In the example above, if your account is eligible for automatic payout and you do not consent to payout on or after August 19, 2021, your payout will automatically be made to you as soon as possible after October 31, 2021, or
- **If you are over age 70, 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 70, unless you consent to an earlier payout as described on the previous page. If you turn age 70 in July 2021 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, 2021, according to Plan provisions. Note that if you do not reach age 70 on or before February 1, 2022, your account will not be distributed to you automatically until after the last business day of the second calendar month following the calendar month in which you turn age 71½, unless you consent to an earlier distribution.

If your total vested Plan balance is more than $1,000, and you are under age 70 (or, if you do not reach age 70 on or before February 1, 2022, age 71½), you must consent to your payout. Payout will be made as soon as possible after your consent is received by the Customer Service Center at **888-968-4015** but no earlier than 30 calendar days after your termination is entered into Walmart Puerto Rico's payroll system.

If you wish, you can choose to delay your payout until any date up to age 70 (or, if you do not reach age 70 on or before February 1, 2022, age 71½) but your Plan balance will be subject to an annual maintenance fee and possibly other expenses. For more 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 Puerto Rico 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 401(k) Account, your Company Funded 401(k) Account, your 401(k) Rollover Account and the Company Match Account will be paid out to you. In addition, if you have a Company Funded Profit Sharing Account (see **Your Walmart Puerto Rico 401(k) Plan accounts** earlier in this summary) you will also be paid the value of the vested portion of your Company Funded Profit Sharing Account. 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** 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 a Puerto Rico IRA or other employer plan which is qualified under Section 1081.01(a) of the Puerto Rico Internal Revenue Code, 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 be distributed in a single lump sum payment directly to you, unless you elect to roll them over to a Puerto Rico IRA or to another employer's retirement plan that is qualified under Section 1081.01(a) of the Puerto Rico Internal Revenue Code.

Your accounts will normally be paid to you in cash. However, you may elect to have your Company Funded Profit Sharing 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. You may also elect to have your 401(k) Account, your Company Funded 401(k) Account and your 401(k) 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 that is 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 70 (or, if you do not reach age 70 on or before February 1, 2022, over age 71½), (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 a Puerto Rico IRA or other Puerto Rico qualified 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 at **888-968-4015** 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 70 (or, if you do not reach age 70 on or before February 1, 2022, until you reach age 71½). To obtain your payout, you should contact the Customer Service Center at **888-968-4015**.

If you leave and are rehired by Walmart Puerto Rico

If you leave Walmart Puerto Rico and its related companies after you become eligible to participate in the Plan and are later rehired by Walmart Puerto Rico as an eligible associate, you will automatically be eligible to participate in the Plan on your rehire date. Similarly, if you leave Walmart Puerto Rico and its related companies after you have met the 1,000-hour requirement but before your actual participation date, you will become a participant on the later of the date you would have initially become a participant or your rehire date. If you were not a participant when you left, or had not satisfied the 1,000-hour requirement, you will be treated as a new associate when you are rehired and will be required to complete the eligibility requirements (see **When participation begins** earlier in this summary) in order to become a participant in the Plan.

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 or less of service. 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 Puerto Rico or a related company 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 Puerto Rico or a related company 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 or terminated participants generally are used to pay Plan expenses and for certain other purposes, such as to restore account balances as discussed above. Any remaining forfeitures will be used to reduce Walmart Puerto Rico's matching contribution.

When you are rehired, your years of service with Walmart Puerto Rico before you left will be counted for purposes of determining your vesting in Walmart Puerto Rico's contributions to your Company Funded Profit Sharing Account.

The income tax consequences of a payout

The tax consequences of your participation in the Walmart Puerto Rico 401(k) Plan (the "Plan") are your responsibility. This explanation is only a brief description of the Puerto Rico tax consequences related to your participation in the Plan. This description is based on current law and current interpretations of the law by the Puerto Rico Department of the Treasury. 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 with respect to your particular situation.

Walmart Puerto Rico is entitled to a deduction on the amount of its contributions, as well as your contributions, to the Plan. Your contributions and Walmart Puerto Rico's contributions to the Plan, as well as earnings on those contributions, generally are not subject to Puerto Rico income taxes until paid to you.

GENERAL TAX RULES

Your contributions and Walmart Puerto Rico's contributions to the Plan are not subject to Puerto Rico income tax until they are distributed to you.

In general, payouts or withdrawals while still working for Walmart Puerto Rico and its related companies will be subject to Puerto Rico income tax as ordinary income.

The Puerto Rico Internal Revenue Code provides favorable tax treatment to payouts in certain circumstances. Specifically, if you receive a total distribution of your account within a single taxable year on account of your separation from service (called a "lump sum distribution"), the taxable portion of the distribution will be generally subject to taxation at the ordinary income tax rates of the Puerto Rico Internal Revenue Code. However, if a 20% Puerto Rico income tax rate is withheld from your payment at the time of the distribution, a preferential Puerto Rico income tax rate of 20% will apply.

Amounts withdrawn due to financial hardship and in-service withdrawals will be subject to a mandatory Puerto Rico income tax withholding of 10%. Likewise, the taxable portion of such distributions will be taxed as ordinary income and will be subject to regular Puerto Rico income tax rates.

If you are not a resident of Puerto Rico at the time you receive a payout, there are special tax consequences for non-residents. You should consult your tax advisor for more information.

POSTPONE PAYING TAXES ON PAYOUTS THROUGH A ROLLOVER

You can postpone paying taxes on all or part of your lump sum distributions if you direct the Plan to issue all or part of your check directly to a Puerto Rico IRA or to another employer's retirement plan qualified under Section 1081.01(a) of the Puerto Rico Internal Revenue Code. This is called a direct rollover. In the case of a direct rollover, the check will be made payable to the Puerto Rico IRA or other plan trustee. If you handle your payout in this manner, no Puerto Rico taxes will be withheld from the amount you are rolling over and such amount will not be taxed until you later receive a payout from the Puerto Rico IRA or other plan. Note that if you choose to roll over only a portion of the lump sum distribution, the taxable portion of the lump sum distribution that you chose not to roll over to another Puerto Rico qualified retirement plan or a Puerto Rico IRA will be subject to a withholding tax at a rate of 20%.

If you do not elect a direct rollover (and instead receive an actual Plan payout), you may still roll over those funds to a Puerto Rico IRA or another Puerto Rico qualified retirement plan, as long as you do so within 60 calendar days after you received the distribution. This is called an indirect rollover. In this case, the check is mailed to you, and you will be responsible for delivering it to the Puerto Rico IRA or other plan trustee within 60 days. Also, because the payout you received was subject to a 20% Puerto Rico income tax withholding, in order to make an indirect rollover of all the amount of the lump sum distribution received (including the 20% Puerto Rico income tax withheld), you must reimburse from other funds (i.e., savings accounts or certificate of deposits) the amount of the 20% Puerto Rico income tax withheld at the time of the distribution. You may claim in your Puerto Rico income tax return a credit against your income taxes for the year the amount was withheld at the time of the distribution.

TAXATION OF PAYOUTS OF WALMART STOCK

There are special rules for distributions of Walmart common stock. You may defer the taxation of a distribution of Walmart stock until the stock is sold. This means that you will not be taxed on the value of the stock at the time it is distributed. The subsequent sale of Walmart common stock will result in a short-term capital gain for the total amount received on the sale, which will be subject to tax at the ordinary tax rates if sold up to one year after the distribution, or at the long term capital gain tax rate (currently 15%) if sold after one year following the distribution. You should also be aware that Puerto Rico IRAs and other qualified plans generally will not accept rollovers of Walmart stock. You should consult your personal tax advisor before electing any distribution in Walmart stock.

TAXATION OF NON-LUMP SUM DISTRIBUTIONS

Distributions from the plan in a form other than a lump-sum distribution on account of separation from service or termination of the Plan are generally taxable as ordinary income. If you receive a partial payment, the payment will be subject to 10% withholding. If you receive your distribution in the form of installment payments (substantially equal periodic payments for a fixed period equal to or that exceed five years), the first $11,000 ($15,000, if you are age 60 or older) that you receive will not be subject to Puerto Rico income taxes. Distributions in the form of installment payments will be subject to withholding at source once they reach $31,000 ($35,000, if you are age 60 or older).

TAXATION OF PAYOUTS TO BENEFICIARIES AND ALTERNATE PAYEES

The tax treatment discussed above also applies to payouts to surviving spouses of deceased participants and also to payouts to spouses and former spouses who are "alternate payees" under Qualified Domestic Relations Orders (QDRO).

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 earlier), your tax statement will show the amount of income to report for the year of the default. The taxable amount is subject to a 10% withholding rate. Withholding, however, is only taken from liquid assets, if any, paid to you during the same year of the deemed distribution. No withholding applies to deemed distributions, as a result of defaulted loans, if no liquid assets are paid to your during the year of the deemed distribution. However, the deemed distribution or defaulted loan will be reported as ordinary income to the Puerto Rico Department of the Treasury.

If at the time of your Termination of Employment, you have an outstanding loan balance that is not paid in full at the time of the distribution, any outstanding loan will become immediately due and payable and thus considered a taxable distribution to you. Thus, at the time of your Plan account distribution, any outstanding balance of the loan could be treated as part of a lump sum distribution, subject to the 20% tax rate.

Filing a Walmart Puerto Rico 401(k) Plan claim

If you think you are entitled to a benefit beyond that processed by the Plan's record keeper (Bank of America), you may file a claim with the Administrator or its delegate at:

Walmart Inc.
Attn: 401(k) Plan Administrator
508 SW 8th Street
Bentonville, Arkansas 72716-0295

For questions about filing a claim, contact Benefits Customer Service 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 of time. 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: 401(k) Plan Administrator
508 SW 8th Street
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 Puerto Rico 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
508 SW 8th Street
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 Puerto Rico 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., Walmart Puerto Rico, the Administrator, the Benefits Investment Committee and the trustee with respect to your retirement benefits.

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 Benefits Division, of Walmart 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 Benefits Division/Administrator
c/o Walmart Inc.
508 SW 8th Street
Bentonville, Arkansas 72716-0295

NAMED INVESTMENT FIDUCIARY

The Benefits Investment Committee is the named investment fiduciary of the Plan. As the named investment fiduciary, 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.
508 SW 8th Street
Bentonville, Arkansas 72716-0295

PLAN TRUSTEE

Banco Popular de Puerto Rico
P.O. Box 362708
San Juan, Puerto Rico 00917

One or more trusts hold all Plan assets, such as contributions by participants and Walmart Puerto Rico's contributions. As trustee of the Trust, Banco Popular 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

004

PLAN YEAR

February 1 through January 31

TYPE OF PLAN

The Walmart Puerto Rico 401(k) Plan is a defined contribution plan (1081.01(d) and profit sharing plan).

ASSIGNMENT

Because this is a retirement plan governed by ERISA and other federal and Puerto Rico 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.

NO PBGC COVERAGE

ERISA created a governmental agency called the Pension Benefit Guaranty Corporation (PBGC). One of the purposes of the PBGC is to provide plan benefit insurance. However, this insurance is available only to defined benefit pension plans and our Plan is a defined contribution plan. Therefore, benefits under the Plan are not insured by the PBGC.

PLAN AMENDMENT OR TERMINATION

Walmart, Inc. 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, Global People Division. 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 Inc. or Walmart Puerto Rico, the Administrator, by any member of the Benefits Investment Committee or by Banco Popular.

You may obtain a copy of the formal Plan document by writing to:

Walmart Inc.
Attn: Benefits Compliance
508 SW 8th Street
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 can recover the mistaken payout from the recipient by either reducing his or her Plan account(s) 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
  508 SW 8th Street
  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

N.W., 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.

PUERTO RICO SPECIAL TAX NOTICE

Prior to receiving a distribution from the Plan that is eligible to be rolled over to a Puerto Rico IRA or employer plan, you will receive a notice explaining the rollover options that you have available when you are eligible for a distribution. 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.

A lump-sum payment from the Plan that is eligible for rollover also known as an "Eligible Rollover Distribution" can be taken in two ways. It can be **paid in a direct rollover** OR it can be **paid to you**. A **direct rollover** of your Plan account may be made to either a Puerto Rico Individual Retirement Account ("PR IRA") or to another employer plan that is qualified under the Puerto Rico Internal Revenue Code (a "PR Plan").

If you choose a direct rollover:

- You choose whether your payment will be made directly to a PR IRA or a PR Plan that accepts your rollover.
- Your payment will not be taxed in Puerto Rico in the year of the DIRECT ROLLOVER, and no Puerto Rico income tax will be withheld.
- Your payment will be subject to Puerto Rico income tax when you take it out of the PR IRA or PR Plan. Depending on the type of PR IRA or PR Plan, the later distribution may be subject to different tax treatment than it would be if you received a taxable distribution from this Plan.

If you choose to have a Plan payment that is an Eligible Rollover Distribution PAID TO YOU:

- You will receive less than the entire amount of your account balance because a certain percentage (typically 20% of the taxable portion of the distribution) must be withheld at the source and sent to the Puerto Rico Department of the Treasury. Any portion of your account balance for which tax was already prepaid as stated under the "Special Rules for Prepayments Made in 2006 and 2014-2015" section below, will be treated as a distribution of an after-tax contribution not subject to taxation or withholding, and no Puerto Rico tax will be withheld.
- Puerto Rico income tax will apply in the year of payment unless you roll it over within 60 days after you receive the payment. Amounts previously subject to a special prepayment of tax during the 2006 or 2014-2015 window period should not be subject to income tax.
- You can roll over all or part of the payment by paying it to a PR IRA or PR Plan that accepts your rollover within 60 days after you receive the payment. The amount rolled over will not be taxed until you take it out of the PR IRA or the PR Plan. You can request a tax refund in your income tax return for any tax withheld from the amount that was **paid to you** and was rolled over to the PR IRA or PR Plan during the 60-day period. Any amount that is not rolled over should be subject to income tax (excluding amounts subject to a special prepayment of tax during the 2006 or 2014-2015 window period).
- If you want to roll over 100% of the payment to a PR IRA or to a PR Plan within 60 days after you receive the payment, you must replace the tax that was withheld from the Eligible Rollover Distribution at the time of the distribution. Therefore, to provide for a complete deferral, you may need to use other money to replace the amount that was withheld. The amounts withheld could be refunded or credited against your tax liability in the year the withholding was made.

Only lump-sum payments due to separation from service, Plan termination, the death of the Participant, or pursuant to a qualified domestic relations order to a Participant, a Beneficiary or an Alternate Payee, will be treated by the Plan as Eligible Rollover Distributions. A lump-sum payment is a payment that can be made in one or more installments of your total Plan account balance within a single calendar year. Separation from service means that your employment with your employer ends due to your termination of employment, death or retirement.

Other (non-lump-sum) payments from the Plan such as in-service withdrawals, deemed distributions that result from defaulted loans, or periodic installments or annuities are taxed under different rules, generally as ordinary income at your income tax rate for the year of distribution and subject to a 10% withholding rate. In cases of periodic installments or annuities, as defined in the Puerto Rico Internal Revenue Code and its regulations, paid after separation from employment, the first $11,000 ($15,000, if you are 60 years of age or older) received during the taxable year are exempt from taxes and the 10% income withholding will not apply to amounts received under $31,000 ($35,000, if you are 60 years of age or older) during the taxable year. In cases of deemed distributions, such as defaulted loans, the 10% withholding is withheld from the liquid assets, if any, paid to you during the same year of the deemed distribution. No withholding applies to deemed distributions, as a result of

defaulted loans, if no liquid assets are paid to your during the year of the deemed distribution. However, the deemed distribution or defaulted loan will be reported as ordinary income to the Puerto Rico Department of the Treasury. Payments made in the form of employer stock are also taxed under different rules, as described below. Consult your tax advisor for more information.

Your distribution may also be subject to U.S. federal income taxation if you are no longer a resident of Puerto Rico at the time you receive a distribution from the Plan. If you are in this situation, you should consult with your tax advisor for more information.

MORE INFORMATION ABOUT ROLLOVERS

How can a rollover affect my taxes? You will be taxed on a payment from the Plan if you do not roll it over. Payments that are Puerto Rico source income will be subject to Puerto Rico income tax. If you do not make a direct rollover from the Plan then withholding will apply, as described below.

Where may I roll over the payment?

Rollover to a PR IRA. You can open an IRA in Puerto Rico to receive the rollover. If you choose to have your payment made directly to a PR IRA, contact a PR IRA sponsor (usually a financial institution) to find out how to have your payment made in a direct rollover to a PR IRA at that institution.

Rollover to another employer's PR Plan. If you are employed by a new employer that has a PR Plan, and you want a direct rollover to that plan, ask the plan administrator of that plan whether it will accept your rollover.

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.

Direct rollover. If you do a direct rollover, the Plan will make the payment directly to your PR IRA or other employer's PR Plan. You should contact the IRA sponsor or the administrator of the PR Plan for information on how to do a direct rollover. You should also be aware that a plan is not legally required to accept a rollover. In addition, if the PR Plan accepts your rollover, the plan may provide restrictions on the circumstances under which you may later receive a distribution of the rollover amount or may require your spouse's consent to any later distribution. Check with the plan administrator of that PR Plan before making your decision.

Eligible rollover paid to you. If you do not do a direct rollover, you may still do a rollover by making a deposit into a PR IRA or another employer's PR Plan that accepts it. If you decide to roll over, you must make the rollover within 60 days after you receive the payment. The amount of the lump-sum payment that is rolled over to a PR IRA or PR Plan will not be taxed in Puerto Rico until you take it out of the PR IRA or PR Plan.

How much may I roll over? Although you can transfer/roll over all or part of the amount actually received, under Puerto Rico law, to have the entire amount of your distribution remain tax-deferred, you must roll over 100% of the Eligible Rollover Distribution, including an amount equal to the amount that was withheld for income taxes. Accordingly, if you do a 60-day rollover you must find other money within the 60-day period to contribute to the PR IRA or the PR Plan to replace the amount that was withheld in order to benefit from a complete tax deferral. Upon a later distribution from the PR IRA or other PR Plan, your distribution will be taxed in accordance with the rules then in effect that are applicable to distributions from PR IRAs or PR Plans.

Example: An Eligible Rollover Distribution of $10,000 is paid to you. Assuming a 20% withholding rate, you will receive $8,000 and $2,000 will be sent to the Puerto Rico Department of the Treasury as income tax withholding. Within 60 days after receiving the $8,000, you may roll over the entire $10,000 to a PR IRA or PR Plan. To do this, you roll over the $8,000 you received from the Plan, and you will have to find $2,000 from other sources (your savings, a loan, etc.). In this case, the entire rollover amount (i.e., $10,000), is not taxed until you take it out of the PR IRA or PR Plan. If you roll over the $10,000, when you file your income tax return you will be credited with the $2,000 withheld and may be entitled to a refund of that amount.

May I roll over after-tax contributions? If you made after-tax contributions to the Plan, these contributions may be rolled over into a PR IRA or to certain employer plans that accept rollovers of after-tax contributions. Your Plan administrator should be able to tell you how much of your payment is the taxable portion and how much is the after-tax portion. If you roll over after-tax contributions, it is your responsibility to keep track of the amount of these after-tax contributions. This will enable the nontaxable amount of any future distributions to be determined.

You can also roll over your after-tax contributions to a nondeductible PR IRA. No penalty or tax is imposed on a distribution from a nondeductible PR IRA if the distribution is made after you turn age 60.

PUERTO RICO INCOME TAX WITHHOLDING

The Plan is required by law to withhold a certain percentage (typically 20%) of the amount paid to you that is subject to Puerto Rico income tax. The amounts withheld are sent to the Puerto Rico Department of the Treasury as income tax withholding. For example, if your Eligible Rollover Distribution consists of $10,000 taxable in Puerto Rico, assuming a 20% withholding rate only $8,000 will be paid to you because the Plan must withhold $2,000 as income tax withholding. However, when you prepare your income tax return for the year, you will report the full $10,000 as a payment from the Plan. You will report

the $2,000 as tax withheld, and it will be credited against any income tax you owe for the year. Lump-sum payments due to your separation from service, if not rolled over, will be considered ordinary income and subject to a special Puerto Rico income tax rate of 20%, if withheld at the time of the distribution (excluding amounts subject to special prepayment of tax during the 2006 or 2014-2015 window period – see "Special Rules for Prepayments Made in 2006 and 2014-2015" below). Therefore, the amounts withheld by your employer will generally satisfy any tax liability regarding the distribution from the Plan.

Special Rules for Prepayments made in 2006 and 2014-2015. Special laws in 2006 and 2014 allowed Plan participants in Puerto Rico to prepay Puerto Rico income tax on any vested taxable funds accumulated in their Plan account at a special 5% tax rate during the period from May 16, 2006 to December 31, 2006 and at a special 8% tax rate during the period from July 1, 2014 to April 30, 2015 (the "window period").

If you took advantage of any of the prepayment options mentioned above, you should keep track of the amount of your Plan balance that was subject to the prepayment. You should present your evidence of prepayment to the Plan Administrator when you request a distribution from the Plan. Any amount of your account balance for which the tax was pre-paid will be treated as a distribution of an after-tax contribution and no Puerto Rico tax will be withheld. The rules described above regarding rollovers of after-tax contributions apply to any portion of your distribution for which the tax was pre-paid. You should contact your tax advisor for more information on this special rule.

SPECIAL RULES AND OPTIONS

If your payment includes employer stock that you do not roll over: There is a special rule for a payment from the Plan that includes employer stock. Under this special rule, withholding will not apply to payments made in the form of employer stock, and you are not required to pay Puerto Rico income tax on the value of the employer stock you receive attributable to services you performed in Puerto Rico until you sell the stock. When you sell the employer stock, special capital gains tax rates may apply depending on the period that you held the employer stock before selling it.

If you have an outstanding loan that is being offset: If you have an outstanding loan from the Plan, your Plan benefit may be reduced/offset by the amount of the loan if the loan is not paid at the time your employment ends. The loan offset amount is treated as a distribution to you at the time of the offset and consequently, will be taxed and taken into account in determining the amount of income taxes to be withheld from the distribution. If you want to do a 60-day rollover of the entire amount, you will need to find other money to replace the taxable portion so that you rollover the full amount of your deferral. Otherwise, you will only get the tax deferral on the portion of the distribution that was rolled over within the 60-day period.

If you are not a Plan participant: If you receive a distribution after the participant's death that you do not roll over, the distribution will generally be taxed in the same manner described elsewhere in this notice.

If you are a surviving spouse or surviving beneficiary: In general, the rules summarized above that apply to payments to employees also apply to payments to surviving spouses of employees and to spouses or former spouses who are "alternate payees." You are an alternate payee if your interest in the Plan results from a qualified domestic relations order, which is an order issued by a court, usually in connection with a divorce or legal separation.

FOR MORE INFORMATION

You may contact the Puerto Rico Department of the Treasury at **http://www.hacienda.gobierno.pr** for more information.

This notice summarizes the Puerto Rico tax rules that might apply to your payment. It is only intended to be a summary. The rules described above are complex and contain many conditions and exceptions that are not included in this notice. In addition, the summary is intended to reflect tax rules as they exist on the date described above. Therefore, you may want to consult with a professional tax adviser before you take a payment of your benefits from the Plan.

For more information

IF YOU HAVE QUESTIONS ABOUT…	GET ANSWERS HERE
When you're eligible for benefits or how to enroll	**One.Walmart.com/Benefits** Call your HR Representative or PR Home Office Benefits Division at **787-653-1065**
Benefits, medical claims or care management	Call the number on your medical plan ID card: **855-830-9887** or **787-945-1348**
Finding a network provider	**mcs.com.pr**
Medical benefits	**855-830-9887** or **787-945-1348** (TTY/TDD **866-627-8182**)
Pharmacy benefits	**mc-21.com** **855-252-2292**
Dental benefits	**deltadentalpr.com** **855-359-6409**
Short-term disability	Multinational: **787-764-1279**
Long-term disability	**One.Walmart.com/LOA > Me > My Time > Disability** Lincoln: **888-778-9251**
Company-paid life insurance Optional associate life insurance Optional dependent life insurance Accidental death and dismemberment (AD&D) insurance Business travel accident insurance	Prudential: **877-294-7026** PR Home Office Benefits Division: **787-653-1065**
Resources for Living®	**One.Walmart.com/RFL** or **rfl.com** **800-825-3555**, available 24/7
Walmart Puerto Rico 401(k) Plan	Bank of America Merrill Lynch: **888-968-4015**
Associate Stock Purchase Plan	**One.Walmart.com/ASPP** or **ComputerShare.com/Walmart** Computershare: **800-438-6278** (**800-952-9245** for the hearing impaired)
For a printed copy of the Spanish language version of the 2022 *Associate Benefits Book*	Call Cenveo at **888-989-7828** and request that a copy be mailed to you (Spanish language version only)

2022 Associate Benefits Book | Summary Plan Descriptions for Puerto Rico Associates